Approved: February 21, 200
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson Representative Kenny Wilk at 9:00 a.m. on February 6, 2002, in Room 514-S of the Capitol.

All members were present except: Representative Doug Spangler, Excused

Committee staff present:
Alan Conroy, Legislative Research
Amy Kramer, Legislative
Becky Krahl, Legislative Research
Audrey Nogle, Legislative Research
Jim Wilson, Revisor of Statutes
Mike Corrigan, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:
Representative Sue Storm
Janet Schalansky, Secretary of SRS
Keith Meyers, Department of Administration
Duncan Friend, Department of Administration

Others attending: See Attached

Representative Sue Storm appeared before the committee and requested the introduction of legislation which would establish an organ donor registry.

Representative Stone moved to introduce into legislation a bill which would establish an organ donor registry. Motion was seconded by Representative Feuerborn. Motion carried.

Representative Wilk moved to introduce into legislation two proposals from the Department of Administration concerning parking regulations on state property and regarding accounts and reports (Attachment 1). Motion was seconded by Representative Campbell. Motion carried.

Janet Schalansky, Secretary of Social Rehabilitation Services, appeared before the Committee and presented an executive summary of the 2002-2003 Business Plan of SRS (Attachment 2).

The Committee expressed concern regarding the proposed elimination for burial assistance in the SRS budget. Possible solutions would be for the counties to assume financial responsibility for the burial expenses, for funeral homes to attempt restitution from the deceased's family, or for the funeral home to absorb the cost of the burial. This would become a public health issue and become the responsibility of KDHE. The Committee requested information on how other states are handling this issue. Another concern of the Committee was the use of Vision cards for certain food purchases and requested information regarding what type of food is allowed and what type of food is disallowed.

Keith Meyers, Department of Administration, introduced Duncan Friend, who educated the Committee on the proposed clearing house for the availability of competitive grants (Attachment 3). He explained that they have conducted a survey which should provide them with the names of those persons, agencies or organizations which are interested in receiving additional information on the availability of this information. The grant writing training program is still in the developmental stages but is expected to be completed by this summer. The Committee encouraged Mr. Friend to have this information available on the state internet site as soon as possible. They requested immediate information for use in their newsletters.

Information on the recent state general fund receipts was distributed by staff (Attachment 4).

The meeting was adjourned at 10:45 a.m. The next meeting is scheduled for Thursday, February 7, 2002.

APPROPRIATIONS COMMITTEE GUEST LIST

DATE: Feb. 6, 2002

NAME	REPRESENTING
Melinda Gaul	DOB
Donna Sheltte	PRATT COUNTY
Linda Weber	Marshall County
Joan Burton	Chase County
Frances Shufflebarger	Jefferson County
Mary Underwood	Jefferson Co
Janice Lyons	Leavenworth Co.
Shaunna Bieberle	Rice County
Patty Jones	Comanche Co.
Crystal Solida	Clark County
Matthew Bergman	Post Hubbell Assoc.
Cheryl Wickersham	SHAWNEE COUNTY
Jack Weiss	Shawnee County
Gloria Auchard	Morris County
Cynthia Linn	Norton County
James A. McClinton	Juvenile Justice Authority
Scott Hecker	Travel Industry Association of Ks.
Diane Duffy	SRS
Trudy Racine	SRS

APPROPRIATIONS COMMITTEE GUEST LIST

DATE:

NAME	REPRESENTING
Angie Reinking	KCSDV Kansas Coalition Against Sexual + Domestic Violence
Joyce Cussiman	Ks Children's Cabinet
Kevin Berens	Main law Firm

STATE OF KANSAS

DEPARTMENT OF ADMINISTRATION
1000 SW Jackson Street
Suite 500
Topeka, Kansas 66612
(785) 296-3011
FAX (785) 296-2702

JOYCE H. GLASSCOCK, *Acting Secretary*

BILL GRAVES, *Governor*

January 29, 2002

Representative Kenny Wilk, Chairperson
House Appropriations Committee
State Capitol, Room 514-S
Topeka, Kansas 66612

Re: Request for Introduction of Legislation

Dear Representative Wilk:

I am writing to request the assistance of the House Appropriations Committee in introducing two Department of Administration legislative proposals. The first would deal with parking enforcement on Capitol Complex lots, not including the Statehouse grounds. The second would eliminate two statutorily required reports regarding Claims Against the State and interest penalties paid or incurred under the Kansas Prompt Payment Act.

The parking enforcement legislation would amend K.S.A. 75-4506 and K.S.A. 75-4508 and repeal existing sections *(lrs1482)*. Currently, tickets issued for violations of parking regulations are issued by the Capitol Police and fines are paid to the District Court. Under this proposal, parking violation fines collected would be deposited in the Buildings and Grounds Fund used to operate and maintain the parking lots. Better enforcement of the lots would allow the Division of Facilities Management to oversell the parking lots at an appropriate level, collect revenue from illegally parked vehicles, and improve services for paying customers. Having the Division of Facilities Management enforce the parking regulations would also allow the Capitol Police to focus its resources on the security needs of the Capitol Complex. The Superintendent of the Highway Patrol, Colonel Don Brownlee, supports this proposal.

Eliminating reporting requirements for Claims Against the State and interest penalties paid or incurred under the Kansas Prompt Payment Act requires amending K.S.A. 46-925 and repealing the existing section, as well as repealing K.S.A. 75-6406. In the first case, the amendment would require this information to be provided upon the

request of any legislator or a legislative committee. Eliminating this reporting requirement for this little used report would free up division resources for more important uses. In the second case, state agencies would be freed from reporting this information that is now easily obtained through use of the central accounting system *(lrs1494)*.

Copies of the two bills are attached. Michael Corrigan and Sherman Parks of the Revisor's Office have been handling the bill drafts for the respective bills. I have asked my Director of Facilities Management, Joe Fritton, and my Deputy Secretary, Keith Meyers, to brief you regarding this proposed legislation. Please let me know if you have questions regarding these proposals or need further information before presenting them to the Committee for introduction. Thank you for your assistance in bringing this legislation to the attention of the Committee.

Sincerely,

Joyce H. Glasscock
Acting Secretary of Administration

Attachments

cc: Keith Meyers
Joe Fritton
Dale Brunton

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Docking State Office Building
915 SW Harrison, 6th Floor North
Topeka, Kansas 66612-1570

for additional information, contact:

Operations
Diane Duffy, Deputy Secretary

Office of Budget
J.G. Scott, Director

Office of Planning and Policy Coordination
Trudy Racine, Director

phone: 785.296.3271 ***fax:*** 785.296.4685

House Appropriations Committee 514-S
February 6, 2002

SRS Overview

Office of the Secretary
Janet Schalansky
(785) 296-3271

HOUSE APPROPRIATIONS
DATE 2/6/02
ATTACHMENT 2

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Appropriations Committee 514-S
February 6, 2002

SRS Overview

Kansas Department of Social and Rehabilitation Services

2002-2003 Business Plan

Executive Summary

January 2002

2-2

SRS Business Plan
2002-2003
Executive Summary

The 2002 Legislative Session presents a time for us to address the budget challenges facing our state while continuing to make plans for the future social service needs of Kansans.

SRS recently revisited our mission statement, created a vision statement, and adopted guiding principles. The mission, vision, and guiding principles, shown in the box below, are the foundation of our agency. We have defined our business, offered a framework for budget reductions, and are making plans for the future based on this foundation.

Our Mission:
To protect children and promote adult self-sufficiency.

Our Vision:
Partnering to connect Kansans with supports and services to improve lives.

Our Way:
1. Act with integrity and respect in our work with customers, partners, and each other.
2. Champion customer success.
3. Demonstrate leadership without regard to position or title; embrace responsibility, take risks, make decisions and act to overcome challenges.
4. Strive for continuous improvement.
5. Demonstrate passion for our mission.
6. Recognize the value of partnerships both within the agency and with community partners to stretch capacity and achieve extraordinary results.

OVERVIEW OF SRS SERVICES AND EXPENDITURES

The next sections provide a high level overview of the services we provide, individuals we serve, and cost trends that influence our expenditures. Following that, we provide information about key decisions the 2002 Legislature will need to make.

SRS is a state leader in all areas related to the social welfare of Kansans. We are looked to for guidance and policy direction. Whether the agency delivers services through in-house resources or through contracting with its allies and partners, SRS remains ultimately responsible.

Since its creation in 1973, SRS has provided services to millions of state citizens. Providing such assistance continues today. As you will see in the summary of assistance, thousands of Kansans gain access to important services such as health care, mental health coverage, food assistance, energy assistance, and child welfare services through SRS each year.

SRS is also a major purchaser of human services. As the following tables shows, SRS FY 2001 expenditures of $1.8 billion provides income and other benefits to thousands of Kansans. In

FY 2001, SRS spent $1.4 billion for direct services on behalf of clients, including $717 million on the purchase of health care services.

Summary of Assistance

The chart below shows the number of consumers/beneficiaries for state Fiscal Years 2000 and 2001 (fiscal year average per month). This is not a complete list of all SRS services.

	SFY 2000	SFY 2001
Child, Adult, and Family Safety and Well-Being Services		
Adoption Contracts	1,397	1,443*
Adoption Subsidy	3,772	4,053*
Foster Care Contracts	3,776	3,661*
Financial and Employment Services		
Child Care	14,524	15,312
Child Support	150,644	154,968
Food Assistance	110,619	117,241
General Assistance	2,220	2,616
Low Income Energy Assistance	26,143	34,850
Rehabilitation Services	7,718	7,033
Temporary Assistance for Families (TAF)	30,692	31,788
TAF Employment Services	6,000	6,762
Health and Medical Services		
State Mental Retardation Hospitals	379	378
Developmental Disability Services	8,307	8,678
Mental Health Services	24,058	21,943
Physical Disability Services	4,310	4,707
State Mental Health Hospitals	479	450
Substance Abuse Treatment and Recovery	13,000	13,500
Health Care Services:		
People Primarily in Managed Care Programs		
--Families	40,000	43,600
--Children	64,700	68,500
--Pregnant Women	5,300	5,300
People Primarily in the Fee-for-Service Program		
--Persons who are Elderly and Disabled	61,140	61,920
--Children in Foster Care, Adoption, or JJA	9,100	9,700
--Persons Provided Partial Health Care Coverage	5,850	6,401
MediKan Fee-for-Service	2,070	2,440
Children's Health Insurance Program	14,792	19,280

*Figures represent persons served per year.

Summary of Expenditures

Annual expenditures in millions for state Fiscal Years 2000 and 2001 (all funds). This is not a complete list of all SRS services.

	SFY 2000	SFY 2001
Child, Adult, and Family Safety and Well-Being Services		
Adoption Contracts	$30.5	$40.3*
Adoption Subsidy	16.0	16.6
Foster Care Contracts	84.4	94.0
Financial and Employment Services		
Child Care	44.2	46.6
Child Support Collections**	146.0	141.9
Food Assistance	81.4	89.2
General Assistance	4.2	4.9
Low Income Energy Assistance	9.3	17.3
Rehabilitation Services	20.0	20.6
Temporary Assistance for Families (TAF)	42.7	44.7
TAF Employment Services	6.9	7.6
Health and Medical Services		
State Mental Retardation Hospitals	46.2	45.6
Developmental Disability Services	215.0	219.3
Mental Health Services	67.9	74.9
Physical Disability Services	58.6	62.8
State Mental Health Hospitals	57.7	57.4
Substance Abuse Treatment and Recovery	14.6	14.9
Health Care Services		
People Primarily in Managed Care Programs		
--Families	67.8	75.8
--Children	92.5	103.2
--Pregnant Women	36.1	33.9
People Primarily in the Fee-for-Service Program		
--Persons who are Elderly and Disabled	359.6	403.1
--Children in Foster Care, Adoption, or JJA	19.8	24.3
--Persons Provided Partial Health Care Coverage	10.1	13.4
MediKan Fee-for-Service	8.6	12.5
Children's Health Insurance Program	24.5	28.8

*SFY 2001 total includes one-time payments to contractors to stabilize the system.
**This line-item is not an expenditure, but total SRS child support collected on behalf of families.

Social service expenditures and the purchases made with these funds have a significant economic impact across our state. The following chart shows the amount of expenditures made in FY 2001 in ten Kansas counties:

SRS Assistance Expenditures: Top 5 Counties		SRS Assistance Expenditures: Bottom 5 Counties	
Sedgwick	$278,371,350	Logan	$1,076,791
Wyandotte	132,029,762	Stanton	904,102
Shawnee	115,329,794	Sheridan	874,301
Johnson	114,823,945	Wallace	816,339
Douglas	44,187,663	Greeley	702,203

EXPENDITURE TRENDS AND COST DRIVERS

Over the years, the nature of SRS expenditures has changed dramatically, as cash assistance rolls have declined and the agency has become the third largest provider of health insurance in the state. Community leaders and others are often surprised to discover that the majority of SRS expenditures are not directed at individuals receiving cash assistance, but rather to local physicians, hospitals, pharmacists, and others who provide a wide range of services for the elderly, disabled individuals, and working families. For example, in FY 2001, almost $65 million was spent on pharmacy costs for elderly recipients of Medicaid.

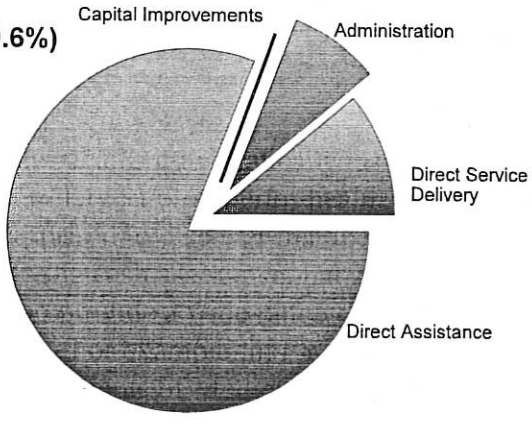
SRS Expenditures by Category

FY 2003 Budget - GBR (in Millions)

Direct Service Delivery	**$234.3 (11.3%)**
Administration	**$163.0 (7.9%)**
Capital Improvements	**$4.2 (.20%)**
Direct Assistance	**$1,665.3 (80.6%)**
Cash Assistance	$57.9
Child Care & Employment	$59.4
Medical Assistance	$909.9
Substance Abuse	$23.0
Mental Health	$66.2
Developmental & Physical Disability	$302.0
Children & Family	$192.9
Rehabilitation Services	$21.9
Other	$32.1

Total $2,066.8

Totals may not add due to rounding



In keeping with its role as the social service safety net, the vast majority of SRS expenditures are made to, or on behalf of, persons with very low incomes. As the following chart shows, the annual income guidelines for programs range from 34% of the federal poverty level to 200%, with cash assistance programs the lowest and the Children's Health Insurance Program (HealthWave) the highest. In comparison, according to the U.S. Department of Labor's Bureau of Economic Analysis, the state's average per capita income was $27,408 in the year 2000.

Poverty Guidelines

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

Selected SRS Services	% of 2001 FPL*	HH-1	HH-2	HH-3	HH-4	HH-5
TAF and GA-Cash & Medical	34%	$2,921	$3,947	$4,974	$6,001	$7,028
Elderly/Disabled Persons on SSI-Medical	74%	6,357	8,591	10,826	13,061	15,296
Children 6-18 Medicaid and Medicaid Waivers	100%	8,590	11,610	14,630	17,650	20,670
Food Assistance and Energy Assistance	130%	11,167	15,093	19,019	22,945	26,871
Children Age 1-5 - Medicaid	133%	11,424	15,441	19,457	23,474	27,491
Pregnant Women & Infants - Medicaid	150%	12,885	17,415	21,945	26,475	31,005
Child Care Subsidy	185%	15,892	21,479	27,066	32,653	38,240
Children's Health Insurance Program	200%	17,180	23,221	29,260	35,300	41,340

*FPL is the Federal Poverty Level

Cash benefit amounts are also well within federal poverty levels. For example, a family of three receives an average of $400 a month in Temporary Assistance for Needy Families. Single, disabled individuals who are eligible for General Assistance receive an average benefit of $160.

Caseload Expenditure Trends

The SRS budget has grown by an average of nine percent over the past five years. The primary cost drivers of that growth were increases in medical expenditures and increasing social service caseloads. Caseload expenditures account for approximately 80 percent of the department's budget. Increasing caseloads at SRS and the Department on Aging account for significant growth in the state's budget.

The term "caseload estimates" is somewhat misleading. Although people sometimes assume that "caseloads" refer only to the number of people receiving services, the expenditures for a particular population are determined by both the number of persons served and the cost of serving clients, and caseload estimates take both into account.

As the box on the right indicates, consensus caseload estimates are made for six SRS programs that provide cash assistance, medical assistance, and childrens' services.

As the following table shows, the Department's expenditures across all major caseload groups are expected to increase by more than $246.8 million, or 20 percent, from Fiscal Year 2001 to 2003. The factors underlying that increase vary by population, but the overall increase of 20 percent is in major part a manifestation of the current economic climate. Some caseloads are very sensitive to labor conditions.

SRS Programs Included in the Consensus Caseload Process

For certain caseloads, Kansas has established a *Caseload Consensus Estimation Process*, in which members of SRS, the Department on Aging, the Division of the Budget, and the Legislative Research Department join to forge an agreement on the expected changes in caseloads.

Not all SRS caseload expenditures are included in the consensus process. Many programs are not included such as the waiver programs, family preservation, and child care subsidy. There are six populations that are included in the caseload consensus process:

- ☐ Temporary Assistance for Families
- ☐ General Assistance
- ☐ Nursing Facilities for the Mentally Ill
- ☐ Regular Medical Assistance
- ☐ Foster Care Contract
- ☐ Adoption Contract

The Temporary Assistance for Families caseload is composed of families with intermittent work histories, so it rises with increases in unemployment. Cash benefits in Kansas have remained fixed since 1993. Therefore, recent growth in expenditures for Temporary Assistance for Families and General Assistance is due to an increase in the number of persons served. Projected increases for FY 2002 and 2003 for these groups are based on the slowing economy and the resulting tightening of the labor market.

The family populations within Health Care also respond to changes in the labor market. Most of the growth in persons receiving medical services comes from low income children and families on cash assistance; however, these groups are relatively inexpensive to serve.

SRS Expenditures for Major Caseload Categories Governor's "Existing Resource" Budget (In Millions)				FY 2001-2003 Change	
Population	**FY 2001 Actual**	**FY 2002 GBR**	**FY 2003 GBR**	**Amount**	**%**
Financial Assistance					
Temp Assist/Families	$44.7	$49.0	$52.5	$7.8	18
General Assistance*	4.9	5.8	5.4	0.5	10
Child Care Assistance	46.6	52.4	59.4	12.8	27
Health Care					
Regular Medical Assistance*	687.3	790.5	862.6	175.3	26
HealthWave	28.8	42.1	47.3	18.5	64
Mental Health & Services for Persons with Disabilities					
NF - Mental Health*	13.5	13.7	12.7	(0.8)	(6)
ICF-MR	23.8	27.2	26.3	2.5	11
MR-DD Waiver**	175.6	196.6	198.8	23.2	13
Physically Disabled	57.6	61.3	58.4	0.8	1
Head Injured Waiver	3.6	7.5	7.5	3.9	108
Child Welfare					
Foster Care Contract	94.0	97.0	99.0	5.0	5
Adoption Contract	40.3	32.0	35.0	(5.3)	(13)
Adoption Support	16.6	17.2	17.9	1.3	8
Vocational Rehabilitation					
Rehabilitation Services	20.6	21.5	21.9	1.3	6
Total	$1,257.9	$1,413.8	$1,507.7	$246.8	20%

*The amount shown includes consensus caseload estimates less policy recommended by the Governor.

**Federal funds of $6.5 million in FY 2002 and $11.0 million in FY 2003 will be moved from the DD Waiver to DD Administration Grants in a technical adjustment.

The elderly and disabled populations have the highest demand for services, with greater costs. The number of elderly and disabled seeking assistance does not respond as directly to economic changes; however, the more marginally employed among the disabled populations are more likely to seek services during economic downturns. Recent and projected expenditure increases for the elderly and disabled are due primarily to the increased utilization of services, such as home health care, that enable these consumers to remain in their homes and communities. Although this trend increases general medical expenditures within SRS, it also appears to reduce growth in the adult care home population served by the Department on Aging. The pricing, or cost of services for this population also has a significant effect on caseload expenditures.

One of the largest cost drivers for medical assistance is the cost of prescription drugs. The cost of prescriptions made up 27.5 percent of Medicaid expenditures in FY 2001, and is approaching $200 million annually.

The number of children in the foster care caseload is expected to decline slightly over the next several years, while expenditures will continue to increase slightly because of reimbursement changes and enhanced provision of mental health services for this population. For the adoption caseload, a projected increase in the number of children served is expected, which will also contribute to increased expenditures.

A detailed explanation of the consensus caseload estimating process and the factors that influence expenditure trends in all six SRS program areas is included in the Executive Summary as Attachment 2 of the 2002-2003 Business Plan. In addition, a more thorough discussion of trends and issues concerning the Medicaid program is provided in the Issue section of Health Care Policy titled The Medicaid Program.

BUDGET DEVELOPMENT PROCESS

Agency Initiatives

As we ended the 2001 Legislative Session and began to prepare our budget submission for FY 2003, we already had serious concerns about our FY 2002 budget. Budgeted growth for FY 2002 was about four percent, compared to the last five year average of nine percent, and estimated funding were approximately $123 million short of estimated funding needs to provide basic services at the current level (without fully funding the anticipated needs). In response, we developed plans to change the way we do business so that the agency could live within the reality of state budget constraints.

During this process, we considered input received from consumers, advocates, business partners, staff, and legislators. This included information we received during our statewide listening tour and business meetings held in the spring of 2001, as well as information we received at various advisory committees and other public meetings held throughout the year.

Shared responsibilities. Responsibility for meeting the social service needs of Kansans is shared: with our partners and other state agencies, between SRS programs and offices, and among state, federal, and local units of government. We also encourage consumers' responsibility to meet a portion of their own needs by relying on local and natural supports.

Transitional services. Emphasis should be placed on services that are temporary instead of services that create long-term dependency.

Alignment with Mission and Vision. Services and programs that are critical to the agency's mission and vision should be preserved.

Protecting the most vulnerable. The highest priority should be placed on the basic social service safety net of services that protect the most vulnerable Kansans' health, safety, and well-being.

We informed legislators of our progress by letter in August and October. As we said then, many of the changes we implemented or proposed required reducing, modifying, or eliminating services. Developing those plans, and this budget, was extremely difficult, because all of our programs and services are important to the people we serve. In developing those plans, we kept several main points in mind, as explained in the accompanying box:

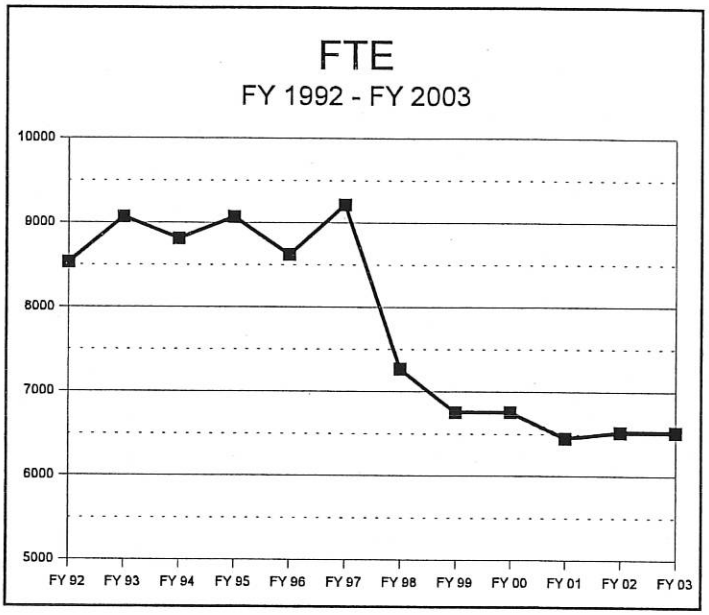
- shared responsibility,
- transitional services,
- alignment with mission and vision, and
- protecting the most vulnerable.

We also attempted to control program growth by refining service priorities and accommodated limited funding increases in critical areas where they were necessary to avoid undermining program integrity or put consumers at greater risk.

At that time, SRS identified several significant policy changes to reduce expenditures to meet the allocated resource estimate. We also made additional informal changes to slow down cost increases in the Medicaid program. Governor Graves has adopted almost all of those SRS proposals in his "existing resources" budget. Unless directed otherwise by the Legislature, we plan to proceed with these changes.

We did not make significant additional cuts in our operating/administrative budget. Efforts to be more efficient and economical have resulted in significant changes over the past few years. As the chart on the following page shows, FTE has been reduced from 9,000 to 6,000 since FY 1992. Although this reduction was due in large part to privatization, transfers to other agencies, and hospital closures, we have also reduced 326 positions in the field, central office and institutions over the past two years. The remaining staff primarily provide direct services to clients. The current financial situation necessitates holding additional positions open to live within our budget, but we can already see the effect this is having on our service delivery. At this

point, we believe it would be difficult to reduce administrative expenditures any more without significantly affecting the Department's ability to serve clients.



We are currently in the process of redistributing field staff between area offices to align staffing more closely with caseload numbers. This process follows several years of a consultant-led study, during which we have developed standard caseload monitoring tools and put them into place statewide. This is requiring a limited layoff process in some areas of the State.

The Department's October 1, 2001 budget submission required additional revenue in order to maintain the same level of services. Additional State General Fund needs amounted to $31 million for the current year and $61 million for FY 2003 above the FY 2002 Legislative approved level, in order to fund a base budget of stable service delivery. Those additional amounts did not include any spending or increased investments to reduce waiting lists, serve additional populations, or meet increasing needs of existing populations.

Governor's Budget Recommendation

Although times were difficult when we prepared the Department's budget last fall, the current situation is clearly worse. While state revenues are decreasing, caseloads are continuing to creep up because of deterioration in the economy. Compared to when we submitted our budget, social service caseloads are up by $3.5 million AF in FY 2002 and an additional $41.6 million AF in FY 2003. After three years of moderated increases in expenditures, growth in Medical Assistance is back in double digits. Increased service utilization by the elderly and disabled population continues to drive costs upward, despite stability in reimbursement rates and the number enrolled. In addition, increased numbers of low-income families and children are applying for services.

In developing his "existing resources" budget, the Governor added resources to cover projected consensus caseload estimates and ensure that vital services are maintained. He also included most of the possible cuts the agency had identified earlier, such as closing or combining units at Parsons, Osawatomie, and Larned State Hospitals, limiting eligibility for General Assistance and

MediKan to 24 months, and reducing payments to workers hired to help disabled adults live in their own homes.

He avoided more drastic cuts, such as eliminating the purchase of wheelchairs, ventilators or oxygen for disabled adults, eliminating the General Assistance and MediKan programs, and not allowing disabled adults to keep more than $475 a month from their Social Security checks. However, he did not make enhancements to reflect the current rate of growth in expenditures.

In his enhanced resources budget, the Governor restored funding for family preservation, developmental disability and mental health grants, and the funeral assistance program. He also included targeted enhancements in funding to reduce waiting lists and increase Medicaid rates. The attached Schedules to this Executive Summary, lists the specific items included in each level of the Governor's budget.

ADDITIONAL ITEMS FOR CONSIDERATION

In addition to the budget, the following items may be of interest.

Federal Legislation and Funding Levels

Over one billion dollars, or 59 percent of SRS funding comes from federal sources, and changes have been proposed in several of those sources. National organizations and federal officials speculate that the Social Services Block Grant (SSBG) may continue to be significantly reduced by Congress. The Temporary Assistance for Needy Families Block Grant (TANF) and Food Stamp program are both up for reauthorization. In addition, funding changes will affect the amount of Medicaid Disproportionate Share funding available for state hospitals; changes are also proposed in the Child Support Enforcement Program. State Children's Health Insurance Program (SCHIP) legislation has been passed that will have an impact on that program as well. Those changes are explained more fully in the appropriate sections of the Business Plan.

Legislative Proposals

The Department is requesting introduction of the following legislative proposals, including several that are needed to fund the Governor's Budget Recommendation.

- *Estate Recovery.* Three proposals in this area are designed to strengthen the language in current statutes to help simplify the process for recovering public-paid medical expenses from a recipient's estate. They include access to records from financial institutions relating to deposits, withdrawals, or interest accruals; imposing a lien on real property of a medical assistance recipient; and assistance and recoupment of funeral refunds.

Projected savings from these proposals are included in the Governor's Budget Recommendation.

- *Medicaid Pharmacy Program Management.* These statutory changes would allow SRS to use additional tools to manage continually increasing drug costs. These tools would ensure the appropriate use of drugs and allow for exceptions when the physician/prescriber designates that the prescription must be dispensed as written.

- *Access to Criminal History Information.* These proposed changes would add the State Security Hospital to the definition of criminal justice agency to allow access to the KBI's criminal history record information and would allow access to the federal National Crime Information Center records.

- *Adding to List of Unclassified Service.* This would permit the Secretary to add designated types of medical professionals to the list of unclassified positions, to allow for easier recruitment of essential staff in our state hospitals.

- *Commitment of Sexually Violent Persons.* This proposal would allow certain extremely ill or physically or mentally incapacitated persons to be considered for transfer out of the sexual predator treatment program at the Larned State Hospital.

- *Parental Financial Participation.* These proposed changes would authorize SRS to establish and collect fees from parents or other legally responsible individuals for services the Department provides to their children.

Continuing to Move Forward

We have continued to move forward with new initiatives where we can, even though some of those initiatives may be slowed a bit to accommodate funding realities. This includes such efforts as Leadership SRS, continuing to integrate our information systems, a long list of intraagency and interagency development efforts, and extensive program development work with our business partners in all areas. Continuing to move forward with some positive developments seems even more important in these difficult times. Key examples include:

- Implementation of Working Healthy, the Medicaid buy-in program for persons with disabilities
- Blending HealthWave and Medicaid into a single health insurance program
- Retaining accreditation for the state hospitals, which comprise an important part of the state's social service safety net for the MH and DD populations
- Continuing to implement Mental Health Initiative 2000
- Planning for similar initiatives in funding and service delivery systems for the

Developmentally Disabled

- Affirming, through the Children and Family Services Review, that the innovations we have made in our child welfare system have arrived at a stable point
- Streamlining the application process for Food Assistance, which enables people to access this 100% federally funded program more easily
- Working with our peers and partners to positively influence the upcoming reauthorization of the welfare reform, food assistance, and child welfare programs at the federal level
- Placing increased emphasis on the 12,000 Kansans who remain on cash assistance because they need extensive services and supports

Conclusion

The 2002 Kansas Legislature has difficult decisions to make. Legislators will bring to those decisions their own understandings of some fundamental questions about social services: Where do we want the safety net? Who should be served, and what expectations should accompany those services? What is society's obligation to assist and protect its vulnerable members? What do their constituents want the state to provide?

Those decisions will be implemented, not made, by the executive branch. In this document, we have attempted to include the information legislators need to make sound, well-informed decisions on behalf of all Kansans. We stand ready to provide any additional information or analysis that may be required during that process.

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Schedule 1

Department of Social and Rehabilitation Services
Summary of Additions in the
Governor's "Existing Resources" Budget

Description	FY 02 (millions)		FY 03 (millions)	
	SGF	AF	SGF	AF
Consensus Caseload - Regular Medical Assistance	$20.4	$71.0	$39.0	$95.0
Consensus Caseload - Nursing Facilities for Mental Health	1.4	1.8	0.5	0.7
Consensus Caseload - Temporary Assistance for Families	0.0	3.0	0.0	3.5
Consensus Caseload - General Assistance	1.0	1.0	0.8	0.8
Consensus Caseload - Foster Care	9.7	6.3	1.4	2.0
Consensus Caseload - Adoption	1.8	5.0	1.9	3.0
Kansas Payment Center contract	0.7	1.7	1.1	2.4
Robert Wood Johnson Grant Business Health Partnership	0.0	0.2	-0-	-0-
State employee health insurance	-0-	-0-	2.9	3.2
SED waiver	-0-	-0-	0.0	0.7
Sexual Predator Treatment Program census increase	0.8	0.8	1.0	1.0
HealthWave Caseload	2.6	9.2	4.1	14.3
Child Care caseload and rate increase	-0-	-0-	(0.4)	4.0
Intermediate Care Facilities for Mental Retardation	1.2	2.7	0.7	1.8
Transfer PD Waiver funds to offset a portion of the cost of Working Healthy ($0.8 million AF, $0.3 million SGF)	-0-	-0-	0.0	0.0
Reduce Grants Provided to Enhance Quality and Expand Availability of Child Care ($3.0 AF, $0 SGF shifted to child care subsidy)	-0-	-0-	0.0	0.0

Schedule 2

Department of Social and Rehabilitation Services
Summary of Key Targeted Program Eliminations, Reductions and Revenue Enhancements - Governor's "Existing Resources" Budget

Description	FY 02 (millions)		FY 03 (millions)	
	SGF	AF	SGF	AF
Targeted reductions and eliminations				
Eliminate the funeral assistance program	($0.1)	($0.1)	($0.7)	($0.7)
Limit length of General Assistance and MediKan to 24 months	-0-	-0-	(4.3)	(4.3)
Reduce Child Care caseload projections	(0.2)	(0.8)	-0-	-0-
Limit spending by targeting family preservation and family services to the most at-risk families	(7.1)	(8.1)	(8.5)	(9.5)
Limit payments for persons in Nursing Facilities for Mental Health to persons with a severe and persistent mental illness	(0.6)	(0.8)	(1.8)	(2.5)
State MR Hospital Reductions	-0-	-0-	(0.5)	(1.4)
Reduce census at Osawatomie and Larned State Hospitals and close units	-0-	-0-	(0.8)	(2.7)
Increase shrinkage at the State Hospitals	-0-	-0-	(1.2)	(1.4)
Reduce school budget at Larned State Hospital	-0-	-0-	(0.2)	(0.2)
Reduce payments to outside medical providers by Larned State Hospital and Osawatomie State Hospital	(0.1)	(0.2)	(0.1)	(0.1)
Eliminate transfer to the Kansas Department of Health & Environment for teen pregnancy program evaluation	-0-	-0-	0.0	(0.2)
Explore new ways to serve elderly blind and visually impaired Kansans in their communities rather than through Topeka-based group and residential programming	(0.01)	(0.03)	(0.01)	(0.03)
Reduce developmental disability community support grants	-0-	-0-	(1.5)	(1.5)
Reduce community mental health center flexible community support grants	-0-	-0-	(3.1)	(3.1)
Discontinue three child welfare projects through Kansas Legal Services	(0.2)	(0.4)	(0.4)	(0.5)
Do not spend new funding for Substance Abuse Treatment medications	0.0	(0.3)	0.0	(0.3)
Reduce attendant care wages on the PD waiver	(0.7)	(1.8)	(0.6)	(1.6)
Reduce administrative expenditures	(0.6)	(5.2)	(0.9)	(7.2)

Schedule 2 continued

Description	FY 02 (millions)		FY 03 (millions)	
	SGF	AF	SGF	AF
Shared responsibility				
Require parents to contribute to the cost of providing support through the HCBS waivers or other community based services for their minor children	-0-	-0-	(1.2)	0.0
Require family financial participation for families accessing preservation services	-0-	-0-	(0.5)	(0.5)
Start pilot project to collect support payments from parents of children in SRS or Juvenile Justice custody	-0-	-0-	(0.8)	0.0
Limit the growth in medical expenditures				
Pharmacy changes – decrease pharmacy dispensing fee	-0-	-0-	(0.7)	(1.8)
Pharmacy changes – change prescription ingredient cost calculation	-0-	-0-	(1.3)	(3.2)
Pharmacy changes – begin a voluntary, preferred formulary	-0-	-0-	(0.4)	(1.0)
Pharmacy changes – increase co-pay for pharmaceuticals	-0-	-0-	(1.3)	(3.3)
Improve administration and management of Home Health services	-0-	-0-	(4.7)	(11.9)
Eliminate enhanced transportation for those on PD and FE waivers and non-emergency medical transportation	(0.3)	(0.7)	(0.5)	(1.2)
Limit terminally ill patients to services provided through the PD waiver	-0-	-0-	(0.2)	(0.4)
Improve billing practices for therapy services	-0-	-0-	(0.1)	(0.3)
Substantially reduce payments to Community Mental Health Centers (CMHCs) and psychologists for services to persons living in nursing facilities for mental health.	-0-	-0-	(1.3)	(1.3)
Reduce Mental Health reimbursement rates provided through MediKan	-0-	-0-	(1.8)	(1.8)
Revenue Enhancements				
Maximize SGF appropriated to the Office of Judicial Administration and reduce SRS SGF for Child Support Enforcement	-0-	-0-	0.1	0.1
Maximize use of federal funds through DD services	0.0	6.5	0.0	11.0
Increase collections from the Estate Recovery Program	-0-	-0-	0.1	-0-
Decrease SGF and increase IGT funding for the DD waiver	-0-	-0-	(19.5)	0.0
Disproportionate Share for State Mental Health Hospitals	-0-	-0-	0.0	10.0

Schedule 3

Department of Social and Rehabilitation Services
Summary of FY 03 Reductions Not Included the Governor's "Existing Resources" Budget

Description	FY 03 (millions)	
	SGF	AF
Elimination of the General Assistance Program	($4.2)	($6.1)
Elimination of the MediKan Program	(8.1)	(11.3)
Increase Child Support Enforcement Non-TAF fees from 4% to 6%	(0.01)	0.0
Reduce Waiver Protected Income Level Eligibility	(0.9)	(2.2)
Increase HealthWave Premiums	(0.5)	0.0
Eliminate Durable Medical Equipment for Adults	(2.8)	(7.0)
Eliminate Vision Services for Adults	(0.5)	(1.1)
Eliminate Dental Services for Adults	(0.5)	(1.3)
Eliminate Audiology Services for Adults	(0.2)	(0.4)
Reduce Eligibility for HealthWave from 200% to 150% of Federal Poverty	(2.5)	(11.7)

Schedule 4

Department of Social and Rehabilitation Services
Summary of FY 03 Enhancements Not Included the Governor's "Existing Resources" Budget

Description	FY 03 (millions)	
	SGF	AF
Increase access to Family Preservation services	$6.5	$6.6
Restore cuts in Family Services	2.0	2.9
Increase access to HCBS for persons with Developmental Disabilities	3.0	7.5
Increase access to HCBS for persons with Physical Disabilities	2.0	5.0
Enhance local substance abuse and domestic violence services	0.9	0.9
Enhance Temporary Assistance for Families Work Supports	2.8	2.8
Increase access to Child Care assistance	2.5	2.5
Enhance substance abuse treatment for at-risk families	1.0	1.0
Restore substance abuse treatment medication funding	0.2	0.2
Increase reimbursement rates for physicians	7.2	18.0
Create a new HCBS waiver for children with autism	0.9	0.9
Enhance dental services for adults	6.4	16.0
Expand Early Head Start	1.8	1.8
Establish SRS Community Response Funds	0.5	0.5
Increase salaries for direct care staff at state hospitals	3.0	3.0
Increase funding for outside medical costs in the state hospitals	0.7	0.7
Increase funding for drug costs in the state hospitals	0.2	0.2
Increase SGF to cover the remaining shortfall of Title XIX funds in the state hospitals	2.3	2.3

Schedule 5

Department of Social and Rehabilitation Services
Summary of FY 03 Governor's Targeted Restorations And Enhancements
Above the "Existing Resources" Budget

Description	FY 03 (millions)	
	SGF	AF
Restorations		
Family Preservation	$2.0	$2.1
Developmental Disability Grants	1.5	1.5
Mental Health Grants	3.0	3.0
Funeral Assistance	0.5	0.5
Targeted Enhancements		
Waiting Lists	5.0	12.5
Medicaid Rates	5.0	12.5
State Employee Salary Increase (2%)	1.5	3.1

Definitions

Governor's "Existing Resources" Budget – the budget presented by the Governor as required by Kansas law, that stays within existing revenue projections and leaves a 7.5 percent ending balance in the State General Fund.

Consensus Caseload Estimates – estimates made by the Consensus Caseload Estimating Group that consists of Division of the Budget, Kansas Department of Legislative Research, Kansas Department on Aging, and Social and Rehabilitation Services. Estimates are made in the Spring and Fall of each year for Regular Medical Assistance, Nursing Facilities for Mental Health (NFs/MH), Temporary Assistance for Families (TAF), General Assistance (GA), Foster Care, Adoption, and Nursing Facilities (NF).

HCBS Waivers – Home and Community Based Service Waivers - services for persons with physical disabilities (PD), developmental disabilities (DD), head injuries (HI), children with a serious emotional disturbance (SED) and children who need technological assistance (TA) to remain in the community.

Title XIX Funds – federal Medicaid funds received by the State Hospitals for Medicaid eligible clients.

SGF – State General Funds – all revenues coming into the state treasury not specifically authorized by statute or the constitution to be placed in a separate fund.

AF – All Funds – total of all funding sources.

Governor's Targeted Restorations and Enhancements – essential services that require new revenue.

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

January 28, 2002

Representative Kenny Wilk, Chair
House Committee on Appropriations
Room 514-S, Capitol Building
Topeka, Kansas 66612

Dear Representative Wilk:

This report has been provided to the Kansas Legislature as required by Senate Substitute for House Bill 2067. This bill required the Department to report on plans to maximize federal financial participation and on the results of community capacity building plans.

I am providing a copy of this report to you and members of the House Committee on Appropriations as I thought it might be of interest to you.

Please let me know if you have questions regarding the report.

Sincerely,

Janet Schalansky

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

cc: Members of the House Committee on Appropriations

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

January 28, 2002

Pat Saville, Secretary
Kansas Senate
Room 360-E, Capitol Building
Topeka, Kansas 66612

Janet Jones, Chief Clerk
Kansas House of Representatives
Room 477-W, Capitol Building
Topeka, Kansas 66612

Dear Secretary Saville and Chief Clerk Jones:

This report is being provided to the Kansas Legislature as required by Senate Substitute for House Bill 2067. This bill requires the Department to report on plans to maximize federal financial participation and on the results of community capacity building plans.

Please let me know if you have questions regarding the report.

Sincerely,

Janet Schalansky

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

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Report to Legislature

Plans for Maximizing Federal Financial Participation and Community Capacity Building Plans

Health Care Policy
Laura Howard, Assistant Secretary

2-25

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Report to Legislature
PLANS FOR MAXIMIZING FEDERAL FINANCIAL PARTICIPATION AND COMMUNITY CAPACITY BUILDING PLANS

During the 2001 Kansas Legislature, considerable discussion occurred on work force challenges and rates paid for developmental disabilities services. SRS rate studies and those of private providers showed shortfalls in meeting competitive salaries for direct service workers. To address part of the work force issues, the legislature passed HB 2067, an amendment to the 1995 Developmental Disabilities Reform Act. In part, this amendment requires the Secretary of SRS:

1) To ensure annually the maximum feasible use of available state and local taxing subdivision (county) funds as match or certified match for federal Medicaid funds. Revenue derived from maximization shall be applied to increase HCBS waiver rates for persons with developmental disabilities (MRDD waiver) or upon agreement with the community developmental disability organizations (CDDOs), for other Medicaid reimbursable services.

2) To require Councils of Community Members (CCMs) within CDDOs to annually develop and implement community capacity building plans to improve the quality and efficiency of service delivery. The capacity building plans shall:

- Identify strengths within the local service area, including natural and community supports;
- Identify barriers to meeting the independence, productivity, integration and inclusion goals of the developmental disabilities reform act; and

3)Report to the 2002 Legislature and each subsequent Legislature on the results of plans to maximize federal financial participation and on the results of community capacity building plans.

Financing in the Developmental Disabilities System

A key mandate in H.B. 2067 is a requirement that the Secretary assure annually that federal financial participation is maximized in the developmental disabilities system. Even prior to the implementation efforts summarized in this report, the developmental disabilities system in Kansas has relied substantially on federal Medicaid funds. Making maximum use of federal Medicaid funds was a key premise in the establishment and expansion of the Home and Community Based Services (HCBS)

Medicaid waiver for persons with developmental disabilities. In fact, prior to current maximization efforts:

- 83% of state general fund and country funds dedicated to developmental disability services were matched with federal funds;

- Only $18.4 million out of $105.8 million in state general and county funds are unmatched by federal Medicaid dollars, for total system funding of $240.3 million

Persons with developmental disabilities are supported in the community from Medicaid funding, from state only funding, and from local county funds:

- As of December 31, 2001, 8,766 Kansans with developmental disabilities received community-based services

- 68.5% of these Kansans were funded through the HCBS MRDD Medicaid waiver;

- 26% of these Kansans received services funded only with state general fund dollars (SGF); and

- 5.5% of these Kansans are supported by other funding sources.

Although the maximization efforts undertaken in accordance with H.B. 2067, did not generate increases in revenue of a magnitude to fully fill the direct care salary gaps identified in the rate studies, additional federal funds have been generated for investment in the developmental disabilities system. Specifically:

- The amount of unmatched state and county funds is reduced from $18.4 million to $8.7 million in the first phase of maximization -- leaving virtually no state funds and only limited county funding unmatched;

- Additional federal funds of $6.8 million are generated in these maximization efforts in FY 2002 for distribution to community service providers;

- A second phase of maximization will increase reimbursement rates for the HCBS-DD waiver in urban high cost areas, using local county funds as match for new federal funds– this second phase will reduce even further the level of unmatched funds in the system;

The remaining pages of this report provide additional detail on the rules surrounding federal financial participation, the collaborative process to implement H.B. 2067, the system impacts of certain maximization choices, summarize the federal rules that must be followed in claiming Medicaid funds, detail the FY 2002 maximization efforts and future plans, and summarize issues related to community capacity building.

MAXIMIZING FEDERAL FINANCIAL PARTICIPATION

The Rules of Federal Financial Participation (FFP)

The goal of HB 2067, the 2001 Amendment to the DD Reform Act, is to match Federal Financial Participation (FFP) to the greatest extent feasible for use in addressing work force issues impacting on the capacity of the DD service system to delivery quality services.

State policy and federal funding rules dictate the extent to which state and local funds can be matched with FFP. The Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, is the federal agency responsible for financial and programmatic oversight of the Medicaid program. Federal laws and regulations govern what can be matched, and how match can be certified:

- Medicaid authorizes the state match of 40% to be provided by either "hard" cash match from the state or by a certified match of either state or local funds.

- Funds can only be certified by public agencies. At the local level, the CDDO, as a quasi-governmental agency, is the only entity that can certify match for Medicaid services.

- The federal government requires that each entity certifying match (in this case, each CDDO), have sufficient funds available to certify match for Medicaid payments for the consumers served in their region.

Current Use and Distribution of Unmatched Funds

The $18.4 million in unmatched state and local funds are distributed across the state, and only provided to CDDOs.

- They are distributed unevenly across the state, based on the formula for the distribution of various state funding sources or according to the level of local county mill levy;

- The unmatched state and county funds are used for a wide variety of purposes that meet needs not met by Medicaid funding (i.e. infant/toddler programs, transportation, housing assistance) and directly support 26% of persons receiving community DD services.

Implementing HB 2067 - Collaborative Teamwork

To accomplish the objectives of HB 2067, SRS convened meetings with various stakeholders from June through December 2001. At the Health Care Policy meeting with CDDOs on August 23, 2001, it was agreed to develop a Federal Financial Participation (FFP) System Design Team.

The purpose of this team was to review the fiscal and administrative issues related to the matching of state and local funds to increase HCBS/MRDD Waiver reimbursement rates. Meetings of the Design Team were held on September 11 and 25, October 2, 3, 16 and 17. A sub-group of the Design Team met on September 18. Members of a Resource Team participated in the meetings on September 11 and October 3. The design team included representatives of community developmental disability organizations and community service providers. In addition, the Resource Team had consumer and advocacy representation.

Analyzing System Impacts of Enhanced Maximization of Federal Funds

The FFP System Design Team worked through an analysis of federal CMS (HCFA) requirements and the current structure of financing and services delivery in the DD services system. The Design Team concluded that there were several factors impacting the maximization goals and a number of system, policy or funding distribution ramifications from certain maximization models:

Factors that Impact Proposed Maximization Goals

- Medicaid rules, the existing DD system infrastructure and local financing methodology impact the ability to achieve maximization as initially envisioned.
- HB 2067 specified, and stakeholders agreed, that services funded with state general funds only (SGF) or with county funds are to be disrupted as little as possible in the maximization effort.
- State aid and County funding not matched to Medicaid are distributed unevenly across the state.
- Currently, Medicaid payments are made directly to hundreds of Community Services Providers (CSPs) and not paid through CDDOs.

Major Systems and Policy Change

- Medicaid allows the state match of 40% to be provided by either "hard" cash match from the state or by a certified match of either state or local funds. Funds can only be certified by public agencies. At the local level, the CDDO as a quasi-governmental agency is the only entity that can certify match for Medicaid services.
- In a certified match scenario, there must be a Medicaid expenditure - the match must "touch" the federal funds. So, a Medicaid service must be provided to an eligible person by a qualified Medicaid provider.
- To satisfy Medicaid requirements, all Medicaid payments would have to be made to the CDDO as the qualified Medicaid provider and not to individual community service providers.
- Payment to community service providers would have to be made by the CDDOs and not directly to CSPs from SRS.

Major Adjustments in Funding Distribution

- Federal Medicaid rules require that each entity certifying match–in this case, each CDDO, have sufficient funds available to certify match for Medicaid payments. As noted earlier, the current distribution of state funds that would be used to certify match is uneven. Also, counties levy different amounts of county funds for DD services. In order to meet this requirement, one or more of the following impacts would result:

  - **Rates Would Vary**
    MRDD waiver rate increases would vary from place to place depending only on how unmatched state and county funds are currently distributed to each CDDO; or

  - **State Funding Would Be Redistributed**
    State funding would have to be redistributed based on how much Medicaid can be matched. This would move funding from CDDOs that are using it for non-Medicaid services.

  - **State Law Conflicts with Federal Requirements**
    HB 2067 directs the use of county funds to be used to match Medicaid funding, but it prohibits SRS from directing how county funding would be used. To satisfy Medicaid requirements, expert consultants have reported CMS requires specific steps be taken when using county funds to match Medicaid funding.

Enhanced Federal Scrutiny of Creative State Financing

- Recent federal reports have identified that one of the greatest contributing factors to increased federal Medicaid expenditures is creative financing by the States. Therefore, it is believed CMS will be watching Kansas very closely to ensure it complies with all federal rules and regulations for drawing down federal Medicaid match.

Designing Federal Financial Participation Alternatives

Preliminary models for federal financial participation maximization were proposed by the FFP Design Team to a public forum of stakeholders on October 24, 2001. One hundred stakeholders including representatives from Community Developmental Disability Organizations (CDDOs), Community Service Providers (CSPs) and advocacy groups were present.

These preliminary models proposed a DD waiver rate increase that resulted in significant reallocation of SGF funds based upon the number of Medicaid waiver recipients in each CDDO. The proposal set forth the significant systems changes that would be required to accomplish such an increase and reallocation, including not only this redistribution, but the flow of all payments to CDDOs rather than to CSPs.

The majority of the stakeholder response to the proposed models concurred with many of the key concerns identified by the FFP Design Team. Stakeholders identified the following potential outcomes and key ramifications of the preliminary models:

Maximizing Federal Funds to Greater Degree Means Moving Towards A Solely Medicaid-Funded System

- The decision to maximize federal funds is a decision to move closer to a system made up entirely of Medicaid-waiver-eligible individuals

Non-waiver-Eligible Persons would Lose Services in an All-Medicaid-Funded System

- The non-waiver-eligible persons currently served in the system could be placed in jeopardy by identifying all state funds as waiver match. Many of these persons are achieving self-sufficiency and independence with the minimal state-only funding by which they are supported. Many waiver-eligible persons are accessing less intense services supported by state general funds only. The loss of these funds could create greater dependency as waiver-eligible consumers turn to that source of funding rather than lose services all together.

Differential Rates A Barrier

- Differential rates across the state for the same service resulting from these models is unacceptable. Rates should only differ if there is a factual basis for that

difference. In addition to the appearance of inequity, differential rates create challenges in achieving "portability"(funding to support services following the consumer when they move).

Gain in Maximization Offset by Administrative Disruption, Cost and Service Loss

- The complexity of the system change required by these models and its associated costs are not justified by the gain. Even with the optimum billing at the model rates, the additional funding to the system would only be one-half to one-third of what has been demonstrated by rate studies to be required for rate relief.

Loss of Service Delivery Flexibility and Responsiveness to Local Need

- Any maximization approach raises concern about the loss of diversity and flexibility of use of state funds. Relying on the Medicaid program exclusively at the present time is a complex policy decision with major ramifications.

It should be noted, however, that there were a number of stakeholders who supported the maximization models that were presented even in light of the concerns raised.

FY 2002 Model for Maximization

On November 1st and 8th the Design Team met to review feedback from the stakeholders regarding the proposals. In light of the concerns raised by stakeholders to the initially developed models, the team discussed alternative options to allow some infusion of new resources into the DD system in the current year.

The plan developed for FY2002 provides significant increases in Medicaid funding by increasing the amount SRS pays the CDDOs for administering the developmental disabilities system. CDDO Administrative payments are made to defray the CDDO's cost of administering the DD Reform Act. These payments are matched by Medicaid through the administrative match process.

Raising these payments and using a "certified match" process allows significant increased federal funding to be paid for community DD services in FY 2002. This effort will generate $6,804,660 in new federal funds in FY 2002. This reduces the amount of unmatched state and local funds from $18.4 to $8.7 million.

On December 4, a meeting with CDDOs was held to negotiate a 6-month contract to implement the proposed maximization plan. Contracts were processed to CDDOs on December 11. During the period January 2002 to June 2002, two quarterly payments will be made to distribute the $6.8 million in new federal funds. CDDOs will distribute the entirety of this funding throughout the community service provider system to address work force issues.

On December 20, a stakeholder informational meeting was held to discuss the FY2002 maximization plan. CDDOs, CSPs, advocacy groups, consumers, and families attended this meeting. Information about the entire maximization process to date can be found at the SRS Health Care Policy Community Supports and Services website, www.srskansas.org/hcp/css/FFPTeam.htm

Next steps in the FFP Maximization Effort

Metropolitan Statistical Area (MSA) Rates

Rate studies and economic cost data indicate that the cost to provide services in urban areas is affected by wage pressures. Relying upon the 2001 DD services rate study produced by Myers and Stauffer, SRS is working with CDDOs in urban areas to increase DD waiver rates.

The nine urban counties affected serve 50% of the persons in the DD services system. Using local county funds as certified match, the proposed model of maximization will allow higher DD waiver reimbursement for urban areas of the state that experience higher than average services costs. Details of this effort are being finalized.

This aspect of maximization will reduce the remaining $8.7 million unmatched state general and county funding even further.

Determining What Maximization Efforts Remain Possible

The FFP Design Team will continue to meet to plan for a long term, sustainable system of increased federal reimbursement that will meet CMS requirements, minimize disruption to services for persons receiving state funded services, and address state wide distribution of state general fund support.

CAPACITY BUILDING EFFORTS

Capacity Building Plans

In June 2001, SRS and CDDOs jointly created guidelines for developing and implementing community capacity building plans to improve the quality and efficiency of service delivery.

- Capacity building refers to the process of stabilizing, improving and/or expanding the ability of the community to provide responsive, quality supports and services to community members with developmental disabilities. The purpose of such efforts is to build systems and networks that are responsive, flexible, and grow to meet the needs of the entire community.

To accomplish capacity building efforts the following will be accomplished:

- Identifying strengths within the local service area, including natural and community supports;
- Identifying barriers to meeting the independence, productivity, integration and inclusion goals of the developmental disabilities reform act;

In accordance with these guidelines each CDDO initially assessed these core system issues:

- **Work Force Issues**
  Designed to stabilize and enhance the work force of direct service professionals
- **Crisis Prevention/Management Plans**
  Designed to address the needs of people who are unserved or underserved, and to identify/address potential service gaps in the region
- **Identifying Generic Community Services & Natural Supports**
  Designed to explore resources that can be obtained, maximized and accessed in an effective and efficient manner to enhance the overall quality of services.

By October 1, 2001, the CDDOs had developed and submitted to SRS, CDDO plans that identified areas of strength and weakness in these core system issues. Based upon local factors, each CDDO selected initial areas for focused attention to strengthen system performance.

Progress reports, building upon initially selected goals and measuring implementation, are being submitted in mid-January 2002, with annual review and updated progress reports thereafter.

The statewide importance of work force issues was acknowledged by all stakeholders. It is important to have core data gathered across CDDO areas, thus a biannual report as to CDDO area specific average wage, turnover rate and vacancy rate for direct service professionals will be submitted by each CDDO. The first report will be submitted January 15, 2002 covering the period July 2001 through December 2001.

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

January 28, 2002

Representative Kenny Wilk, Chair
House Committee on Appropriations
Room 514-S, Capitol Building
Topeka, Kansas 66612

Dear Representative Wilk:

This report has been provided to the Kansas Legislature as required by House Bill 2283. In section 29 of House Bill 2283, the Department is directed to develop a plan for reducing the reliance of the state on Nursing Facilities/Mental Health (NF/MH) facilities and to determine the number of individuals currently in care who are candidates for community-based services. A workgroup was established and directed to develop this plan. This report is the completed work of this workgroup.

I am providing a copy of this report to you and members of the House Committee on Appropriations as I thought it might be of interest to you.

Please let me know if you have questions regarding the report.

Sincerely,

Janet Schalansky

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

cc: Members of the House Committee on Appropriations

Mtg (4-3/-02 10 AM)

2-35

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

January 28, 2002

Pat Saville, Secretary
Kansas Senate
Room 360-E, Capitol Building
Topeka, Kansas 66612

Janet Jones, Chief Clerk
Kansas House of Representatives
Room 477-W, Capitol Building
Topeka, Kansas 66612

Dear Secretary Saville and Chief Clerk Jones:

This report is being provided to the Kansas Legislature as required by House Bill 2283. In section 29 of House Bill 2283, the Department is directed to develop a plan for reducing the reliance of the state on Nursing Facilities/Mental Health (NF/MH) facilities and to determine the number of individuals currently in care who are candidates for community-based services. A workgroup was established and directed to develop this plan. This report is the completed work of this workgroup.

Please let me know if you have questions regarding the report.

Sincerely,

Janet Schalansky

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

NFMH PROVISO WORKGROUP REPORT

January 2002

NFMH PROVISO WORKGROUP
EXECUTIVE SUMMARY

The NFMH Proviso Workgroup was established in July 2001, in response to a Proviso issued by the Legislature that:

> "the Secretary of SRS is hereby authorized and directed to continue meeting with the directors of nursing facilities for mental health and the directors of community mental health centers and to develop a plan for reducing the reliance of the state on NF/MH facilities and to determine the number of individuals currently in care who are candidates for community-based services. In addition, the Secretary of SRS shall not transfer any client from a facility bed prior to the plan being reviewed by the Legislature during the regular session in 2002 unless it is to comply with the Omstead [sic] decision."

In order to fulfill the directive from the Legislature, Secretary Schalansky requested the Governor's Mental Health Planning Council's Subcommittee on Housing and Homelessness to form a workgroup to create a plan. In addition, CMHC's, NFMH's, and SRS staff will continue to meet quarterly, to review the plan's development and implementation.

The Workgroup, comprised of such diverse entities as representatives from: the Kansas Department of Commerce and Housing, the Kansas Department of Aging, the Kansas Association for the Medically Underserved, Community Mental Health Centers (CMHC), Nursing Facilities for Mental Health (NFMH), Independent Living Centers, Social Rehabilitation Services' Department of Mental Health, Substance Abuse Treatment and Recovery's (MHSATR) Consumer Advisory Council, met six times from July to October. The work of the group is summarized below, and the full report is attached.

The following values and premises guided the Workgroup throughout their planning process. The following values and premises were discussed, reviewed, and agreed to by the members.

Values

1. People have the right to make informed choices about their life based on education of the full array of choices available.

2. Consumer and family voice is essential and directive.

3. Services are provided in the least restrictive environment with a focus on community-based supports.

4. People can experience a personal process of recovery from mental illness (for further explanation of the recovery concept, see Appendix XIV).

5. We value an active collaborative process between NFMH's, CMHC's, Social Rehabilitation Services (SRS), individuals with mental illness and other stakeholders.

Premises

1. The vast majority of individuals with SPMI prefer to live independently. (Tanzman and other studies).

2. There are individuals with SPMI currently living in NFMH's who can and want to leave. (Screening for Continued Stay Project).

3. There is a way to assess whether a consumer living in an NFMH can and wants to leave. (Continued Stay Project).

4. Mental Health Initiative 2000 resulted in increased funding for intensive community-based services. (NFMH Proviso Workgroup).

5. The Plan developed is based upon scientific research such as the Surgeon General's Report, the Office of Inspector General's Report, etc. (NFMH Proviso Workgroup).

6. Individuals with SPMI who leave NFMH's and do not need nursing home level of care will not be transinstitutionalized to NFs, but will live in the communities of their choice. (NFMH Proviso Workgroup).

7. Every consumer leaving an NFMH will have adequate community supports to do so . (NFMH Proviso Workgroup).

Recommendations

These are overarching recommendations of the NFMH Proviso Workgroup. Many of the recommendations were reached by unanimous approval and some were reached on the basis of consensus.

The charge to the Workgroup was to identify the core recommendations of the plan. The group recognized the recommendations listed here are not exhaustive, but do cover the critical elements necessary to successfully reduce the State's reliance on NFMH's.

The Workgroup divided into three subgroups, Front Door, Back Door and Community Resources. Specific recommendations of the subgroups are found in Appendix XX. Please refer to them for the detailed recommendations of the individual groups.

1. Community mental health centers, affiliates, and other key community service providers must adopt a "do whatever it takes" attitude to divert individuals with SPMI who could live more independently from entering NFMH's, and to support those leaving NFMH's in maintaining community tenure. Throughout the process, individualized, formal, person-centered planning will occur with each consumer before changes occur.

2. To ensure that all potential community-based services have been considered prior to NFMH admission, CMHC's will perform screening assessments of individuals with mental illness (using the PASRR Level II).

3. To determine whether individuals with mental illness continue to need this level of care, CMHC's will perform screening assessments of individuals with SPMI on a semi annual basis (using the Continued Stay assessment).

4. CMHC's will designate staff as NFMH Liaisons to participate in each individual's process from the time of admission through discharge from NFMH's.

5. Individuals residing in NFMH's should be included in performance outcome measures for CMHC's.

6. Individuals with SPMI being diverted or discharged from NFMH's should have sufficient access, in a timely manner, to flexible funds to assist them in transitioning to the community.

7. Individuals with SPMI being diverted or discharged from NFMH's should have sufficient access, in a timely manner, to rental subsidies which remain available until a permanent affordable housing solution is obtained.

8. For the next five years, the Governor's Mental Health Planning Council will conduct an annual review of the 2002 NFMH Proviso Plan to monitor progress in addressing priorities and to have a mechanism in place to respond to feedback.

9. Representatives of Kansas Department of Aging (KDOA), SRS, CMHC's, NFMH's, individuals with mental illness, and other stakeholders will form a task force to advise and oversee the transition of PASRR Level II process: an assessor contracting process, and SRS/KDOA collaborative oversight process. The above task force should also redesign the Level II assessment tool and endorse newly developed training materials. Recommendations should be implemented no later than July 1, 2002.

10. SRS-MHSATR will oversee provision of training and education regarding community-based alternatives to individuals with SPMI, family/guardians, CMHC's, and NFMH's.

11. SRS-MHSATR will insure that the Counties of Responsibility be determined for every NFMH resident no later than July 1, 2002.

12. SRS-MHSATR will insure that CMHC's complete the initial round of Continued Stay Assessments with all current NFMH residents no later than December 31, 2002.

13. Any further reductions in NFMH funding will be shifted to fund mental health services in the community, including flexible funding for those leaving NFMH's to pay the necessary items listed in each persons' individualized plans that are not paid for by other sources.

14. There should be incentives, such as bridge funding, for NFMH's to convert into a new kind of community-based service provider.

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1. An Overview of the Kansas NFMH System

History

The Nursing Facility for Mental Health (NFMH) program began in the early 1980's as an alternative to placing individuals with severe and persistent mental illness (SPMI) in traditional nursing facilities. In 1988, under the Medicare Catastrophic Act, Congress declared that facilities "of more than 16 beds that (are) primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" were to be known as "Institutions for Mental Disease," or, IMDs.

As the Federal Government has historically taken the position that inpatient services for people with SPMI are a state responsibility, IMDs were declared exempt from receiving Federal reimbursement for services provided to individuals over the age of 21, and under age 65. Consequently, 100% of the stays of NFMH residents in that age range have been financed using State General Funds. Despite such similarities to the State Psychiatric Hospitals, the NFMH program was left out of Mental Health Reform.

For a number of years, NFMH's have been major providers of residential treatment services for individuals with mental illness. In the earlier days of CMHC development of community support services, there were few long-term, 24-hour treatment options for this population. NFMH's provided a resource for individuals who were assessed as unable to live successfully in the community without access to intensive levels of assistance available around the clock. However, over the last 15 years, as national attention and resources have focused on developing intensive community-based services, many new, less restrictive treatment options have become available for persons with SPMI. Community service providers now have the technology and service capacity in many areas to provide very intensive levels of service to people in their home communities. This major change in the service system requires reassessment of the use of large capacity institutional treatment settings.

Conversions and Closures

On September 24, 1993, the Centers for Medicare & Medicaid Services (then known as "HCFA") provided the Department of Social and Rehabilitation Services (SRS) with a report based on review of the NFMH program. Among their recommendations was a suggestion that NFMH's considered "dual facilities" (having both traditional nursing facility beds and mental health beds) be designated as either NFMH's or NFs, but not both, as the NFMH designation prevented non-SPMI residents' stays from being reimbursed by Federal funds. Seven NFMH's chose to convert to NFs, reducing the number of NFMH's from 23 to 16, and the number of beds from approximately 1,200 to 927. (The NFMH Proviso Workgroup noted, that, by keeping such entities licensed as nursing facilities, their ability to focus on providing mental health services has been limited.)

In January of 1994, an 83-bed NFMH in Sedgwick County ceased operation, giving the community less than one month's notice that they would be closing. The Sedgwick County Mental Health Department negotiated with SRS to receive the full amount of funding due to the NFMH for the rest of the fiscal year, with an agreement to provide decreasing amounts in subsequent years. The money allowed them to increase community mental health staffing capacity while providing immediate, ongoing and flexible housing-related financial assistance. In doing so, they were able to successfully assist the existing 77 NFMH residents in finding primarily placement in independent living situations, most of whom have remained in the community to this day. They summarized their experience in a report, commenting that:

> "The most important lesson from the Heartland closure is that people who one day are deemed by sophisticated screening methods to be only capable of institutional life can the next day, with the right supports, be living in the community. Institutionalization is therefore less a commentary on an individual's functioning and more a statement of what community services are in place."

Also in 1994, Johnson County Residential Care Facility entered into an agreement with SRS to close its 39-bed NFMH. In exchange SRS provided funding allowing its owner, Johnson County Mental Health Center (JCMHC), to increase community-based staffing capacity and provide housing-related financial assistance. JCMHC's decision to pursue this arrangement was based upon 4 factors:

1. "Shift in philosophy from "continuum of care" model to "Supported Housing" model."
2. "... census began to decline as... (JCMHC) expanded supported housing services and increased capacity."
3. "Institutional environment creates problems for some clients because it cannot respond effectively to individual needs."
4. "SRS... presented a position paper to the Legislature proposing the eventual phase-out of all NFMH's consistent with the philosophy of community base services in the least restrictive environment."

Closure occurred over a six-month period. A December 2000 follow up report on 32 of the 36 residents found that most individuals remained living independently, and few had experienced any subsequent hospitalization.

In January of 2000, a third NFMH in rural Johnson County notified SRS that it would cease operation. SRS contracted with two CMHC's to assess 40 residents' needs and transition them to other community and residential settings. As with the other closures, funds were made available to assist with housing and other costs associated with the transition.

Additional change in the number of licensed beds (at the request of different NFMH's) has led to the current 13 NFMH's being licensed for a total of 783 beds.

Time Line

Early 1980's:	Kansas begins NFMH Program
1988:	Congress designates facilities with more than 16 beds as Institutions for Mental Disease (IMD's), disallowing federal Medicaid reimbursement for NFMH residents aged 22-64
1990.	Kansas Mental Health Reform Act is implemented, increasing community-based services and reducing the number of people with mental illness living in state hospitals
1990:	Americans with Disabilities Act is passed, expanding states' responsibilities to provide reasonable accommodations for individuals with disabilities
1993:	Federal review of Kansas NFMH program recommends that facilities be designated as either NFMH's or NF's, resulting in 7 converting to NF's and reducing NFMH's to 16
1993:	NFMH in Sedgwick County ceases operation. SRS contracts with the CMHC to oversee transition of residents into community and other less restrictive settings
1994:	NFMH in Johnson County contracts with SRS to close its facility and transition residents into community
1999:	U.S. Supreme Court issues Olmstead Decision, requiring states to place qualified individuals with mental disabilities in community settings rather than institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement
1999:	U.S. Surgeon General releases groundbreaking Report on Mental Health, presenting evidence on effective treatments and community-based services, promising changes in the organization and financing of mental health care, and the emergence of the consumer and family movements to combat discrimination
2000:	NFMH in rural Johnson County ceases operation. SRS contracts with area CMHC's to transition residents to community and other residential settings
2000:	SRS researches and drafts outline for NFMH's to use in converting to another form of service provider in partnership with CMHC's
2000:	Legislative Post Audit Report (LPA) recommends changes in public mental health system
2000:	Report assessing crisis services statewide shows gaps in services
2000:	SRS begins workgroup to implement reccomendations in LPA report
2001:	Mental Health Initiative 2000 begins, increasing community-based services
2001:	Kansas legislature issues Proviso directing SRS to work with NFMH's, CMHC's and other stakeholders to devise a plan to reduce the state's reliance on NFMH's
2001:	Kansas has 13 NFMH's operating a total of 783 beds

Current System

Currently, Kansas has 13 licensed, privately owned NFMH's operating 783 beds. Responsibility for the NFMH program is shared by several entities. The NFMH's are licensed and surveyed by the Kansas Department of Health and Environment and adhere to the same regulations as all other adult care homes. The NFMH facilities are certified to participate in the Medicaid program. SRS does the rate setting and reimbursement for services provided by the NFMH's. SRS also imposes Civil Monetary Penalties on an NFMH when, as a result of a survey conducted by KDHE, the NFMH is found to be in noncompliance with regulations. A map showing the location of each NFMH is provided on page 14, and a chart identifying each NFMH follows:

Nursing Facilities for Mental Health in Kansas

Facility	Town	County	Number of Beds
Applewood Rehabilitation	Chanute	Neosho	46
Edwardsville Manor	Edwardsville	Wyandotte	102
Heritage Village of Eskridge	Eskridge	Wabaunsee	60
Florence Health Care	Florence	Marion	60
Westview of Peabody	Peabody	Marion	52
Indian Trails Mental Health Living Center	Topeka	Shawnee	82
Countryside Health Center	Topeka	Shawnee	60
Brighton Place North	Topeka	Shawnee	34
IHS Community Care	Topeka	Shawnee	50
Gatewood Care Center	Russell	Russell	46
Friendship Manor Rehabilitation Center	Haviland	Kiowa	50
Medicalodge of Paola	Paola	Miami	93
Valley Health Care Center	Valley Falls	Jefferson	52

The NFMH facilities are the largest providers of institutionally-based care for people with psychiatric disabilities in Kansas. Yet, there is no formal tie of these privately owned facilities to CMHC's, the primary providers of public mental health care in the community. As the next section will show, federal regulations guiding admissions and reviews of individuals in NFMH's do not require connection to, or participation with, CMHC's in determining whether these individuals need institutional care. This differs from the state hospital system, where CMHC's act as "gatekeepers" to insure appropriate assessment, placement and review of community-based alternatives. Also, as outlined in additional sections, the majority of adults with SPMI are being successfully served in the community, and a significant number of those residing in NFMH's do not differ in characteristics, symptoms, or level of disability from those being served in less restrictive settings.

Federal Oversight (PASSR)

In 1995, as set forth by K.S.A. 39-968, the Department of Social and Rehabilitation Services entered into an interagency agreement with the Department on Aging to administer the federally mandated Preadmission Screening And Resident Review process (PASRR). According to this law each individual, prior to admission to a Medicaid certified facility shall receive an assessment that screens for the presence of mental illness or mental retardation/ developmental disability. If the presence of either mental illness or mental retardation/developmental disability is identified in the screening process, the individual is referred for a more in-depth assessment, known as a Level II assessment.

It should be noted the criteria set-forth in the federal language for an individual with mental illness to receive a Level II assessment is quite narrow. There must be a documented diagnosis of serious mental illness; the individual must have had two hospitalizations within the last two years or currently receiving supportive services [MH case management, MH group home or receiving IM psychotropic medication]. This stringent definition impacts the number of Level II assessments that are conducted in Kansas each year. Of the 12,936 screenings conducted in SFY-00, only 343 triggered a Level II for mental illness based on this criterion.
The Level II assessment is conducted for the purpose of determining whether an individual requires the level of services provided by a nursing facility or if they require specialized mental health services in a hospital. The intent of PASRR, according to CMS is "to prevent the placement of individuals with MI (mental illnesses) or MR (mental retardation) in a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility (page 56451 of the Federal Register/Rules and Regulations).

If an individual disagrees with the outcome of a Level II assessment, each individual or their legal representative has a right to appeal the decision. Each individual is given direction if he/she wishes to appeal at the time they are notified of the Level II determination.

In a recent study conducted by the Office of Inspector General, 19 purposely selected nursing facilities in five states were visited. Kansas was one of the five states. The resulting report generalizes much of its findings and does not directly identify any state but the report does provide ample evidence that the PASRR Level II system, "the primary mechanism by which individuals with mental illness in nursing facilities are monitored, is inadequate to identify whether... individuals with mental illness are appropriately screened, evaluated and placed in nursing facilities". The report acknowledges the federal definition of a serious mental illness which puts forth multiple conditions that must be met to classify an individual as requiring a Level II allows states to avoid assessment of some residents with serious mental illness (see criteria above). Nursing facilities have their own admission process to determine their ability to care for individuals who have a mental illness but who may not trigger a Level II preadmission screening.

To ensure the success of their collaborative oversight of the PASRR Level II program, as well as other joint ventures, SRS and KDOA meet monthly. During the past year, they have focused discussions on findings of the OIG report, PASRR studies, as well as other issues related to improving the Level II process. In addition to their monthly meeting, a representative of SRS-MHSATR is a member of the CARE Oversight Council, a group with statutory responsibility for the PASRR Level I and II program.

In addition, in 1996, the annual reassessment of nursing facility residents ceased to be a Federal requirement. Nursing facilities request a reassessment if at any time an individual has a significant change in their mental health status but, in contrast to state psychiatric hospitals, there are no CMHC liaisons formally able to participate in admissions, reviews for timely discharges and in assisting residents to transition into the community.

Findings from NFMH Studies

SRS has been conducting an assessment of the NFMH service system and the population being served by these facilities for nearly a decade. Through contracts with the University of Kansas School of Social Welfare, research has focused on a review of the "Minimum Data Set" (MDS), which is a federally required set of data routinely reported by all nursing facilities, and the "Level II PASRR" screening assessments that are required for persons with mental illness prior to an admission to a nursing facility. Appendices III, IV and V provide copies of the entire research reports used by the Workgroup and from which the following highlights are derived:

Since 1996, three studies of MDS data for NFMH residents have consistently yielded indications that a number of NFMH residents may have the potential to live successfully in the community if they are provided with intensive community supports that are now available. It should be noted that all of the studies involving the MDS data set have recommended that face-to-face assessments be

conducted for all NFMH residents to obtain a clearer picture of each resident's needs, strengths, resources, and personal goals.

It is important to note that while MDS data provides a wealth of information regarding nursing facility residents' limitations and needs for assistance, it is a data set that is primarily designed for facilities serving elderly and physically disabled individuals and is focused on the identification of problems within a medical model framework. Therefore, the MDS data set has limited potential for identification of the capabilities, resources, and psychosocial rehabilitation potential of residents with mental illness. Despite these limitations, MDS studies provide a strong indication that a number of NFMH residents do not have disabilities that are any more severe than those of many individuals with SPMI who are currently being served successfully in the community.

1996 NFMH Status Report

MDS data for 897 NFMH residents was analyzed. Findings from this report indicated that:

- The overwhelming majority of NFMH residents did not have physical conditions that are disabling in severity.
- A large number (24%) of residents appeared to have neither physical or mental disabilities that would prevent them from living in the community.
- The majority of residents identified as having disabling conditions due to mental illness had been categorized as such using subjective criteria that appeared to be applied differently across NFMH facilities.

2000 PASSR Study

A study of 135 residents was done, utilizing their PASRR Level II assessments. Analysis led to following conclusions and concerns:

- The majority of those involved in the referral and screening process are medical professionals, not Community Mental Health Center staff (who are familiar with the availability of supports needed in individuals' home communities);
- The tool is not written in such a way as to require the screener to clearly explain the reasons that individuals with SPMI need nursing facility level of care; and
- Some of the screeners' service recommendations (i.e., vocational skills, independent living skills) would seem to be more appropriately provided in community settings;
- The current screeners often had recorded insufficient detail in the description of needed services to determine whether nursing facility level of care would be the only feasible option.

Additionally, the study provided adequate measurements of demographics and other key data, which include that, of the 135 residents assessed:

- 92% were under the age of 65, with 54% being under the age of 46.
- 66% were hospitalized at the time of PASRR Level II screening.
- 61% are indicated as being the responsibility of the four large urban CMHC's.
- 73% have diagnoses of schizophrenia or schizoaffective disorder.
- 90% have no medical diagnosis which indicates a potential need for nursing facility care.

2000-2001 Screen For Continued Stay Pilot Project Study: Phase One, MDS Review

To address the gap created by eliminating the PASRR annual review requirement, and to collect further information about the ability of the community to support NFMH residents in transitioning to the community, the School of Social Welfare developed an assessment tool, the "Screening for Continued Stay". A first step in identifying those in NFMH's who would be likely candidates for being screened with this assessment tool was to use the MDS data set to identify key factors. An interim report includes demographic data collected on the entire NFMH population (748) as of September 30, 2000:

- 68% are under age 65.
- 55% were admitted to an NFMH from a psychiatric hospital.
- 56% have resided at the NFMH for more than three years.
- 74% have a diagnosis of schizophrenia.
- 42% have a legal guardian.
- **82% are eligible for Medicaid.**

It was determined that criteria such as: being under the age of 65, having no disability indicators other than "decision ability impaired", having no mobility assistance required, and, requiring no "special care/treatments" other than monitoring were indicators of potential for individuals with SPMI to transition into the community.

- **Of the 748 residents, 36% (267) met these criteria.**

2000-2001 Screen For Continued Stay Study: Phase Two: Pilot Project

Five NFMH's and seven CMHC's participated in the pilot project, where the Screen for Continued Stay tool was used with 23 NFMH residents and a comparison group of 20 adults with SPMI being served in the community, for purposes of comparing the service needs of the two groups and testing the efficacy of the screening tool and process.

Of the 23 people residing in NFMH's, screening results include:

- 30% have been recommended for discharge into the community.
- 22% require community alternatives which are currently not available, and, therefore, discharge is not recommended.**
- 17% have disability levels too severe to recommend discharge at this time.
- 22% of residents have potential to live in the community but choose to remain in NFMH's.
- 9% of guardians/families choose that residents should remain in NFMH's even though they have potential to live in the community.

** Additional services added through Mental Health Initiative 2000 may decrease this figure. Also, the pilot study did not address reasons why community alternatives were not available. Further, this was a pilot test of the assessment tool so there was no requirement to follow up on these recommendations as there will be when assessment becomes a mandatory procedure.

Highlights of Key Service Findings:

- Case management was the principle service found to be most needed by NFMH residents (96%) and most used by clients living in the community (100%)
- Affordable housing or housing subsidies was next, with 91% of NFMH residents needing this and 95% of community clients using this resource
- Natural supports, such as friends, family, roommates, church, etc., was third highest with 96% of NFMH residents needing this resource and 90% of community clients using natural supports

The Olmstead Decision

As listed in the Legislative Proviso, the Olmstead Decision by the U.S. Supreme Court is one factor affecting the need to address the NFMH program in Kansas. Given the data indicating that a number of NFMH residents are likely candidates for living in the community, in less restrictive settings, the mental health system is at risk of being out of compliance with the Olmstead Decision. What follows is a summary of the decision and implications for states.

The case Olmstead v. L.C. and E.W. involves two women from Georgia who were diagnosed with mental retardation and mental illness. Both women were voluntarily admitted to a psychiatric unit in a Georgia hospital. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based setting, the women remained hospitalized. Seeking community-based placement, they filed suit against Commissioner Olmstead from Georgia Department of Human Resources. They claimed a right to care in an integrated setting based on the guarantees under Title II of the Americans with Disabilities Act (ADA).

On June 22, 1999, the Supreme Court issued a landmark decision in the Olmstead case that, under the ADA, States are required to administer their services, programs, and activities "in the most integrated setting appropriate to (individuals') needs". The ruling reinforced the fundamental intent of the ADA, which is elimination of discrimination based on disability.

President Bush issued an Executive Order regarding community-based alternatives for individuals with disabilities on June 18, 2001. President Bush called for the Secretaries of Health and Human Services, Education, Labor and Housing and Urban Development, and the Commissioner of the Social Security Administration to swiftly implement the Olmstead Decision. Prior to receiving the Executive Order, the U.S. Department of Health and Human Services issued a letter to all governors, stating that "no person should have to live in a nursing home or other institution if he or she can live in his or her community." Moreover, it stated that "unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act".

The Center for Mental Health Services (CMHS) is providing support to all 50 states, the District of Columbia, Puerto Rico, and Virgin Islands to support an Olmstead Coordinator in each jurisdiction. Kansas Department of Mental Health, Substance Abuse Treatment & Recovery, in conjunction with University of Kansas, hired a Community Integration Specialist in the summer of 2001. This position focuses on the NFMH program and other Olmstead related activities.

The Surgeon General's Report on Mental Health

One of the Workgroup's premises that guided their planning process stated that the plan would be based upon scientific research from the Surgeon General's Report on Mental Health, as well as other reports. The Surgeon General's Report relies on scientific evidence and emphasizes the importance of delivering state-of-the-art treatments and services versus maintaining services and systems that are outmoded. It also stresses the importance of fighting social stigma and upholding the civil rights of those affected by mental illness. While the report itself is too vast to include as an appendix, what follows are some conclusions and highlights as they relate to this plan:

- "A variety of treatments of well-documented efficacy exist for the array of clearly defined mental and behavioral disorders that occur across the life span."

- "Obstacles that may limit the availability or accessability of mental health services for some Americans are being dismantled, but disparities persist."

- "Stigmatization of mental illness is an excuse for inaction and discrimination that is inexcusably outmoded."

- "We have acquired an immense amount of knowledge that permits us, as a Nation, to respond to the needs of persons with mental illness in a manner that is both effective and respectful."

- "The housing preferences of people with schizophrenia and other serious mental disorders are clear: these individuals strongly desire their own decent living quarters where they have control over who lives with them and how decisions are made."

- "A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and preventions interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems."

Conclusions

Given the overview of the NFMH system, its federal oversight, the studies completed over the last decade, the Olmstead Decision and the Surgeon General's Report, several conclusions can be drawn. These are:

1. The NFMH program in Kansas has decreased in size even as community-based services have increased their capacity to serve people with SPMI in less restrictive settings.

2. As closures and conversions occurred, SRS and CMHC's have successfully transitioned NFMH residents to the community and to other appropriate residential settings, by investing in the necessary array of individualized services and supports.

3. Due to Federal restrictions on IMD facilities, State General Funds and not Federal Medicaid dollars, comprise the majority of the NFMH budget.

4. Although the NFMH program is the largest provider of institutionally-based mental health services in Kansas, there is:

    - limited Federal confidence in the assessment process which places individuals with SPMI in NFMH's (according to the OIG Report),
    - no systematic review of whether each individual with SPMI continues to need that level of care, and
    - no requirement to connect people to community-based mental health providers for those who can and want to leave NFMH's.

5. Several studies have been done that indicate a significant number (24%-30%) have neither physical or mental disabilities that would prevent them from living in the community with adequate supports and services tailored to their individual situations.

6. Studies also indicate most NFMH residents are Medicaid eligible, and could have their mental health services reimbursed with Federal dollars if they were residing in the community.

7. The Olmstead Decision has created a mandate for the state's public mental health system to address the needs of those residing in NFMH's who have the ability and desire to leave the institution and live in the community.

8. The U.S. Surgeon General's Report on Mental Health challenges states to adopt evidence-based practices, and re-design and integrate existing service systems.

Insert map here

2. Scope of Proviso Workgroup's Charge

Over the last decade, SRS has conducted an assessment of the NFMH system, and the population residing in these facilities. Numerous studies and initiatives have been pursued. As outlined in the conclusions of the first chapter, several factors on the federal and state levels have come to bear on the public mental health system that called for systems change. This lead to the SRS budget proposal to reduce reliance on NFMH facilities by 15% for FY 2001. These factors include:

1. The NFMH program in Kansas has decreased in size even as community-based services have increased their capacity to serve people with SPMI in less restrictive settings.

2. As closures and conversions occurred, SRS and CMHC's have successfully transitioned NFMH residents to the community and to other appropriate residential settings, by investing in the necessary array of individualized services and supports.

3. Due to federal restrictions on IMD facilities, State General Funds and not Federal Medicaid dollars, comprise the majority of the NFMH budget.

4. Although the NFMH program is the largest provider of institutionally-based mental health services in Kansas, there is:

    - limited Federal confidence in the assessment process which places individuals with SPMI in NFMH's (according to the OIG Report),
    - no systematic review of whether each individual with SPMI continues to need that level of care, and
    - no requirement to connect people to community-based mental health providers for those who can and want to leave NFMH's.

5. Several studies have been done that indicate a significant number (24%-30%) have neither physical or mental disabilities that would prevent them from living in the community with adequate supports and services tailored to their individual situations.

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7. The Olmstead Decision has created a mandate for the state's public mental health system to address the needs of those residing in NFMH's who have the ability and desire to leave the institution and live in the community.

8. The U.S. Surgeon General's Report on Mental Health challenges states to adopt evidence-based practices, and re-design and integrate existing service systems.

While approving the Budget recommendation, the 2001 Legislature, in response to community concerns about adequate resources being available, issued the following Proviso:

> "the Secretary of SRS is hereby authorized and directed to continue meeting with the directors of nursing facilities for mental health and the directors of community mental health centers and to develop a plan for reducing the reliance of the state on NF/MH facilities and to determine the number of individuals currently in care who are candidates for community-based services. In addition, the Secretary of SRS shall not transfer any client from a facility bed prior to the plan being reviewed by the Legislature during the regular session in 2002 unless it is to comply with the Omstead [sic] decision."

3. Workgroup Formation

In order to fill the directive from the Legislature, Secretary Schalansky requested the Governor's Mental Health Planning Council be responsible for oversight of the planning process. The Council delegated to the Housing and Homelessness Sub-committee the responsibility to create a workgroup to formulate the plan, provided that the scope of the plan addressed more than only housing issues, but also planning for mental health and daily living supports, as well.

The Sub-committee appointed members who have expert knowledge of the Kansas mental health system and are directly involved in the NFMH arena. Individuals on the workgroup represent such diverse entities as: Department of Commerce and Housing, the Kansas Alliance for the Mentally Ill, the Kansas Association for the Medically Underserved, Independent Living Centers, Kansas Advocacy and Protective Services, as well as individuals with SPMI, Community Mental Health Centers and NFMH staff, and other stake holders (see Appendix I for the complete list of members). While some members officially represented a specific stakeholder group, several of these are also family members of adults with SPMI and/or consumers of mental health services.

The Charge of Each Subgroup

In order to organize the Workgroup effectively so they had the ability to devise a plan in the time frame given, it was proposed to divide into three subgroups, each focusing on a key aspect of the plan. The Workgroup agreed to divide into three subgroups: Front Door, Back Door and Community Resources.

- The Front Door subgroup was charged to examine ways to improve the referral, screening, and admissions process to insure that only those with SPMI who need NFMH level of care actually enter these facilities.

- The Back Door subgroup was charged to examine strategies that increase NFMH residents' abilities to leave the facility once they no longer need and choose to have that level of care.

- The Community Resources subgroup was charged to identify the services and resources needed to effectively support People with SPMI in the community as they leave the NFMH.

Each subgroup's membership included a consumer, a representative from a CMHC and an NFMH as well as other stakeholders most interested in that aspect of the plan. The subgroups identified the core recommendations of the plan and the large Workgroup identified the overarching values, premises, recommendations.

Communication and Collaboration

One value identified by the Workgroup was to use an active, collaborative process between NFMH's, CMHC's, SRS, individuals with mental illness, and other stakeholders. Since communication is key to this process, the members discussed and agreed to act as conduits of information, questions, and feedback from the constituent group they represented. During meetings it was stressed that everyone needed to actively participate, bring in feedback from those they represented, and to speak up if a member felt they did not have equal input in the planning process.

Further, an exhaustive mailing list was compiled for SRS to use in mailing out minutes and drafts of the members' work products so that stakeholders across the state were kept abreast of the plan's development and could use this information to send feedback through their representatives.

It was made clear to the Workgroup that while no changes would be made to the intent of the group's values, premises and recommendations, additional information would be added or changed to the supportive body of the report to provide additional context and explanation. Workgroup members were encouraged, and did make comments on the body of the report and appendices, leading to changes and additions to the full report even as it made its way through the review process.

During this time, the quarterly CMHC/NFMH/SRS meetings continued to occur, and all members and other stakeholders received Workgroup minutes as mentioned above.

4. Time Line and Tasks of the Workgroup

The NFMH Proviso Workgroup met over a 4 month period. A time line of their work follows:

- **July 17, 2001:** Initial meeting to discuss purpose of the group, the charge from the Legislature, and history of the NFMH system.

- **August 7:** Divided Workgroup to address 3 issues - Decreasing admission to NFMH's (Front Door), Increasing transition from NFMH's (Back Door), and Community Resources.

- **September 5:** Met to develop first draft of the three components of the Plan. Afterward, mailing of summary of accomplishments from meeting.

- **September 18:** Met as large group for each small group to report. Met as small groups to review comments and develop next draft. Mailed summary of accomplishments from meeting.

- **October 2:** Met as large group for each small group to report. Met as small groups to review comments and develop next draft. Mailed summary of accomplishments from meeting.

- **October 9:** Last meeting for review as a group. The plan's values, premises and recommendations were discussed, altered, and finalized by majority vote or by consensus. Rather than meet again, the group chose to send additional comments and revisions to the body of the report for purposes of clarification to SRS through written means.

- **October 16:** SRS-MHSATR faxed, e-mailed and mailed via U.S. Postal Service final review of the report to members. Offered members an opportunity to submit feedback on the report, including the body, by noon on October 19th. Changes were made based on their input.

- **October 24:** Housing and Homelessness Subcommittee of the Governor's Mental Health Planning Council met to approve Plan. Offered members an opportunity to submit comments. A majority of the members present had also served on the Proviso Workgroup. Minor wording changes were made to clarify the intent of the plan, as agreed to by all Workgroup members present. The Sub-committee then unanimously approved the plan.

- **November 20:** Governor's Mental Health Planning Council met to review Plan, and then submitted to Secretary Schalansky. Offered members an opportunity to submit comments.

- **Late November :** Final copy of Plan mailed to each Workgroup member.

- **January, 2002:** Secretary Schalansky presents Plan to the Legislature.

Meeting Content and Presentations

The following summarizes the content of those meetings, and the presentations that were included:

- Background information on the Kansas NFMH system.
- Development of a vision and values to guide the work of the group
- University of Kansas' three studies on the NFMH system and the Continued Stay Pilot Project completed by Office of Social Policy Analysis
- Background information on the PASRR Level II assessment process.
- Information on the U.S. Supreme Court Olmstead Decision
- Information on the Mental Health Initiative 2000
- Presentation of the Heartland NFMH and Johnson County NFMH Closures
- Presentation on the Heartland NFMH Closure Focus Groups
- Information on Recovery, Person-Centered Services, Consumer Housing Preferences
- Division into subgroups and subsequent discussions on the following topics: Front Door, Back Door, and Community Resources
- Discussions and development of recommendations
- Drafting of report

(NOTE: See Appendices for full list of all written materials used by the Workgroup and subgroups in their planning process)

5. Core Values and Premises of the Workgroup

The group agreed that any plan developed should be based on these following values and premises:

Values

1: People have the right to make informed choices about their life based on education of the full array of choices available.

2: Consumer and family voice is essential and directive.

3: Services are provided in the least restrictive environment with a focus on community-based supports.

4: People can experience a personal process of recovery from mental illness (for further explanation of the recovery concept see Appendix XIV).

5: We value an active collaborative process between NFMH's, CMHC's, SRS, individuals with mental illness and other stakeholders.

Premises

1: The vast majority of individuals with SPMI prefer to live independently. (Tanzman and other studies, Surgeon General's Report)

2: "If we primarily use formal mental health resources, despite our best intentions, we tend to foster a dependency in clients that does not promote recovery. When we develop and use naturally occurring resources, we have a much better chance at creating the types of personal connections that lead to community integration and recovery." (Basic Case Management Training Manual)

3: There are individuals with SPMI currently living in NFMH's who can and want to leave. (Screening for Continued Stay Project)

4: There is a way to assess whether a consumer living in an NFMH can and wants to leave. (Continued Stay Project)

5: Mental Health Initiative 2000 resulted in increased funding for intensive community-based services. (NFMH Proviso Workgroup)

6: The Plan developed is based upon scientific research such as the Surgeon General's Report, the Office of Inspector General's Report, etc. (NFMH Proviso Workgroup)

7: Nearly all individuals with SPMI currently living in NFMH's would qualify for State and Federally funded benefits should they move to the community. (University of Kansas studies on NFMH program)

8: "Individual needs must be met flexibly, and supports are developed for specific individuals, rather than expecting people to be molded to present program goals or standardized services." (Carling, et al.)

9: "Every consumer leaving an NFMH will have adequate community supports to do so." (NFMH Proviso Workgroup)

10: Individuals with SPMI who leave NFMH's and do not need nursing home level of care will not be transinstitutionalized to NF's, but will live in the communities of their choice. (NFMH Proviso Workgroup)

6. Evidence-Based Practices

During the past decade, a quiet but significant revolution has occurred in the field of mental health services. Enormous advances have been made in treatments available for persons with SPMI. New medications have emerged; new services and supports have proven effective. The U.S. Surgeon General's Report on Mental Health, along with other sources, provides an overview of these evidence-based services that resulted in positive outcomes for people with SPMI and their families.

As stated in the Workgroup's premises, the plan they developed was to be based on scientific research from several sources. What follows are highlights of services and interventions that were discussed, presented or in some way reviewed by the Workgroup as part of the planning process.

Focus on Recovery

As noted in the Surgeon General's Report, the focus on recovery is having a significant impact on individuals with SPMI and families, mental health research, and service delivery. The report credits several converging factors leading to a renewed hope for recovery versus maintenance:

> (1) improvements in medications, including many that are more effective in reducing symptoms while having fewer negative side effects;
>
> (2) improved treatments and preventative techniques, including self-management of symptoms to reduce crisis and improve function;
>
> (3) research supporting the finding that when individuals with mental illness have more optimistic attitudes and positive expectations, the course of their illness improves; and
>
> (4) the impact of the consumer and family movements on improving mental health services in ways that support growth, choice and change versus control and maintenance.

Interventions found to be associated with individuals' recovery process include: community support/case management, effective medications, vocational/educational activity, self-will/self-monitoring, and spirituality. Peer support, self-help, and involvement in consumer-run organizations are also mentioned. Underpinning these initial findings is the need to focus services and supports on the whole person - mind, body and spirit - so that resources such as food, housing, medical care, work and social connections are attended to as well.

Kansas is in its third year of devoting statewide attention to the recovery movement, and is investing expertise and resources in incorporating recovery-based concepts into its comprehensive system of mental health services. Essential aspects of recovery that are guiding changes in MHSATR policy and service delivery include:

1. Emphasizing growth and change versus maintenance;
2. Focusing on practices that are hope-inducing versus spirit-breaking;
3. Encouraging peer support and empowerment;
4. Increasing the consumer voice in policy development and service delivery;
5. Attending to the importance of work, decent housing and real community integration;
6. Respecting personal choice and real participation in one's recovery journey.

The current attention paid to recovery is well recognized as an important turnabout in the way we think about mental health and, even more importantly, what expectations we have for the mental health system. Due to increasing interest in managed care and accountability, our criterion for acceptable outcomes has shifted from one of expecting services to stabilize individuals so they are safe from self/others, to a higher standard for service providers of expecting individuals to have the resources and support necessary to become well and participate fully in society.

Case Management

Numerous studies done nationally and in Kansas identify case management as a critical service component of the array of community-based services designed for people with SPMI. According the Surgeon General's Report,

> "The purpose of case management is to coordinate service delivery and to ensure continuity and integration of services. Case Managers engage in a variety of activities, ranging from simple roles in locating services to more intensive roles in rehabilitation and clinical care. The less intensive models of case management seem to increase clients' links to, and use of, other mental health services at a relatively modest cost. More intensive models also appear to help clients to increase daily-task functioning, residential stability, and independence, and to reduce their hospitalizations. Overall, models that focus on specific outcomes are more effective than those with global, vaguely defined goals" (p.286).

Strengths Based Case Management

Kansas has chosen to use a more intensive model of case management, focusing on well-defined goals. Strengths-based case management is well researched, and has demonstrated its ability to reduce hospitalizations and increase positive outcomes. Kansas, a pioneer in its practice, has used the model for more than twenty years. The model focuses on five main outcomes: independent living, reduced hospitalization, employment/vocational activity, educational activity, and community participation. Key features of this case management model include:

- Outreaching and working with people in the community, in their homes, etc., and not expecting people to come to them in order to get service

- Having small caseload sizes that vary in terms of the intensity of support each consumer needs (Kansas requires no more than 25 to 1 ratio and many are even 10 or 5 to 1, versus other states where the caseload ratio can be as high as 50 to 1 or more)

- Working as case management teams in order to provide back-up and additional support as consumers' needs or life situation changes

- Placing primary attention on helping people get the resources they need to live as independently as possible, including medications, food, clothing, housing, transportation, daily living skills, social activities and relationships, health care, work, school, attainment of personal goals, etc.

- Acting as the key connection/linchpin of services so that consumers have smooth access to other professionals, i.e. psychiatrists, nurses, supported employment staff, attendant care, and also to community resources, i.e. churches, recreational programs, social clubs, peer support and self-help groups, etc.

When the Strengths model was developed, it represented a new way of thinking about individuals with SPMI and provision of mental health services. Unlike traditional models, which focus on the "problems" or deficits of individuals with SPMI , the strengths model allows staff to recognize and assist consumers to use their individual strengths and resources. This empowerment approach assumes that all consumers possess untapped reserves of mental, physical, and emotional resources that can be called upon to help them develop, grow, and overcome their problems.

Research continues to be done on effective ways to engage and work with individuals with SPMI who have difficulty connecting to or benefitting from mental health services. For this subgroup of individuals, such as those who struggle with severe mental illness and substance abuse (dual diagnosis), or those who are homeless, or who have other complex needs, additional works still needs to be done. Kansas is researching various approaches, bringing these concepts into the state, and adapting them to our system. Examples include: increased training in working with people with a dual diagnosis, increased development of crisis services and access standards, and mental health initiatives with the corrections and substance abuse treatment systems.

Wellness Recovery Action Planning (WRAP)

Providing tools and education to help people with SPMI manage their own symptoms and create relapse prevention plans are cited as a powerful and tangible change in services by the Surgeon General's Report. Noting a proliferation of interventions in this area, the report states: "Illness management training programs now teach individuals to identify early warning signs of relapse and to develop strategies for their prevention" (p. 99). As discussed in the Workgroup, by helping people take control over their own experience of symptoms, the types of crises that once led to the need for structured, institutional care can sometimes be reduced or ameliorated.

SRS, through its contract with KU, has been making this type of education and training available to consumers and CMHC staff for two years. Using research and materials from Mary Ellen Copeland, a nationally known writer and expert in the recovery and consumer movements, individuals with SPMI throughout Kansas are being trained to develop their own plans to control symptoms and reclaim a more meaningful and positive lifestyle.

WRAP is a self-designed plan that teaches individuals with SPMI, "how to keep yourself well, to identify and monitor your symptoms and to use simple, safe, personal skills, supports, and strategies to reduce or eliminate symptoms. It is not meant to replace, but to complement, professional health support and medications, though in more and more cases people are able to shift the balance of care to this self-management approach over time." (Mary Ellen Copeland)

During the past two years, more than 300 individuals with SPMI, and 150 community providers have been trained in WRAP, and many individuals with SPMI have started their own local WRAP support groups. Goals for FY2001 included having KU's certified WRAP trainers train a group of 6-12 individuals with SPMI to help facilitate WRAP workshops, providing technical assistance until this group became certified to lead WRAP workshops independently. It is estimated that at least 150 individuals with SPMI and 60 providers will participate in WRAP workshops in FY2002. In addition, a research study is being planned to measure the impact of this project on participants.

Consumers as Providers (CAP)

The Surgeon General's Report makes several references to the movement to employ consumers of mental health services in the provision of these services to their peers: "Consumers are being hired at all levels of the mental health system, ranging from case manager aides to management positions in national advocacy organizations as well as state and federal government agencies" (p. 95). One of several examples from the report includes the fact that of 400 agencies providing supported housing to people with SPMI, 38% employed consumers as paid staff (p. 291).

Training individuals with SPMI to work as mental health service providers is a program in its third year of operation in Kansas. MHSATR contracts with KU School of Social Welfare and the WSU Self-Help Network to offer the 15-week curriculum and training program, which includes the completion of internships at local CMHC's. Overall, the project has a 68% employment rate. Increasingly, CMHC's are hiring consumers to fill a variety of paid positions, including case management, attendant care, peer outreach workers, psychosocial staff, and consumer advocates.

Consumer Run Organizations (CROs)

Peer support and self-help play a key role in recovery for many individuals with SPMI. Research summarized in the Surgeon General's report indicates numerous benefits to people with SPMI who participate in some form of peer support and self-help, including consumer run organizations. These include:

- lessened feelings of isolation
- increased practical knowledge and coping skills
- changes in self-defeating thoughts with involvement in wellness-promoting activities
- shared problem solving
- fewer symptoms and less hospitalization
- improved self-confidence and psychological well-being
- improved sense of control over their lives

From eleven in FY 1999, the number of state-funded CROs grew to seventeen for FY 2001 and then to twenty for FY 2002. These organizations provide a variety of services to their members, including peer support, social, educational and recreational activities, paid and volunteer positions, skill building activities such as cooking, shopping, cleaning, etc., and even food and clothing banks in some.

In addition, consumer leaders from the CROs formed the CRO Network in 1999. This group meets quarterly. The Network's purpose is to encourage the growth of new and existing CROs throughout the state, and to promote improved operations as not-for-profit businesses. The WSU Self-Help Network provides support and technical assistance to this Network.

Supported Housing

Over the last two decades, the has been a national movement away from encouraging people with disabilities to live in large, congregate settings. Knowledge and research have pushed states and service systems toward individualizing services for those people who are most disabled, based on findings that by moving them from place to place, and having them live in facilities with many other people with disabling conditions actually made them more disabled by their illness or symptoms. As stated in the Surgeon General's report, the residential programs states developed to help move people with SPMI out of state hospitals merely replicated the institutional setting, proved ineffective in meeting consumers' needs, and added to social stigma (p. 293).

Given these problems, and the fact that the housing preferences of consumers are well documented, i.e. they want to live in decent housing of their choice, with control over who lives with them and how decisions are made, and they want access to mental health services where they live, then supported housing has been emphasized as the primary approach to housing for adults with SPMI.

The philosophy of supported housing is that, "living independently is the best training for independent living". Independent living does not mean that individuals with SPMI must live alone, or, that they are without other supportive services. However, it does require providers to direct those supports at assisting individuals with SPMI in actively choosing and maintaining the housing they desire. Supported housing is not a building or facility, but a set of community-based services. Within those services, there may be a component of highly focused and time-limited residential treatment; however, such settings should not be considered housing but treatment settings.

The supported housing approach rejects the idea that individuals with SPMI must move through a series of "step down" or "transitional" settings so as to earn the right to their own housing. It also discourages mental health agencies from assuming the dual role of service provider and landlord, though it charges them to actively involve themselves in increasing the availability of affordable housing opportunities in their communities.

Conferences, training, and technical assistance focusing on supported housing practices have been provided to CMHC's over the last several years. Most, if not all CMHC's already successfully apply a supported housing approach to their work in helping people live independently. For those receiving community-based services, 85% are living independently and 24% are working in competitive jobs.

7. Array of Community-Based Services

Current Community Mental Health Services

In 1997 the network of CMHC's had a combined staff of over 2,000 providing mental health services to every county in Kansas. Together, they form an integral part of the State's total public mental health system. The independent, locally operated CMHC's are dedicated to fostering a quality, freestanding system of services and programs for the benefit of citizens needing mental health care and treatment. CMHC's initiate and maintain close cooperative working relationships with other groups, organizations, and individuals having similar interests and goals.

The Community Support Services (CSS) programs of the CMHC's generally organize and deliver services at the local level for the targeted population of adults with SPMI. Case management is the core service. As outlined in the previous section, CSS and its case management services are designed to provide specialized and individualized services to adults with SPMI that are proven to be effective for this population. These interventions and supports address all areas of their lives, including housing, public benefits and income, social and daily living skills, health care, employment, education, transportation, and relationships with friends, family, and peers.

CMHC/CSS programs can and do provide services to NFMH residents in order to help them move into the community. SRS will continue to support CMHC's in providing the services necessary to helping individuals transition from NFMH's.

Treatment and Services

As licensed comprehensive CMHC's, these agencies offer the following required basic services for adults with SPMI:

- Outpatient Services
- 24-hour emergency services
- Consultation and Education
- Screening
- Aftercare
- Case Management
- Medication Management
- Attendant Care

Specialized Services include:

- Observation/Stabilization
- Drop-In Services for persons with severe and persistent mental illness
- Vocational Services for persons with severe and persistent mental illness
- Homeless Projects
- Residential Programs
- Social Detox for Alcohol and Drug Abuse Services
- Intermediate Residential Care for Alcohol and Drug Treatment
- Half-Way Houses for Alcohol and Drug Services
- Parent Education Classes
- Psychosocial treatment groups
- Deaf and Hard of Hearing programs

It should be noted that while CMHC's and their CSS programs are the predominate provider of services to adults with SPMI, other organizations do exist that augment these services. The growth of the Consumer Run Organizations described earlier, are important resources for this population. Also, Independent Living Centers, designed to serve people with any disability, can also be considered as helpful and supportive resources for people with SPMI.

The Surgeon General's Report clearly states that ancillary services are important adjuncts to any community-based mental health system of services for adults with SPMI. These include:

1. Consumer self-help and consumer operated programs
2. Consumer advocacy at the local, state and national levels
3. Family self-help
4. Family advocacy at the local, state and national levels
5. Human services, including housing, income, education, employment and health coverage
6. Integrated service systems

8. Recent Systems Improvements

There are several current initiatives that impact the ability of the Mental Health system to make the changes discussed in this report. Those include Mental Health Initiative 2000, and current efforts to increase housing resources.

Mental Health Initiative 2000

A Legislative Post Audit report of March 2000 recommended changes in the Kansas public mental health system. These changes included reviewing current financing mechanisms in order to increase federal funding. The report also encouraged SRS to move in this direction in order to increase accountability for state funds. The Kansas system has historically relied on grants to fund CMHCs, and these grants are not distributed according to the number of people served, the number of services provided, outcomes in the lives of people, or the size of the population in the catchment area. SRS began working with a small group of CMHCs in the summer of 2000 to design a package of changes to address these issues.

At the same time, SRS contracted for a review of crisis services statewide, after hearing from many stakeholders, advocates, and providers that a lack of crisis services existed in every area of the state. This report did indicate a serious lack of crisis supports, and outlined steps necessary to begin filling these gaps.

These two initiatives were the basis of Mental Health Initiative 2000, and the first phase of implementation began in January of 2001. This initiative was based on three goals: increased accountability for the public mental health system, increased crisis supports for every CMHC, and development of new access standards for public mental health services.

The first phase of implementation included raising Medicaid rates substantially for those services that consumers and families say are most effective in helping them live in the community. Increased provision of these services began immediately, and continues to grow as other parts of the initiative are implemented. The second phase included development of crisis plans for every catchment area in Kansas. These plans detailed how increased revenue would be invested in filling the gaps of crisis services.

These two steps, increased community based services and crisis plans, significantly impact the ability of the Kansas mental health system to carry out the recommendations in this report. The timing of these initiatives is critical to the ability to meet the needs of current NFMH residents, in community settings. These services are already expanding prior to the closure of any NFMH beds.

It also changes the way in which we think about financing NFMH closure or downsizing. Past closures have included grants to CMHCs in order to meet the needs of these individuals. However, the changes in how CMHCs are financed puts more emphasis on a fee-for-service model that actually has funding follow the person. CMHCs do not receive funding unless services are actually provided. Unlike previous downsizing when Medicaid rates were not sufficient to provide increased services, the current system provides rates that make it possible to provide community-based services with little additional support. The work groups addressed the needs that are not covered within the Medicaid program, such as housing and flexible funding.

Current Housing Efforts

SRS has worked with the Kansas Department of Commerce to apply for housing vouchers, specifically for individuals leaving NFMHs. These vouchers would provide much needed assistance in accomplishing the recommendations of this report. SRS now has staff devoted full-time to the development of housing resources, and will continue to seek federal, state, and local funds for expanding housing options.

However, while these resources certainly make it easier to accomplish recommendations, many CMHCs have developed housing resources and supports outside of grant funds in order to support individuals leaving institutional settings. Even in the areas of the state with the highest cost housing, individuals leaving institutional settings have been successful in securing safe affordable housing by having roommates, and/or applying for Section 8, or using CMHC transitional housing options.

9. The Future Role of NFMH's in Kansas

The Workgroup discussed concerns about how the implementation of the Proviso Plan would impact the future of the NFMH program as it currently is operated. Members acknowledged that their recommendations, if approved by the legislature, would definitely result in systems-level change. Given their agreement to devise a plan based on person-centered values, evidence-based practices, active collaboration, and direct attention to key resources being in place to insure successful transition of NFMH residents into the community, the Workgroup was clear in their desire that its recommendations would result in moving the system forward in a positive way.

The fact that there will continue to be a subgroup of individuals with SPMI with complex needs who will be difficult to serve, even with the expanded array of community-based and in-home services available, was noted by the members. Examining ways that NFMH's could alter their current services, partner with CMHC's to serve this subgroup differently, or change their way of doing business in order to become an integrated part of the public mental health system entered into the Workgroup's discussions. One drawback to these discussions, however, is the fact that NFMH's are private entities, many of which are owned by out-of-state corporations whose boards of directors have sole authority in business decisions. Discussion included the difficulty of influencing corporations to change their practices, since the state has no formal authority to change the type of business they choose to operate.

As part of their work, members reviewed information concerning an initiative available for NFMH's to convert into another kind of service provider. A summary follows:

Conversion of NFMH into a Community-Based Service Provider Initiative

MH/SATR has proposed to the NFMH's and CMHC's that they affiliate with the purpose of converting the NFMH into a new service delivery system comprised of an array of less restrictive housing options for residents, coupled with a comprehensive buildup of intensive community-based and in-home supports and services. NFMH staff could work in a variety of roles in tandem with CMHC staff, depending on the specifics of their affiliation agreement. Some CMHC's have affiliation agreements with other service organizations, so this would only be an extension of an existing service delivery practice.

Conversion to a 16 beds or less facility, will lead to the ability to access federal dollars that can be used to support community integration for individuals residing in NFMH's as well as consumers who have moved to the community, and insure more effective use of State General Funds. MHSATR proposed that the service provision arrangements and financial plans be spelled out in an affiliation contract between the CMHC and NFMH.

The array of services to be provided through an affiliation of a CMHC and an NFMH will include:

1. Individualized assessment and treatment planning with the client, and relevant staff;
2. Case Management;
3. Counseling or therapy
4. In-home services and protective oversight, such as attendant care and nurse aid services;
5. Nursing and medical services;
6. Psychiatric services;
7. Community-based psychosocial and recreational activities;
8. Transportation;
9. Medical and physical health services;
10. Peer support activities and staff;
11. Vocational services;
12. Crisis respite services;
13. Other services as needed

This conversion option has been offered to all NFMH's and CMHC's, and many written materials and offers of technical assistance have been made available during their quarterly meetings to help them guide their planning process. Discussions on the idea of conversion with one NFMH and one CMHC have occurred and MHSATR is seeking additional participants (see Appendix XVI for more detail).

Once the programmatic, staffing, and financial details of the plan have been spelled out in the affiliation agreement, SRS continues to offer the parties the ability to enter into a contract with SRS that addresses, as one part of the plan, how the conversion will be financed, and to negotiate the amount of "bridge money" needed by both parties to insure successful implementation of the plan. At this point, SRS has not received notice that any NFMH's or CMHC's have completed their affiliation agreement and are ready to enter into a contract.

Other Possible Scenarios for NFMH's

Although the Workgroup took no formal action to provide NFMH owners any specific recommendations regarding how to change the NFMH facilities themselves, SRS staff developed the list below as additional potential options for these facilities. What is listed below does not represent the opinions or ideas of the Workgroup members. Rather, it is offered as additional possible options for general consideration:

- Sell NFMH facilities to a CMHC, who can then convert it into a multi-purpose building, with some rooms devoted to crisis respite care, others to social detox for those with a dual diagnosis, and other space converted for use as offices, a drop-in center, meeting space, etc.

NFMH staff could be hired and trained to provide attendant care and other in-home services to SPMI living in the community, as well as retaining some staff to work with those who are there for short-term stays. (This is identical to the conversion option outlined above, except that the corporation sells its facility instead of entering into an affiliation agreement).

- Work with SRS to determine how many NFMH's are actually needed in the state and devise a plan where some facilities would voluntarily close their doors in a planned manner.

- Work with SRS and other entities to convert the facility from a nursing home to a building comprised of private studio apartments for adults with SPMI, saving a part of the facility for office space for staff and social/shared common space for peer support activities, consumers and their guests. These apartments would co-locate independent living space for consumers who have multiple challenges or disabilities with immediate access to staff for assistance when needed or desired. NFMH staff could be hired and trained to provide this type of in-home support.

- NFMH's could sell their facilities to another corporation who would convert it to a regular nursing facility (NF) for elderly adults needing skilled nursing care in such a setting. (They could also convert to an NF for the elderly population themselves - Regardless, the Workgroup was very clear in stating that residents of NFMH's should not be transinstitutionalized by being placed in NF's unless that individual requires skilled nursing care).

- NFMH's could sell their facility to a city or township, who could convert it for a variety of uses, such as a community center, a place for private retail businesses to locate, office space for private and/or public entities, or some combination of the above. (This has occurred in some rural towns with NF's that chose to cease operation).

- Work with SRS or an individual CMHC to close the NFMH but provide attendant care services or home care services to consumers around the state.

- Currently, one facility in Kansas is licensed as an NFMH but also has a wing as a Residential Health Care Facility (RHCF). That facility targets those RHCF beds for individuals who are private pay or are connected with the Veterans Administration. An option would be to convert enough beds to RHCF beds in order to have the remaining number of beds 16 or less.

For some of the ideas listed above, Community Development Block Grant (CDBG) funds could be used to help pay for facility conversion. This has been done in other states.

While by no means an exhaustive list, this section is offered to exemplify the fact that numerous options do exist for these facilities, and that through active collaboration and creative thinking, it is possible to envision a positive future for the NFMH program in Kansas.

10. For Further Consideration

KSA 75-7304 establishes the Long Term Care Ombudsman office and KSA 75-7304 (c) defines facilities of whom this office provides its services. NFMH's are excluded from that program. Residents in NFMH's can access SRS's Abuse Hotline, Kansas Advocacy and Protective Service, KDHE complaint hotline, and MHSATR Quality Enhancement Coordinators but there is no ombudsman program specific to NFMH residents as there is to residents in regular nursing facilities.

11. Workgroup Recommendations

These are overarching recommendations of the NFMH Proviso Workgroup. Many of the recommendations were reached by unanimous approval and some were reached by consensus.

The charge to the Workgroup was to identify the core recommendations of the plan. The group recognized the recommendations listed here are not exhaustive, but do cover the critical elements necessary to successfully reduce the State's reliance on NFMH's.

The three subgroups: Front Door, Back Door and Community Resources, have specific recommendations and are found in Appendix XX. Please refer to them for the detailed recommendations of the individual groups.

1. Community mental health centers, affiliates, and other key community service providers must adopt a "do whatever it takes" approach to divert individuals with SPMI who could live more independently from entering NFMH's, and to support those leaving NFMH's in maintaining community tenure. Throughout the process, individualized, formal, person-centered planning will occur with each consumer before changes occur.

2. To ensure that all potential community-based services have been considered prior to NFMH admission, CMHC's will perform screening assessments of individuals with mental illness (using the PASRR Level II).

3. To determine whether individuals with mental illness continue to need this level of care, CMHC will perform screening assessments of individuals with SPMI on a semi annual basis (using the Continued Stay assessment).

4. CMHC's will designate staff as NFMH Liaisons to participate in each individual's process from admission through discharge from NFMH's.

5. Individuals residing in NFMH's should be included in performance outcome measures for CMHC's.

6. Individuals with SPMI being diverted or discharged from NFMH's must have sufficient access, in a timely manner, to flexible funds to assist them in transitioning to the community.

7. Individuals with SPMI being diverted or discharged from NFMH's must have sufficient access, in a timely manner, to rental subsidies which remain available until a permanent affordable housing solution is obtained.

8. For the next five years, the Governor's Mental Health Planning Council conduct an annual review of the 2002 NFMH Proviso Plan to monitor progress in addressing priorities and to have a mechanism in place to respond to feedback.

9. Representatives of KDOA, SRS, CMHC's, NFMH's individuals with SPMI, and other stakeholders will form a task force to advise and oversee the transition of PASRR Level II process: assessor contracting process, and SRS/KDOA collaborative oversight process. The above task force should also redesign the Level II assessment tool and endorse newly developed training materials. Recommendations must be implemented by July 1, 2002.

10. SRS-MHSATR will oversee provision of training and education regarding community-based alternatives to individuals with SPMI, family/guardians, CMHC's, and NFMH's.

11. SRS-MHSATR will insure that the County of Responsibility be determined for every NFMH resident no later than July 1, 2002.

12. SRS-MHSATR will insure that CMHC's complete the initial round of Continued Stay Assessments with all current NFMH residents no later than December 31, 2002.

13. Further reductions on NFMH funding, should be used to fund mental health services in the community for those leaving NFMH's. This money should be used as flexible funding to pay for necessary items listed in each persons' individualized plan that are not paid for by other sources.

14. There should be incentives, such as bridge funding, for NFMH's to convert into a new kind of community-based service provider.

STATE OF KANSAS

DEPARTMENT OF ADMINISTRATION
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JOYCE H. GLASSCOCK, *Acting Secretary*

BILL GRAVES, *Governor*

"Update on Maximizing Federal Grants and Revenues in Kansas"
Provided to the House Committee on Appropriations
by Keith Meyers, Deputy Secretary of Administration
February 6, 2002

Mr. Chairman and Members of the Committee,

Thank you for the opportunity to provide you this update on Department of Administration activities regarding the recommendations of the Legislative Budget Committee on maximizing federal grants and revenues in Kansas.

The Department of Administration has been asked to further study how Kansas' state agencies, local governments, non-profit organizations and private businesses could increase their take of available federal grants and other federal revenues. Part of the charge given the Department is to convene a working group of these stakeholders to discuss various options available to us. After discussions with Chairman Wilk and Representative Nichols, Secretary Glasscock, as a preliminary step to establishing a working group, has sent a survey to state agencies to determine interest in participating in the working group, and to determine if agencies have hired consultants or consulting firms for the purpose of seeking out and applying for federal grants. For your review, this survey is attached. Agencies have been asked to respond by February 15, 2002.

The Legislative Budget Committee reviewed activities of the State of Illinois and its federal clearinghouse as a means for communicating via the Internet the availability of federal money. You may recall the State of Illinois reported a 16 percent increase in federal funding after implementing their clearinghouse. As a result of our research on this topic, we identified several states – Illinois, Texas and Iowa – that have developed web sites which provide consolidated links to online information about grant availability, training and tutorials. Given that information former Division of Information Systems and Communications (DISC) Director Don Heiman, asked the DISC Manager of Internet Services, Duncan Friend, to develop a Grants Clearinghouse for Kansas that Mr. Friend will demonstrate for you today.

Before I turn the presentation over to Mr. Friend, I would like to point out that our proposed approach incorporates a Texas practice that involves notifying users of an opportunity for grant writing training. In our demonstration the State of Kansas would make this training available through the Department of Administration, Division of Personnel Services. The key training objective would be to have participants finish the course with a completed grant application in hand.

Former Director Heiman envisioned that we could partner with the Information Network of Kansas (INK) to communicate updates via e-mail on federal grant/fund opportunities to interested state agencies, local units of government, non-profits, and business. When interested parties would access this information, they would also learn about the grant writing training that would facilitate the grant application process. The Department of Administration believes that a Kansas Grants Clearinghouse presents an outstanding opportunity to enhance access to federal funds throughout the State of Kansas.

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JOYCE H. GLASSCOCK, *Acting Secretary*

BILL GRAVES, *Governor*

MEMORANDUM

TO: The Honorable Rocky Nichols, Kansas House of Representatives

FROM: Joyce H. Glasscock, Acting Secretary

DATE: February 5, 2002

RE: **Seeking the Availability of Federal Funds**

In response to our conversation regarding efforts state agencies take to identify and obtain grants, subsidies or other funds available from the federal government, I sent the enclosed survey to all executive branch agency heads inquiring about their utilization of outside consultant(s) or consulting firm(s) for the purpose of identifying and accessing federal dollars. The survey was not sent to the Board of Regents or to elected officials. If you wish for those agencies to be included in this survey, please let me know.

We asked agencies to respond by February 15, 2002. Upon receipt of the responses and compilation of the data, I will be happy to forward the findings to you and the House Committee on Appropriations.

In the meantime, if you have questions about the survey, please contact me at 296-3011.

Enclosure: Survey

cc: Chairman Kenny Wilk

BILL GRAVES
Governor

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http://da.state.ks.us

DEPARTMENT OF ADMINISTRATION

MEMORANDUM

TO: All Agency Heads

FROM: Joyce H. Glasscock, Acting Secretary

DATE: February 1, 2002

RE: **Seeking the Availability and Maximizing the Use of Federal Funds**

The Department of Administration has been requested by a joint legislative budget committee to report on what efforts state agencies take to identify and obtain grants, subsidies or other funds available from the federal government. Specifically, does your agency hire outside consultant(s) or consulting firm(s) for the purpose of seeking out and applying for federal dollars?

To assist us in responding to this request, please complete the short enclosed survey and return it to my office by ***February 15, 2002***. Please keep your responses very brief. We will contact you if we need additional information.

Additionally, at the suggestion of the committee, I may convene a working group to study if the state currently maximizes opportunities for accessing and utilizing federal funds. Please indicate on the enclosed survey if you do or do not wish to have a representative from your agency participate on such a working group. I anticipate the group would be dissolved after we received the necessary feedback and direction sought by the legislature.

I appreciate your cooperation in providing this information. If you have any questions with regards to this request, please contact Deann Tiede in my office at 296-2554.

Enclosure

Utilization of Consultant(s) or Consulting Firm(s) to Seek Out Federal Funds Survey

Agency Name: _____

- If convened, do you wish to have your agency participate on a working group as described in the cover memo?

  ❑YES ❑ NO

- Does your agency hire consultant(s) or consulting firm(s) for the purposes of seeking out and applying for federal grants or subsidies?

  ❑YES ❑ NO **(If no, please sign and date this form and return it to the address below.)**

- Please list the consultant(s) or consulting firm(s) your agency contracts with for this purpose:

Name of Consultant/Consulting Firm	Location of Consultant/Firm *(City/State)*
Name of Consultant/Consulting Firm	Location of Consultant/Firm *(City/State)*
Name of Consultant/Consulting Firm	Location of Consultant/Firm *(City/State)*

- Briefly describe the terms of the contract(s):

_____

_____

_____

_____

_____

_____

- Briefly describe your agency's compensation arrangement with each consultant(s) or consulting firm(s):

_____

_____

_____

_____

_____

_____

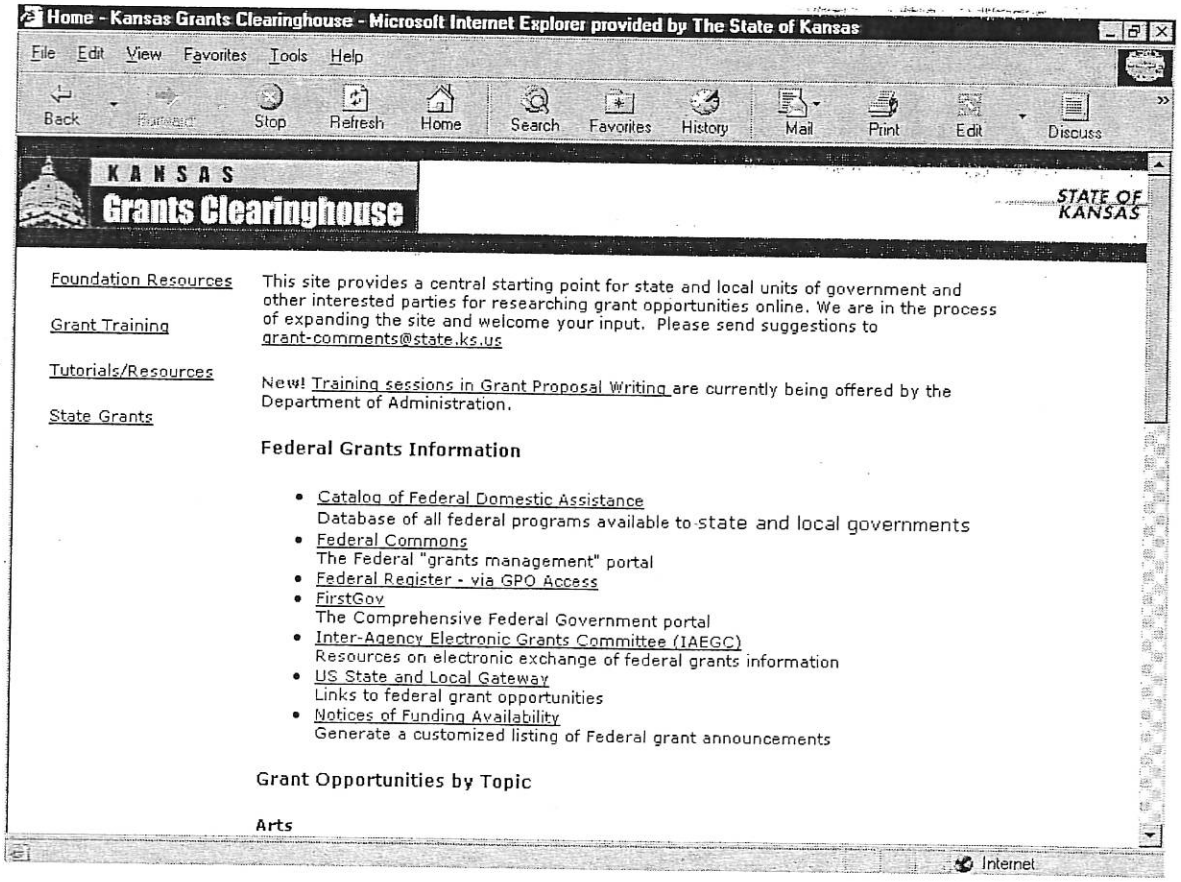
Signature of Agency Head	Date

Return completed survey to Department of Administration; ATTN: Deann Tiede; Curtis State Office Building, Ste. 500; Topeka, KS 66612. Direct questions about the survey to Deann at 296-2554 or via e-mail at deann.tiede@state.ks.us.

Kansas Grants Clearinghouse Web Site
Wednesday, February 6, 2002

The primary purpose of the Kansas Grants Clearinghouse Web Site is to assist and support state agencies and local units of government in obtaining grants from the federal government and other sources by providing a central location from which to access accurate and timely information about such programs. In addition, the site will provide links to information from state agencies about grant programs they offer to citizens, businesses, local units of government, and other parties. A section of the site will also be devoted to funding available from private foundations. The site will be hosted and maintained by the Department of Administration and accessible from the State home page at www.accesskansas.org.

The current site uses a set of links connecting users to Federal and State grant sites. A link is also provided to the Department of Administration's Learning Services enrollment form for grant writing training. Each page of the site provides a brief statement soliciting suggestions and an email address to which suggestions can be sent. Over time, it is expected that state agencies would contribute additional links to be added to the site that they have found helpful, as well as links to information on grant programs they offer. As part of a proposed training offering, attendees will also be introduced to the resources available on the site and encouraged to provide feedback that will improve its usefulness to them.



Proposed Training Session: *Grant Proposal Writing*

As part of the development of the Kansas Grants Clearinghouse Web Site, we investigated the possibility of offering training to help grant seekers expand their skills in locating funding opportunities and preparing grant proposals. The objective would be for participants to leave the workshop with a clear understanding of how to begin the grant writing process, where to look for resources, and how to prepare a highly competitive grant proposal in order to obtain grant funds from public or private sources at the federal, state, and local levels.

The Department of Administration's Division of Personnel Services contacted several states, Kansas Regents universities, and private entities and found training available through both public and private sources. The State of Texas conducts a comprehensive two-day class and has offered to share their curriculum and training materials with us. The State of Illinois reports that they have patterned their class along the same lines as the Texas offering. We have also located a university professor at a local Regents institution with experience in teaching grant proposal research and writing that would be available to teach such a course.

It is expected that the Division of Personnel Services will be able to coordinate up to four training sessions per year beginning in April 2002. These sessions could be conducted in multiple locations as demand is identified. The estimated cost of a 2-day session is $250 per participant. The training would also be open to municipal, local and county government, non-profit, and private organizations. Employees who are responsible for either writing or evaluating grant proposals would benefit from this training. A preliminary outline of subjects that would be covered in the training is provided below:

- A description of the general grant process with a special focus on how grants are reviewed
- Information about the location of funding sources and the use of electronic media to find them, including an introduction to the Kansas Grants Clearinghouse Web Site
- Instruction on how to review an application to determine if it is appropriate for your agency
- Training on the use of planning tools for the creation of effective grant proposals
- Information on suggested approaches for identifying partners and creating coalitions
- Information on the budgeting process and how to maximize grant funding for your project
- Instruction on how to create an appropriate evaluation plan for your project
- Training on the most effective methods for producing your grant proposal
- A draft proposal-outlining exercise followed by peer critique

KANSAS Grants Clearinghouse

STATE OF KANSAS

Foundation Resources

Grant Training

Tutorials/Resources

State Grants

This site provides a central starting point for state and local units of government and other interested parties for researching grant opportunities online. We are in the process of expanding the site and welcome your input. Please send suggestions to grant-comments@state.ks.us

New! Training sessions in Grant Proposal Writing are currently being offered by the Department of Administration.

Federal Grants Information

- Catalog of Federal Domestic Assistance
  Database of all federal programs available to state and local governments
- Federal Commons
  The Federal "grants management" portal
- Federal Register - via GPO Access
- FirstGov
  The Comprehensive Federal Government portal
- Inter-Agency Electronic Grants Committee (IAEGC)
  Resources on electronic exchange of federal grants information
- US State and Local Gateway
  Links to federal grant opportunities
- Notices of Funding Availability
  Generate a customized listing of Federal grant announcements

Grant Opportunities by Topic

Arts

- National Endowment for the Arts Funding site

Criminal Justice

- Kansas Sentencing Commission
  Helpful links for finding Criminal Justice-related grants

Education

- U.S. Department of Education Grants site
- Research Guide to Funding for Technology in Education
  also from the U.S. Department of Education
- Kansas State Department of Education's Links to Grant Information

Housing

- U.S. Department of Housing and Urban Development (HUD) Funding

Human Services

- GrantsNet - U.S. Department of Health and Human Services
  A Roadmap for Applying for and Managing Federal grants
- Welfare Information Network
  Funding Opportunities from various Federal agencies

Research

- Community of Science
  Research and funding information from databases of the U.S. Department of Agriculture, National Institutes of Health, and others

Technology

- CFDA Grant Index - Science and Technology Sub-categories
- Department of Defense Innovation Research and Technology Transfer Grants
- Kansas Technology Enterprise Corporation
- Kansas Department of Commerce and Housing Business Development
-

Transportation

- Federal Department of Transportation Grants Information

Page last modified on: January 27, 2001
Send us your questions and comments about this site
Please read our disclaimer
State of Kansas home page: www.accesskansas.org

KANSAS Grants Clearinghouse

STATE OF KANSAS

Home

Foundation Resources

Grant Training

State Grants

Tutorials/Resources

Please send suggestions to grants-comments@state.ks.us

New! Training sessions in Grant Proposal Writing are currently being offered by the Department of Administration.

Tutorials and Guidebooks

- Basic Elements of Grant Writing
  from the Corporation for Public Broadcasting
- Grant Proposal Guide from the National Science Foundation
- Grant Writing Tutorial
- How to Write a Research Grant Application (3rd ed.)
  from the National Institutes of Health (.pdf format)
- Proposal Writing Short Course, and Proposal Budgeting Short Course both from the Foundation Center

Writing Aids

- American Heritage Dictionary
- Merriam-Webster Dictionary
- Roget's Thesaurus
- Columbia Encyclopedia
- Kansas Library Catalog
- Search Engines: Google, Yahoo!, AlltheWeb

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KANSAS Grants Clearinghouse

STATE OF KANSAS

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Tutorials/Resources

Grant Training (DRAFT - FOR DISCUSSION)

Please send suggestions to grant-comments@state.ks.us

Grant Proposal Writing Course

Course Number: GW 091
Dates: Multiple sessions throughout Spring-Summer 2002
Length: 2 Days
Cost: $250.00
Eligibility: State and local government, non-profit, private organizations
Enrollment: **Online Enrollment** is available for this class.

This course is designed to give participants the practical skills they will need to begin the development of grant proposals. Participants will leave the workshop with a clear understanding of how to begin the grant writing process, where to look for resources, and how to prepare a highly competitive grant proposal in order to obtain grant funds from public or private sources at the federal, state, and local levels. All class participants receive the Program Development and Grant Writing Manual that includes all of the information presented at the workshop. This manual can also serve as a reference guide for participants as they begin to develop their own grant proposals. Course information includes:

- a description of the general grant process with a special focus on how grants are reviewed

- information about the location of funding sources and the use of electronic media to find them, including an introduction to the Kansas Grants Clearinghouse site

- instruction on how to review an application to determine if it is appropriate for your agency

- training on the use of planning tools for the creation of effective grant proposals

- information on suggested approaches for identifying partners and creating coalitions

- information on the budgeting process and how to maximize grant funding for your project

- instruction on how to create an appropriate evaluation plan for your project

- training on the most effective methods for producing your grant proposal

- a draft proposal-outlining exercise followed by peer critique

Participants receiving the maximum benefit from the proposal writing seminar typically: 1) have little or no grant writing experience, or 2) have written some grant proposals but have no formal training. We encourage those working in all issue areas to attend. If participants are not actively working on a proposal to fund a project at this time, it may be helpful for them to think of a project they would like to develop in the future and bring a rough outline for the project design to the seminar with them.

KANSAS Grants Clearinghouse

STATE OF KANSAS

Home

Foundation Resources

Grant Training

Tutorials/Resources

State Grants

Please send suggestions to grant-comments@state.ks.us

- Kansas Arts Commission Grants
- Kansas Historic Preservation Office
  from the Kansas State Historical Society
- Kansas Humanities Council Grants
- Kansas Institutional Conservation Program (ICP)
  Funds for schools and hospitals for energy conservation improvements - administered by the Kansas Corporation Commission
- Kansas Juvenile Justice Authority Grant Announcements
- Kansas State Department of Education Grant Information
- Land and Water Conservation Fund Grants
  from the Kansas Department of Wildlife and Parks
- Outdoor Wildlife Learning Sites (OWLS) Grants
  from the Kansas Department of Wildlife and Parks

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KANSAS Grants Clearinghouse

STATE OF KANSAS

Home

Grant Training

State Grants

Tutorials/Resources

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Please send suggestions to grant-comments@state.ks.us

- The Foundation Center
  Comprehensive site w/links to a "learning lab", and frequently asked questions.
- Foundation Links
  List linking directly to grant information for many private foundations

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State of Kansas home page: www.accesskansas.org

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February 5, 2002

To: Legislative Budget Committee

STATE GENERAL FUND (SGF) RECEIPTS
July through January, FY 2002

This is the third month of experience under the revised estimate of SGF receipts in FY 2002 made by the Consensus Estimating Group on November 2, 2001. The figures in both the "Estimate" and "Actual" columns under FY 2002 on the following table include actual amounts received in July-October. That means that this report deals mainly with the difference between estimated and actual receipts in November through January.

Total receipts through January of FY 2002 were $97.6 million or 4.1 percent below the estimate.

The only taxes that exceeded the estimate by more than $1.0 million were estate ($5.6 million) and sales ($2.2 million). Taxes that fell below the estimate by more than $1.0 million were corporation income ($55.3 million), individual income ($35.0 million), compensating use ($5.6 million), liquor enforcement ($2.3 million), and financial institutions privilege ($1.4 million).

Receipts for January were negatively impacted by the ice storm, which closed state offices on January 29 and part of January 30. This caused tax remittance processing delays in the Department of Revenue. About $7.8 million in receipts were deposited during the final two days of the month, compared with approximately $50 million during the final two processing days of January 2001. Additional individual income, sales, and compensating use tax receipts likely will be processed during the first few days of February that otherwise would have been credited to the SGF at the end of January. However, the shortfall in individual income tax receipts appears not to be entirely a result of weather-related processing delays. Estimated payments for December and January (combined) were $16 million below the same two-month period from a year ago.

Recall also that, due to significantly larger than anticipated refunds, corporation income taxes through the end of December were $54.6 million below the estimate. An additional refund not contemplated by the current estimate is due because of a Kansas Supreme Court opinion in *In re Tax Appeal of Panhandle Eastern Pipeline Co.* (January 25, 2002). That refund, likely to be in excess of $26 million, had not been paid by the end of January.

Interest and agency earnings exceeded the estimate by $1.6 million and $1.9 million, respectively. Transfers from the SGF exceeded the estimate by $8.4 million. On January 18, the Department of Revenue transferred $9.2 million from the SGF for the final payment to a vendor for the Department's Project 2000. The transfer and subsequent payment, while included in the FY 2002 SGF projections, had not been anticipated for January.

Total taxes for FY 2002 to date fell below last year's collection by $34.3 million or 1.4 percent.

This report excludes the deposit to the SGF of $350.0 million due to issuance of certificates of indebtedness in September and December. These certificates will be discharged prior to the end of the fiscal year.

The next meeting of the Consensus Revenue Estimating Group to review and, if necessary, revise SGF estimates for FY 2002 and FY 2003 is scheduled for March 8, 2002. Normally, this meeting would be held on or a day or two before April 4, but is being held earlier this year at the request of the President of the Senate and Speaker of the House in view of the unusually difficult state budget issues with which the Legislature must contend.

STATE GENERAL FUND RECEIPTS
July-January, FY 2002
(dollar amounts in thousands)

	Actual FY 2001	FY 2002 Estimate*	FY 2002 Actual	Difference	Percent Increase-- FY 2002 Over FY 2001	Percent Increase-- FY 2002 Over Estimate
Property Tax:						
Motor Carriers	$ 10,925	$ 11,390	$ 11,829	$ 439	8.3 %	3.9 %
Income Taxes:						
Individual	$ 1,095,579	$ 1,128,000	$ 1,092,957	$ (35,043)	(0.2) %	(3.1) %
Corporation	101,494	90,000	34,713	(55,287)	(65.8)	(61.4)
Financial Inst.	13,194	14,800	13,392	(1,408)	1.5	(9.5)
Total	$ 1,210,268	$ 1,232,800	$ 1,141,063	$ (91,737)	(5.7) %	(7.4) %
Estate Tax	$ 22,378	$ 27,400	$ 32,958	$ 5,558	47.3 %	20.3 %
Excise Taxes:						
Retail Sales	$ 848,262	$ 874,500	$ 876,707	$ 2,207	3.4 %	0.3 %
Comp. Use	133,084	148,000	142,395	(5,605)	7.0	(3.8)
Cigarette	28,733	29,100	28,470	(630)	(0.9)	(2.2)
Tobacco Prod.	2,410	2,500	2,500	(0)	3.7	(0.0)
Cereal Malt Bev.	1,451	1,475	1,420	(55)	(2.1)	(3.7)
Liquor Gallonage	8,689	8,500	8,589	89	(1.2)	1.0
Liquor Enforce.	20,844	22,200	19,936	(2,264)	(4.4)	(10.2)
Liquor Dr. Places	3,613	3,900	3,504	(396)	(3.0)	(10.2)
Corp. Franchise	6,732	7,025	6,933	(92)	3.0	(1.3)
Severance	50,269	37,100	36,693	(407)	(27.0)	(1.1)
Gas	42,427	28,000	27,822	(178)	(34.4)	(0.6)
Oil	7,842	9,100	8,871	(229)	13.1	(2.5)
Total	$ 1,104,087	$ 1,134,300	$ 1,127,148	$ (7,152)	2.1 %	(0.6) %
Other Taxes:						
Insurance Prem.	$ 24,615	$ 24,650	$ 25,059	$ 409	1.8 %	1.7 %
Miscellaneous	694	750	583	(167)	(16.0)	(22.3)
Total	$ 25,309	$ 25,400	$ 25,642	$ 242	1.3 %	1.0 %
Total Taxes	$ 2,372,967	$ 2,431,290	$ 2,338,639	$ (92,651)	(1.4) %	(3.8) %
Other Revenue:						
Interest	$ 53,015	$ 26,500	$ 28,096	$ 1,596	(47.0) %	6.0 %
Transfers (net) **	52,694	(103,700)	(112,073)	(8,373)	--	(8.1)
Agency Earnings and Misc.	27,351	29,500	31,378	1,878	14.7	6.4
Total	$ 133,061	$ (47,700)	$ (52,599)	$ (4,899)	-- %	10.3 %
TOTAL RECEIPTS***	$ 2,506,028	$ 2,383,590	$ 2,286,040	$ (97,550)	(8.8) %	(4.1) %

* Consensus estimate as of November 2, 2001.

** Estimates include transfers out attributable to Project 2000 of the Dept. of Revenue.

*** Does not include the $350.0 million to the SGF from issuance of the Certificate of Indebtedness.

NOTE: Details may not add to totals due to rounding.

Kansas Legislative Research Department

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