

MINUTES OF THE COMMITTEE ON SENATE WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 10:30 a.m. on February 4, 2002 in Room 123-S of the Capitol.

All members were present except: All present

Committee staff present:

Deb Hollon, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Assistant Revisor of Statutes
Judy Bromich, Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee:

Janet Schalansky, Secretary, Department of Social and Rehabilitation Services
Sara Adams, Director of Information Systems, Keys for Networking, Inc., and Lori Ellis, parent of a child with SED
Paul Klotz, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
Josie Torrez, self
Tom Laing, Executive Director, InterHab
Robert Day, Director of Medical Policy, Department of Social and Rehabilitation Services
Chris Collins, Director of Government Affairs, Kansas Medical Society

Others attending: See attached list

Bill Introduction

Senator Jordan moved, with a second by Senator Schodorf, to introduce a bill concerning establishing the e-technology communication fee fund (1rs1892). Motion carried on a voice vote.

Chairman Morris referred the following bill to the KPERS Issues Subcommittee:

SB 484 – KPERS accidental death benefit coverage, certain employees of state board of regents or its institutions or of state board of education institutions

Two letters were distributed to the Committee from Janet Schalansky, Secretary, Department of Social and Rehabilitation Services as follows:

- Report on Plans for Maximizing Federal Financial Participation and Community Capacity Building Plans, as required by **Senate Substitute for HB 2067** (Attachment 1) and
- Report on Nursing Facilities/Mental Health Facilities (NF/MH) Proviso Workgroup Report to determine the number of individuals currently in care who are candidates for community-based services (Attachment 2) as required by **HB 2283**.

Chairman Morris opened the public hearing on:

SB 421 – Social and Rehabilitation Services; fixing of certain fees and disposition thereof

Staff briefed the Committee on the bill.

Janet Schalansky, Secretary, Department of Social and Rehabilitation Services, spoke in favor of **SB 421** (Attachment 3). Secretary Schalansky mentioned that SRS believes that **SB 421** is a reasoned, equitable approach to continuing critical services to children while requiring families, who are able, to contribute

CONTINUATION SHEET

toward the cost of these services. She noted that the fees would be reasonable, and directly related to the cost of services and parental income. Committee questions and discussion followed.

Chairman Morris requested, upon a question by Senator Barone, that Secretary Schalansky visit with the Revisor to get an amendment drafted regarding the fees from parents on line 16 and there is nothing in the bill in regard to parental income. Secretary Schalansky noted that they would not recommend setting this at a level that would deter families from using the service. Senator Barone also requested a list of programs where fees are or are not charged.

Sara Adams, Director of Information Systems, Keys for Networking, Inc., spoke in opposition to **SB 421** (Attachment 4). Ms. Adams testified that she represents families whose children have mental illness, who are affected by the bill. She also mentioned that spending state monies early for mental health services saves the state money and the best "deal" for the family and for the state is still community services.

Lori Ellis, Circleville, spoke in opposition to **SB 421** (testimony is found in the testimony of Sara Adams, Keys for Networking, Inc., Attachment 4). Ms. Ellis explained that she opposes **SB 421** because she would have to choose between medications and services, the costs involved with these problems and children are kept out of institutions by these services.

Josie Torrez, self, submitted written testimony in opposition to **SB 421** (Attachment 5).

Paul Klotz, Executive Director, Association of Community Mental Health Centers of Kansas, Inc., submitted written testimony in opposition to **SB 421** (Attachment 6).

Tom Laing, Executive Director, InterHab, submitted written testimony in opposition to **SB 421** (Attachment 7).

Committee questions and discussion followed. Chairman Morris thanked the conferees for their appearance before the Committee. The Chairman closed the public hearing on **SB 421**.

Chairman Morris opened the public hearing on:

SB 422 – Social and rehabilitation services; reimbursement for certain drugs; rules and regulation requirements changed

Staff briefed the Committee on the bill.

Robert Day, Director of Medical Policy, Department of Social and Rehabilitation Services, spoke in favor of **SB 422** (Attachment 8). It was explained that this is one of the Department's legislative proposals and the purpose is to provide the Department with the ability to better manage its pharmacy program, so that they may be able to reduce the growth in that area of their budget. Mr. Day addressed dispensing of generic drugs and an expedited prior authorization process.

Chris Collins, Director of Governmental Affairs, Kansas Medical Society (KMS), spoke in favor of **SB 422** (Attachment 9). Ms. Collins mentioned that the KMS supports the Department of Social and Rehabilitation Services (SRS) in its efforts to ensure that maximum value is received for every dollar spent within the escalating Kansas Medicaid budget. In regard to the philosophy behind SRS' proposed amendments to the prior authorization rules and regulation process, the KMS is in support of it.

Committee questions and discussion followed. Chairman Morris thanked the conferees for their appearance before the Committee. The Chairman closed the public hearing on **SB 422**.

The meeting adjourned at 11:40 a.m. The next meeting is scheduled for February 5, 2002.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST

DATE February 4, 2002

NAME	REPRESENTING
Julian Thomas	DOB
Sarah Adams	Keyp for Networking, Inc
Jeri Ellis	20 Grant St. Circleville, Ks - parent
Pat Hubbell	Phumo
Matthew Bergman	Pat Hubbell Assoc.
Jann Howard	SRS
Janet Schalarzky	SRS
Robert Day	SRS
Marilyn Jacobs	SRS
Judy Reese	SRS
Stuart Little	Dannon & Assoc.
Michael White	Attorney Law
John Petersen	Ks Governmental Consulting
Larry Kynec	OSK
Dale Jeffman	FAMILIES TOGETHER
Josie Torres	KCOD
Kirk Conway	TILRC
Shawn Hennessy	Greater KC Chamber
Mike Huttles	Pharmacia
Tom Knox	Pharmacia
Nancy Zogelman	Pfizer
Carol A. Curtis	AstraZeneca Pharmaceuticals LP

SENATE WAYS AND MEANS COMMITTEE

GUEST LIST

DATE 02/04/02

NAME	REPRESENTING
David K Ross MD	Doctor for the Day
XXXXXXXXXX	XXXXXX
Mary Obley	SRS
Jill Shelley	Legislative Post Audit
Marsha Strahm	CWA of Ko.
J. Chubb	SOS
Lynn Keg	Kansas Advocacy & Protective Services
Michelle Heydon	Kansas Advocacy & Protective Services
Mike Hammond	Assoc. of CMHCs of Kansas
Brad Smart	Pfizer, Inc.
Karin Ann Power	KAAP
Jason Moore	KS Pharm Assoc
BOB ALDERSON	KPHA
Barbara Belcher	Merck
Bill SNEED	MERCK



KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

January 28, 2002

Senator Stephen Morris, Chair
Senate Committee on Ways and Means
Room 120-S, Capitol Building
Topeka, Kansas 66612

Dear Senator Morris:

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 Senate Committee on Ways and Means as I thought it might be of interest to you.

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

Sincerely,

A handwritten signature in cursive script that reads "Janet Schalansky".

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

cc: Members of the Senate Committee on Ways and Means

Senate Ways and Means
2-4-02
Attachment 1



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,

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Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

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

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Office of Planning and Policy Coordination
Trudy Racine, Director

phone: 785.296.3271 *fax:* 785.296.4685



Report to Legislature

**Plans for Maximizing Federal Financial Participation and Community Capacity
Building Plans**

Health Care Policy
Laura Howard, Assistant Secretary

**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 county 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.



KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

January 28, 2002

Senator Stephen Morris, Chair
Senate Committee on Ways and Means
Room 120-S, Capitol Building
Topeka, Kansas 66612

Dear Senator Morris:

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 Senate Committee on Ways and Means as I thought it might be of interest to you.

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

Sincerely,

A handwritten signature in cursive script that reads "Janet Schalansky".

Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

cc: Members of the Senate Committee on Ways and Means

Senate Ways and means
2-4-02
Attachment 2



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

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Janet Schalansky, Secretary
Department of Social and Rehabilitation Services

Enclosure

JS:bw

**NFMH PROVISIO
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.

TABLE OF CONTENTS

1.	An Overview of the Kansas NFMH System	1
	History	
	Conversions and Closures	
	Time Line	
	Current System	
	Federal Oversight (PASSR)	
	Findings from NFMH Studies	
	The Olmstead Decision	
	The U.S. Surgeon General's Report on Mental Health	
	Conclusions	
2.	Scope of Proviso Workgroup's Charge	15
3.	Workgroup Formation	16
	Charge of each Sub-Group	
	Communication and Collaboration	
4.	Time Line and Tasks of the Workgroup	18
	Meeting Content and Presentations	
5.	Core Values and Premises of the Workgroup	20
6.	Evidence-Based Practices	22
	Focus on Recovery	
	Case Management	
	Wellness Recovery Action Planning (WRAP)	
	Consumers as Providers (CAP)	
	Consumer Run Organizations (CRO's)	
	Supported Housing	
7.	Array of Community-Based Services	28
	Current Community Mental Health Services	
	Treatment and Services	

8.	Recent Systems Improvements	30
	Mental Health Initiative 2000 Current Housing Efforts	
9.	Future Role of NFMH's	32
	Conversion of NFMH into a Community-Based Service Provider Initiative Other Possible Scenarios for NFMH's	
10.	For Further Consideration	36
11.	Workgroup Recommendations	37

Appendices:

- A. List of NFMH Workgroup Members
- B. List of Materials Received by NFMH Proviso Workgroup
- C. KU School of Social Welfare "1996 NFMH Status Report"
- D. KU School of Social Welfare "PASRR" Study
- E. KU School of Social Welfare "Screening for Continued Stay" study, October 2000
- F. Under Court Order, What Community Integration Means for People with Mental Illness: The Supreme Court Ruling in Olmstead v. L.C.
- G. Executive Order by President George W. Bush: Community-Based Alternatives for Individuals with Disabilities
- H. Olmstead Plan Template
- I. Mental Health Initiative 2000: Crisis Supports, Access, Accountability
- J. Memo from Karen Suddath to CMHC Directors regarding Increase in Medicaid Rates
- K. Community Resources/Crisis Services Summary
- L. CMHC Service Definitions

- M. Mental Health Reform Act County of Responsibility Determination Criteria
- N. Consumer Run Organizations Information
- O. Recovery Paradigm
- P. Answers to Frequently Asked Questions About Supported Housing
- Q. SRS-MHSATR's Blueprint for NFMH Conversion into Community-Based Service Provider
- R. Summary of Johnson County Mental Health Center's NFMH's Closure Plan
- S. Summary of Sedgwick County Department of Mental Health's Heartland NFMH's Closure Plan
- T. Transcripts of Focus Groups of Individuals with SPMI, Employees involved in Heartland NFMH's Closing and minutes of the Community Stakeholders Focus Group
- U. Recommendations Produced by each of the Workgroup's Sub-Group

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 recommendations 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 (PASSR). 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 PASSR, 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 accessibility 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 led 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),
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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.

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, there 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.

Kansas Department of Social and Rehabilitation
Services
Janet Schalansky, Secretary



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Senate Ways and Means Committee
February 4, 2002 at 10:30 a.m.

Senate Bill 421 - Parental Financial Participation

Janet Schalansky, Secretary
785.296.3271

Senate Ways and Means
2-4-02
Attachment 3

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee
February 4, 2002 at 10:30 a.m.

Senate Bill 421 - Parental Financial Participation

Chairman Morris and members of the committee, thank you for allowing me to appear before you today in support of Senate Bill 421. This proposal, which the Department requested this Committee introduce, authorizes SRS to fix, charge, and collect fees from parents for services the Department provided to their minor children. The fees would be reasonable, and directly related to the cost of services and parental income. They would be fixed in order to recover all or part of the expenses incurred in providing such services. The fees would be credited to the Department's social welfare (fee) fund. The language of this proposal is permissive; it authorizes SRS to establish such fees, but does not require a fee to be established for any particular program.

The concepts of fairness and shared responsibility underlie the Department's request for this legislation. Because all of the services SRS provides are important to the people it serves, the concept of shared responsibility is a reasonable one. Regarding fairness, current practices are not uniform across programs: the agency charges fees for some services and not for others. For instance, parents are billed for the cost of care provided to children in state hospitals, depending on their ability to pay and assets. Parents are expected to provide financial support for children in the foster care system, and are charged monthly premiums for HealthWave.

SRS funds and provides other services to families without charge. These include such things as family preservation services, in-home attendant care for children with disabilities, home modification to accommodate children with disabilities, or other assistive technology and equipment. Historically, SRS has not charged for those services; in part because of Medicaid rules. However, in these current tight financial times, it seems reasonable and responsible to expect families, who have the means, to share in the cost of services provided to their minor children.

To clarify the options about charging parental fees, Department staff recently consulted with the regional office of the Center for Medicare and Medicaid (CMS - formerly HCFA) regarding what alternatives might exist for programs funded by Medicaid. The CMS regional office responded that federal rules do not prohibit SRS from establishing a parental contribution for services provided to children on Medicaid as long as such contributions are separate and apart from the Medicaid

program and service provision is not contingent upon payment of the fee. SRS believes that passage of S. B. 421 would enable the Department to charge parents in a way that is consistent with CMS requirements.

SRS currently expects to establish parental fees for in-home services provided to children through the HCBS (Home and Community Based Services) and SED (Serious Emotional Disturbance) waivers and family preservation/family services. The Department estimates that approximately \$1.7 million will be collected in fees from parents as a result of this change. The Governor's Existing Resources Budget Recommendation reduces the SRS base budget by this amount in anticipation of the receipt of these fee funds in FY 2003. The fees will be used to replace state general funds currently used in the programs. This will allow SRS to still collect all of the federal matching funds currently available for many of these programs using fewer state general funds.

SRS is beginning to develop procedures to assess and collect fees for these services. In developing proposed procedures, the Department will be consulting with families, advocates, and stakeholders to determine what recommendations they might have.

SRS believes SB 421 is a reasoned, equitable approach to continuing critical services to children while requiring families who are able to contribute toward the cost of these services. I appreciate your support of this bill.



Keys for Networking, Inc.

February 4, 2002

To: Members of the Senate Committee
From: Sarah Adams, Director of Information Systems *SA*
And Lori Ellis, parent of a child with SED

I am testifying today against SB 421. I represent the families whose children have mental illness, who are affected by this bill. This an attempt by SRS to balance the budget on the backs of families who are raising the most fragile children in the state. Families with serious emotional disabilities not only have children who need care; they must also argue almost on a daily basis, even with each other that the child should have services today. What will happen when faced with these up front costs and co-pays, instead of seeking help, parents will put off getting services until the need is so severe, the services won't work.

I have with me Lori Ellis (Circleville) who says for her child, this 6% co-pay would cost her approximately \$1,000 a month until the co-pay is met for services and medications. This means that she would first spend money on the medications, he would not get services because she could not afford it. This means that he is now on a medication only treatment plan which does nothing but maintain behaviors, not improve them.

With no services plus puberty, (Charlie is 16), he would likely end up in a hospital, but there isn't one for him to go to so the family then has to consider the options I spoke to you about last week. This family faces issues that are familiar to you--because we have spoken before you so many times--of giving custody of their child to the state when they cannot provide adequate care. Or families face court action and loss of the child to the juvenile justice system when they can no longer control the child. Spending state monies early for mental health services saves the state money. The best "deal" for the family and for the state is still community services. I developed the following grid to compare for you the cost of the alternatives to community based care. Please consider the real costs to families in this grid—who lost their children to these systems. I remind you the juvenile justice and foster care systems are already overwhelmed with children who need mental health services.

Average cost per year for state hospital care: Rainbow	\$140,890
Average cost per year for state hospital care: Larned	\$101,470
Beloit Juvenile Correction cost per year	\$69,901
Larned Juvenile Correction cost per year	\$58,000
Atchison Juvenile Correction cost per year	\$55,000
Topeka Juvenile Cost per year	\$51,000
Average cost per year for foster care	\$27,000
Average cost in the community per year (waiver children)	\$12,300

Thank you for allowing written comments on SB 421.

My husband and I are the parents of two sons. Our youngest, Joe is 16 years old and has autism. Joe has received HCBS/DD waiver services since he was 12 years old. Before age 12, we enrolled him in day care settings. After age 12, there is no day care available and since we both work full time we requested HCBS waiver services.

Joe can not stay home alone as he does not know what to do in emergency situations. If the phone rings, he will not answer it. If someone comes to the door of our house, he lets anyone in, whether he knows that person or not. He constantly needs direction (i.e., do his homework, go to the bathroom, turn on the television, etc.).

SB 421 concerns us for the following reasons:

Who will determine the "reasonable" fees charged to parents?

Who will determine costs "directly related" to such service?

How will costs of such services be "fixed" in order to recover all or part of the expenses incurred by providing such services?

We would like to ask the department to obtain input from parents/stakeholders regarding this matter. SRS will need to take into consideration household income along with other out-of-pocket expenses families have on behalf of their child with a disability. These other expenses may include wheelchair and equipment repair, diapers and/or briefs, special diet/formula, transportation, and assistive technology expenses that help their child be more independent.

We understand the State's budget difficulties this year and our family would be willing to assist the department in developing either a sliding scale fee charged to families or a percentage of services families would be responsible for.

The majority of parents that include a child with a disability have taken on the responsibility of providing care for them in their homes instead of costly institutional and segregated settings. Many of them are overwhelmed with the daily care their child needs. Any and all assistance they receive from the department is very much appreciated and we would like to see that assistance continued.

Josie Torrez
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Senate Ways and Means
2-4-02
Attachment 5



Association of Community Mental Health Centers of Kansas, Inc
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Kansas Senate Ways and Means Committee

Testimony on
SB 421

February 4, 2002

Presented by
Paul Klotz, Executive Director
Association of Community Mental Health Centers of Kansas, Inc.

Senate Ways and Means
2-4-02
Attachment 6

Mr. Chairman and members of the Committee, I am Paul Klotz, Executive Director of the Association of Community Mental Health Centers of Kansas, Inc. I represent the 29 licensed Community Mental Health Centers (CMHCs) in Kansas who provide community-based mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week.

I appear before you today as an opponent to Senate Bill 421. The Association and its members believe a fee for services would serve as a disincentive to families seeking treatment and would result in delayed treatment, if they seek treatment at all – mostly likely resulting in costly hospitalization. For example, fewer families served by the Home and Community Based Services SED Waiver might also put the SED Waiver in jeopardy over time as utilization decreases significantly due to such a disincentive. The “big picture” purpose of the SED Waiver is to enhance the ability of the most severe SED children to access the array of services they need, and thus, to decrease demand and pressure of institutionalization in state hospitals.

The fee proposal doesn't even pass the most basic "litmus test" of supporting these original goals. Our members are currently helping these same families through flexible funding to pay for utilities, school supplies, clothing, auto repair, etc. It is very difficult to expect them to have the extra money to pay more fees for our services.

Interpretation of Impact by Several CMHCs

The Johnson County Mental Health Center reviewed the impact of this proposal on 127 clients who are currently being served by the SED Waiver. Under the terms of a possible 6% fee, as originally suggested by SRS, 58% of SED Waiver families would be charged more to participate in the SED Waiver than if they declined to participate in the SED Waiver. By declining to participate in the SED Waiver, the families would be charged the standard sliding scale at a lower monthly cost. Hence, this legislation could actually create a disincentive to participate in the waiver. The other 42% of these families would find the fee to be less expensive than the sliding scale; however, this would still be a substantial increase over the current costs that these families experience under the SED Waiver. Thus, this would create a disincentive to seek treatment.

The impact of these disincentives is two-fold. First, many of these families would simply refuse to seek services for their SED children. Our experience to date suggests that these families are extremely resistant to assume significant financial responsibility for the mental health needs of their child. As a result, this legislation may significantly reduce the number of SED children who receive highly needed services. This, of course, is in direct opposition to the stated purpose for seeking the SED Waiver.

The second impact of this disincentive relates to the significant reduction in funding that Johnson County Mental Health Center would receive. Because families would find it to their advantage to decline the SED Waiver, the Center would experience a decline in funding while simultaneously experiencing an increasing demand for subsidized services in the form of their sliding scale. As a result, they would experience a financial pressure to reduce the size of their Community Based Services Program; this, too, is in direct contrast to the intent of the SED Waiver which has been to assure that we could serve more SED children in our communities.

Area Mental Health Center, a Center located in the Southwest part of Kansas, serves thirteen counties. They reviewed this proposal and they too oppose this idea. They have a few kids whose family would be required to pay a fee, and they project that this fee could be between \$180 - \$200 per month, based on a 6% fee, as originally proposed by SRS. This does not sound like much for the number of services required by SED children, but they know that it would deter some families from seeking services. Centers cannot deny services due to inability to pay (this may be refusal instead of inability, which is another issue) so this could become a paper chase like the Medicaid co-pay.

ComCare, a CMHC serving Sedgwick County, also feels that collecting a fee is not going to be that helpful. It may sway some individuals from wanting to be on the SED Waiver completely. It is not worth the risk of families not wanting to be on the SED Waiver. This is not a good solution. The SED Waiver was designed to be a mechanism by which a client and their family could access a full array of services in order to stabilize the identified child and as a result, the family system as well, thus helping to keep the child in the home or community rather than having to be placed in a more restrictive setting. The vast majority of these families have financial struggles and have already expended a tremendous amount of family resources to seek and obtain help for their child. There is also a tremendous concern that a number of families have already had to relinquish custody of their children to get them the help that they need due to financial concerns.

Mr. Chairman and members of this Subcommittee, I urge you to vote no on this legislation.

Thank you.



February 4, 2002

TO: Senator Steve Morris, Chair, and
Members of the Committee on Ways and Means

FR: Tom Laing, Executive Director
InterHab: The Resource Network for Kansans with Disabilities

RE: Senate Bill 421, establish fees for families to access services

Senate Bill 421 grants broad fee-setting powers to the Secretary of SRS for families with children in need. SB 421 proposes to allow SRS to set and collect fees from families of children with disabilities, among others. **InterHab asks the Committee to not act on this bill until more detail is provided by SRS regarding the implementation of this proposal.**

SRS officials work daily under the burden of great service expectations which are not matched with sufficient resources. Given that dilemma, we do not fault them for having brought this proposal forward.

However, given the tightened budget facing all state agencies, it seems inappropriate that the Legislature would single out for special assessments on families who face some of the most challenging issues of any Kansas families.

It is reasonable to do what SRS has done, to propose to you that additional resources are needed, and to propose a means by which such resources can be gotten. It is unreasonable that such a bill might be considered with no more information than is being provided today.

If it becomes the intent of this Administration, and is supported by this Legislature, to allow state agencies to begin levying what in effect would be "agency taxes" on families who are served, then it seems only fair that the nature of such assessments and the amounts that will be charged should be considered and approved by the Legislature.

We ask that you move slowly on Senate Bill 421, and that you insist on further details before your final action is taken. Thank you for your consideration of our concerns.

Senate Ways and Means
2-4-02
Attachment 7

Kansas Department of Social and Rehabilitation
Services
Janet Schalansky, Secretary



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Senate Ways and Means Committee, Room 123-S
February 4, 2002 at 10:30 a.m.

Senate Bill 422

Health Care Policy
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Senate Ways and Means
2-4-02
Attachment 8

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee, Room 123-S
February 4, 2002 at 10:30 a.m.

Senate Bill 422

Senator Morris and members of the committee, I am Robert Day, Director of Medical Policy/Medicaid in the Health Care Policy Division of SRS. Thank you for the opportunity to appear before you today to provide information on Senate Bill 422. This is one of the department's legislative proposals. The purpose of this legislation is to provide the department with the ability to better manage its pharmacy program, so that we may be able to reduce the growth in this area of our budget.

Senate Bill 422 amends K.S.A. 39-7,117, 39-7,120 and 39-7,121 which govern the Medicaid Pharmacy Program. The changes are designed to provide SRS more flexibility in controlling costs associated with our prescription drug program – the most expensive component of SRS' health care budget. These changes specifically address generic drugs and the prior authorization process.

Dispensing of Generic Drugs The Legislative Division of Post Audit proposed in its review of the Medicaid pharmacy program that the program should, as is the case in many states, mandate the dispensing of generic drugs unless the physician has written or provides verbal instructions to the pharmacist to dispense the drug as written. While the current program has a voluntary compliance with generic use of over 80%, we believe that mandating the use of generic drugs, if available, can increase that compliance even higher with no adverse effects on the beneficiary. It should be noted that this section of the bill does not extend the scope of pharmacist discretion allowed under existing regulations. This section simply mandates the use of generic drugs unless the physician or patient insists on the branded drug.

Expedited Prior Authorization Process The second section of Senate Bill 422 eliminates the requirement of going through a rule and regulation process each time it is determined that prior authorization (PA) should be required for an individual drug. The current process can take up to six months before a drug can be placed on a PA status. Prior authorization is one of the few ways the Medicaid program can ensure that drugs are being appropriately and cost effectively prescribed. This section of the bill would allow for the placement of a drug on a temporary PA while we complete the regulatory review process. In order to place a drug on an interim PA, the Drug Utilization Review Board, comprised of clinicians, would hold a public hearing on the use of the PA prior to requesting an interim PA. In order for the PA to remain in place for more than 120 days SRS would be required to submit such a request through the usual rules and regulation process.



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TO: Senate Ways and Means Committee

FROM: Chris Collins
Director of Government Affairs

DATE: February 4, 2002

RE: SB 422: Medicaid Pharmacy Programs

Ladies and Gentlemen of the Committee:

Thank you for the opportunity to testify today in favor of SB 422.

The Kansas Medical Society supports SRS in its efforts to ensure that maximum value is received for every dollar spent within the escalating Kansas Medicaid budget. KMS is willing to partner with SRS in measures to achieve that goal. Limitations on formularies and prior authorization requirements are common oversight mechanisms of pharmaceutical expenditures in other states' Medicaid programs. They have been utilized in Kansas since 1994 and are a reasonable means of controlling cost without affecting quality of care.

KMS supports the philosophy behind SRS' proposed amendments to the prior authorization rules and regulations process. In this time of increased attention to budgetary concerns, the proposed changes strike a reasonable balance between the need to oversee some of the Medicaid program's largest cost drivers and good sound clinical judgement regarding quality of care. SRS may implement rules and regulations regarding permanent prior authorization thirty days after receipt of comments on the rules and regs by the drug utilization review board. Pharmaceuticals may be placed on a temporary prior authorization for a period not to exceed 120 days with notice to interested parties and without the promulgation of rules and regs. These changes in the regulatory scheme allow Medicaid increased flexibility to proactively manage its pharmacy cost.

While supportive of this philosophy, KMS has a significant concern with Sec. 1(c)(1) of the bill, which addresses prescription substitution within the Medicaid program. The section mandates that a pharmacist will dispense the brand name legend drug as prescribed only when the prescriber has "personally written in handwriting 'dispense as written' or 'D.A.W.'" or in the case of an oral prescription, expressly indicated that the prescription is to be dispensed as communicated. The

Senate Ways and Means
2-4-02
Attachment 9

SB 422
KMS Testimony
Page 2
February 4, 2002

intent behind the language is clear: the pharmacist is to dispense a generic or less expensive equivalent if the prescriber and the patient do not object.

Physicians generally have a prescription pad in their office with a uniform format. It contains the statutorily required prescribing information, such as their name, address and DEA number. The printed prescription pad usually has a box, which can be checked, that says "Dispense as Written" or the language itself is printed on the pad. While the concept of cost-savings is an important one, this proposed language that requires the prescriber to hand write this prescribing restriction creates a different prescribing and dispensing standard than that applicable to all other patients. This new language would create an additional medical-legal standard that applies only to Medicaid patients. While physicians are willing to be responsible partners in the Medicaid program, this creates yet another administrative burden for physicians who, in the exercise of their clinical judgement, feel that a particular medication is best for their patient.

While KMS is respectful of the need to explore cost-savings in the Medicaid budget, we would welcome the opportunity to work with SRS and the committee to find a less burdensome alternative to this measure. Again, thank you for the opportunity to testify before you today.