MINUTES

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

August 16, 2010
Room 548-S—Statehouse

Members Present

Representative Bob Bethell, Chairperson
Senator Carolyn McGinn, Vice-chairperson
Senator Laura Kelly
Senator Kelly Kultala
Senator Dwayne Umbarger
Representative Jerry Henry
Representative Peggy Mast
Representative Melody McCray-Miller (appearing by phone)

Member Absent

Representative Brenda Landwehr

Staff Present

Kathie Sparks, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Estelle Montgomery, Kansas Legislative Department
Iraida Orr, Kansas Legislative Research Department
Doug Taylor, Office of the Revisor of Statutes
Jackie Lunn, Committee Secretary

Conferees

Dave Halferty, Director, Nursing Facility and PACE Division, Kansas Department on Aging
Amy Deckard, Senior Fiscal Analyst, Kansas Legislative Research Department
Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services
Tom Laing, Executive Director, InterHab
Nick Wood, Disability Rights Center
Jane Rhys, Executive Director, Kansas Council on Developmental Disability
Shannon Jones, Executive Director, SILCK
Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association

Cindy Luxem, CEO, President, Kansas Health Care Association/Kansas Center for Assisted Living
Michael J. Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, Inc.
Walt Hill, High Plains Mental Health Center, Hays, Kansas
Robin Cole, Pawnee Mental Health Services, Manhattan, Kansas
Sue Claridge, Private Citizen, Emporia, Kansas

Morning Session

Chairperson Bethell called the meeting to order at 10:20 a.m. and welcomed the Committee, staff, and guests. He called on Dave Halferty, Director, Nursing Facility and PACE Division, Kansas Department on Aging, to give his testimony on the following:

- Nursing Facility Admissions January through March 2010 (Attachment 1);
- Provider Assessment Model for **Sen. Sub. for Sen. Sub. for Sub. for HB 2320** (Attachment 2);
- Nursing Facility Reimbursement Changes for Fiscal Year 2011 (Attachment 3); and
- Update on Provider Assessment Implementation (Attachment 4).

Mr. Halferty, addressed questions and concerns of the Chairperson and Committee. He noted that the spike in nursing facility caseload, which occurred in January 2010, was due to a system error which has been corrected. He went on to explain there has been a decline in nursing home case loads which he attributed to individuals remaining in their homes until they were more frail and requiring more services. Mr. Halferty stated he would provide to the Committee the annual census in nursing facilities for the past 10 years; the list of providers; and the costs. He moved on to explain the revised modeling projections on the Nursing Home Provider Assessment. He noted the new cost projections had been submitted and should be approved between January and April of 2011. The provider impact should result in 324 nursing homes experiencing a net financial gain, with an average gain of $135,000 per home; 19 homes will have a net loss, with an average loss of $31,000 per home; and one will experience no impact. Upon the conclusion of Mr. Halferty's testimony, a discussion occurred on the provider assessment between the estimates and the actual along with the effect on the providers.

Chairperson Bethell introduced Amy Deckard, Senior Fiscal Analyst, Kansas Legislative Research Department to present an overview of the approved budget for FY 2010 and FY 2011. Ms. Deckard presented written copy of the overview (Attachment 5). Ms. Deckard provided the Committee with an explanation of the approved FY 2011 Human Services Expenditures; the Home and Community Based Service Waivers Expenditures from all funding sources FY 2008 to FY 2011; Home and Community Based Service Waivers Expenditures from the State General Fund FY 2007 through FY 2011; the number of individuals on Home and Community Based Services Waiting List; and the actions taken by the 2010 Legislature regarding Home and Community Based Service Waivers. Ms. Deckard addressed the questions and concerns of the Committee during her presentation.

Upon the conclusion of Ms. Deckard's overview, Chairperson Bethell broke for lunch and stated that the afternoon session would start at 1:30 p.m.

Afternoon Session

Chairperson Bethell called the afternoon session to order at 1:30 p.m. and called on Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services (SRS), to present (Attachment 6). The Secretary discussed the Home and Community Based Services (HCBS) Waivers and the Money Follows the Person Grants. He provided information regarding Community Based Service Waivers that provide services to persons with developmental disabilities (DD), which included the number of individuals served and the funding for each of the programs. At the current time there are 2,444 people on the waiting list with 1,047 people receiving DD services. During FY 2010, the 295 vacancies were filled with individuals in crisis situations. Additional funding, which is estimated to serve 145 additional DD individuals, has been made available in FY 2011.

On January 1, 2010, waiver changes were implemented by SRS to avoid further overspending. The major waiver changes were the elimination of Oral Health Services and Temporary Respite Care.

Secretary Jordan explained that the Physical Disability (PD) Waiver has implemented a waiting list to avoid further overspending. Currently 7,300 individuals are being served in the PD Waiver. On January 1, 2010, changes were implemented by SRS to avoid further overspending. The changes included: eliminated oral health services; limited personal services to 10 hours per day unless there is a crisis situation; limited assistive services to crisis situations only, with the approval by the program manager; and eliminated the criteria that a person could enter services if the individual was at imminent risk of serious harm because the primary caregiver/givers were no longer able to provide the level of support to meet the consumer's basic needs due to the primary caregivers' own disabilities, return to full time employment, hospitalization or placement in an institution, moving out of the area, or death.

The Secretary spoke about the Traumatic Brain Injury (TBI) Waiver which is designed to serve individuals who otherwise require institutionalization in a Head Injury Rehabilitation Hospital. The TBI Waiver services are provided at a significant cost savings over institutional care and provide an opportunity for each person to live and work in their home and communities.

The following changes were implemented to avoid further overspending: eliminating the Oral Health Services; limiting personal services to 10 hours a day unless there is a crisis situation; limiting assistive services to crisis situations only; and moving third year continuation of service review to a program manager as opposed to the committee.

The Technical Waiver is designed to serve children ages 0 to 22 years of age who are medically fragile and technology dependent, requiring intense medical care comparable to the level of care provided in a hospital setting. The services provided through this waiver are designed to ensure that the child's needs are addressed effectively in the child's family home. There is no waiting list for this program.

The Serious Emotional Disturbance (SED) Waiver is for youth with a diagnosis of serious emotional disturbance and allows federal Medicaid funding for community based mental health services. In FY 2010, $48,448,927 was paid through this waiver to serve a total of 6,021 children.

The Autism waiver is the newest of the waivers with the first funding approved in FY 2008. The waiver now is serving 45 children with 247 children on a waiting list.

The federally funded Money Follows the Person Demonstration Grant is designed to enhance participating states' ability to increase the capacity of approved HCBS programs to serve individuals who currently are residing in institutional settings. SRS and the Department on Aging are working together with the Long Term Care Ombudsman's office to identify individuals who currently are residing in institutional settings and assisting them to move into home settings of their choice.

In January 2010, Governor Parkinson responded to the report of the Kansas Facilities Realignment and Closure Commission by issuing an Executive Order, which set the stage for focused work, that will lead to the downsizing and consolidation of the two remaining state developmental disability hospitals in Kansas: Kansas Neurological Institute and Parsons State Hospital. Since the Executive Order was issued, SRS has been working both internally and with stakeholder representatives to implement the 11 directives of the Order, all designed to enhance opportunities for Kansans with developmental disabilities to experience effective community services.

In closing, Secretary Jordan stated SRS has convened an advisory group which was charged with assessing and developing recommendations regarding the directives in the Executive Order. That group presented its report to Governor Parkinson. SRS will continue to use the report as a guide for implementation of the Executive Order. During Secretary Jordan's testimony, he addressed the questions and concerns of the Committee.

Chairperson Bethell introduced Tom Laing, Executive Director, InterHab (Attachment 7). Mr. Laing opened by commending the 2010 Kansas Legislature for recognizing and addressing the needs of Kansans with developmental disabilities. He went on to say that the community network of supports for Kansans with developmental disabilities is still in crisis. He stated that during the 2010 Session of the Legislature, the members showed great determination to slow down the avalanche of growing need and to rekindle a dialog that more honestly discussed the challenges they face. In closing, Mr. Laing stated that during the 2011 Session of the Legislature, the members need to lead with a renewed legislative determination to support these programs more adequately and more reasonably.

Chairperson Bethell introduced Nick Wood, Disability Rights Center of Kansas (Attachment 8). Mr. Wood opened by explaining that the Disability Rights Center of Kansas is a public interest legal advocacy agency which is part of national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. In closing, Mr. Woods presented recommendations to prevent unnecessary institutionalization and stood for questions.

Chairperson Bethell introduced Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities (Attachment 9). Ms. Rhys stated, as a former special education specialist, she is aware of the large sums spent educating children with disabilities. She explained that a state funded program teaches employment skills to individuals with developmental disabilities but because the HCBS-DD have not been adequately funded, the training is lost. The Council on Developmental Disabilities has concerns with the number of individuals with developmental disabilities that are on the waiting list (unserved) and also those not receiving enough care (underserved). She stated closing the state institutions will allow more individuals to come off the waiting list.

Chairperson Bethell introduced Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas (SILCK) (Attachment 10). Ms. Jones opened by stating the 10 percent Medicaid rate reductions applied to all Medicaid services delivered on or after January 1, 2010, has been devastating. The Centers for Independent Living are the gate keepers for the PD waiver

services. All Centers for Independent Living made cuts internally; they reduced the work hours of some of their employees; froze wages of employees; reduced employees' mileage reimbursement; 81 employees were laid off and requests were made for voluntary lay-offs and retirements; open center positions are not being filled; and there is a freeze on hiring for all positions. In closing, she stated that SILCK will urge the 2011 Legislature to take advantage of the incentives and new opportunities in the federal Affordable Care Act to strengthen home and community based services so that people who want to live in the community have the ability to make that choice. A short question and answer session followed with Ms. Jones and the Committee.

Chairman Bethell introduced Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association (Attachment 11). Mr. Kaberline explained that the services available through the Area Agencies on Aging fall into five broad categories; information and access services, community services, in-home services, housing, and elderly rights. Within each category, a range of programs is available. Budget cuts to the in-home services system over the last two sessions threaten even the minimal services many frail elderly need to remain living in their communities. In closing, he stated there is no question that, given the magnitude of budget reductions, access to health care and in-home services in our state have been impaired resulting in Kansas seniors receiving care in more expensive settings or not receiving care at all. The Kansas Agencies on Aging Association would appreciate an opportunity to discuss these issues and concerns with the Legislature. A question and answer session followed with Mr. Kaberline and the Committee.

Chairperson Bethell introduced Cindy Luxem, CEO, President, Kansas Health Care Association/Kansas Center for Assisted Living (Attachment 12). Ms. Luxem stated that the impact of the budget reductions to HCBS have affected their members in two ways.

Nursing home participation goes up when things like sleep support cycle are eliminated. In addition, when services are reduced, the number of providers decrease which prevents the discharge of residents from nursing homes because of lack of services in the community. Residents who are living independently are really the ones who suffer if the provider does not provide HCBS in their homes. In closing, she suggested that in order to improve the number of assisted living providers, a tax credit could be created. Upon the conclusion of her testimony, she introduced Carol Feaker, Midwest Health Consulting, to give her testimony (no written testimony was provided). Ms. Feaker stated several states are having problems similar to the ones Kansas is experiencing with HCBS. She also explained how Medicaid requires that billing be done on 15 minutes increments to receive funding from Medicaid, and how this is a paper work problem for several providers.

Chairperson Bethell introduced Michael J. Hammond, Executive Director Association of Community Mental Health Centers of Kansas (CMHC), Inc. (Attachment 13). Mr. Hammond stated budget cuts are placing the public mental health system at a breaking point. Every Kansan who walks through the doors of a CMHC is impacted by budget cuts. Its workforce also is being impacted by the cuts. In closing, Mr. Hammond stated the following is needed:

- Provide increased capacity for crisis stabilization beds;
- Provide an appropriation of $3.1 million to increase capacity at Osawatomie State Hospital for a 30 bed unit; and
- Provide an appropriation of $500,000 to pay for staffing and other operating expenditures for Larned State Hospital to open permanently 11 beds that have not been budgeted for by SRS.

Mr. Hammond also expressed support for state funding to establish local private mental health inpatient hospital beds across Kansas, to alleviate the demand for state psychiatric hospital beds. Upon the conclusion of Mr. Hammond's testimony, a question and answer session followed.

Chairperson Bethell introduced Walt Hill, Executive Director, High Plains Mental Health Center, Hays, Kansas (Attachment 14). Mr. Hill stated the impact of the budget cuts is that it is taking twice as long for a patient to be seen for medication evaluation. The Center sees 5,000 plus patients each year, and approximately half are treated with a combination of services that involve medications for various mental disorders. Faced with continued cuts of over a million dollars annually in state funding, High Plains has reduced staffing levels by 20 percent; cut office hours; reduced employees benefits; eliminated non-mandated services; reduced domestic violence interventions; reduced community education and intervention; and made other internal cuts to adjust to cuts in funding imposed by SRS and the Legislature. In closing, he stated to close just voluntary beds creates a system that jeopardizes patients and communities. He expressed his concerns over the past three years regarding the shortage of state hospital beds. Finally, Mr. Hill pointed out that the Legislature added a proviso to the spending bill asking SRS to conduct a study to determine the number of state hospital beds required. To date, this has not been accomplished.

Chairperson Bethell introduced Robbin Cole, Pawnee Mental Health Services, Manhattan, Kansas (Attachment 15). Ms. Cole stated that the Pawnee Mental Health Services has made numerous changes which were necessary to preserve community based services to individuals whose lives are affected by mental illness and substance abuse. The cuts in funding, which have necessitated these changes, when combined with the cuts in funding which have necessitated the temporary suspension of voluntary admissions to the state psychiatric hospitals, are a recipe for disaster.

Chairperson Bethell introduced Sue Claridge, a private citizen from Emporia, Kansas, to give her testimony (Attachment 16). Ms. Claridge informed the Committee of her family's story, and its reliance on Medicaid and the mental health centers. In closing, she stated she hoped that what she shared gives the Committee a clearer understanding about how the budget cuts will affect families and communities in a big way. A short discussion followed.

Chairman Bethell adjourned the meeting at 4:45 p.m. with the next scheduled meeting on September 8, 2010, at 10:00 a.m. in room 548-S, Statehouse.

Prepared by Jackie Lunn
Edited by Kathie Sparks

Approved by Committee on:

September 8, 2010
(Date)

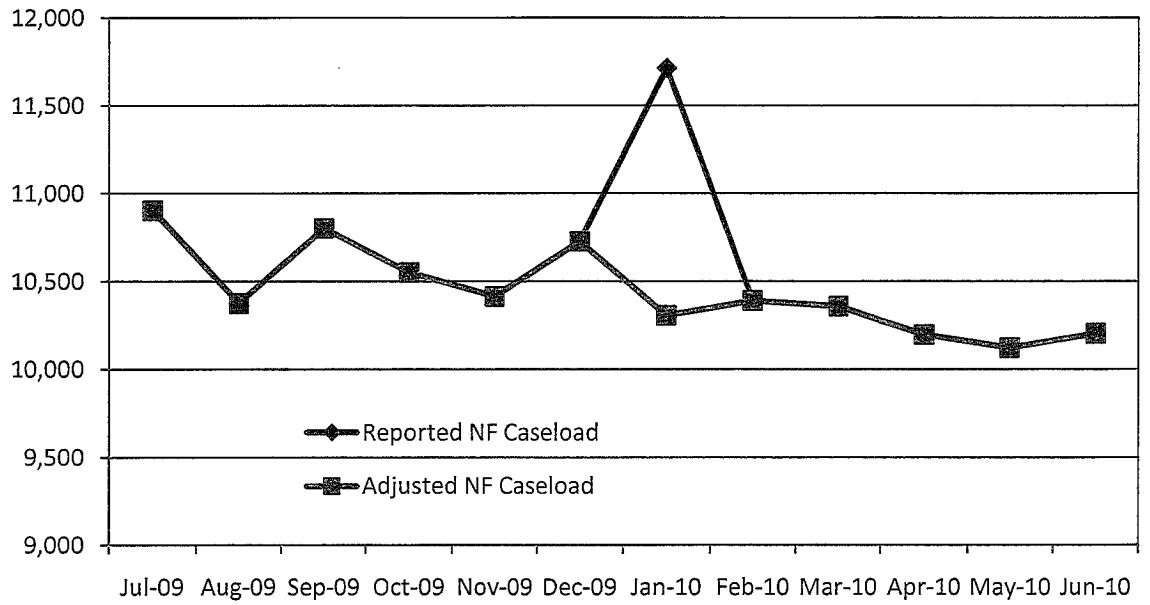
KANSAS
DEPARTMENT ON AGING

Mark Parkinson, Governor
Martin Kennedy, Secretary
www.agingkansas.org

Joint Committee on
Home and Community Based Services Oversight
Aug. 16, 2010

Nursing Facility Admissions Jan. – March 2010
Dave Halferty, Reimbursement Manager
Nursing Facility and CARE Division

SFY 10 Nursing Facility Caseload



Joint Committee on Home and
Community Based Services Oversight
August 16, 2010
Attachment 1

New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
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Provider Assessment Model for SB Sub for SB Sub for Sub HB 2320

Assessment Parameters

Assessment Basis

All providers are assessed fee per licensed bed except for the two state operated facilities

General Assessment Rate	1,500	Applies to homes except those that meet criteria below
Small Facility Assessment Rate	250	Applies to homes with fewer than 46 beds
High Medicaid Assessment Rate	250	Applies to homes with more than 25,000 Medicaid days
CCRC Assessment Rate	250	Applies to homes registerd by KID as continuing care
State Operated Facility Assessment Rate	0	Applies to Kansas Soldiers Home and Kansas Veterans Home
Average Assessment Rate	1,016	The average assessment rate produced by all tiers
Total Assessable Beds	22,772	
Estimated Assessment Revenue	23,128,500	

Statistical Tests	Percent of Total Revenue (Must be less than 5.5%)	P1/P2 Must be > 1 if not broad based		B1/B2 Must be > 1 if not broad or uniform	
	2.05%	P1	0.5374	B1	0.0000001725
		P2	0.5589	B2	0.0000001329
		P1/P2	0.961397	B1/B2	1.298189

Assessment Revenue Use

NF Reimbursement Program Adjustments			Total Benefit	Homes Impacted
Restore 10% Cut (Jan-Jun '10)			19,208,570	327
Inflate and Rebase Provider Rates	Hold harmless % of old rate	103.22%	34,176,120	328
Pass-Through for Medicaid Share of Assessment			12,927,564	327

Administrative Expenses	Total Cost
Additional FTE's	95,406
Consulting Fees	30,000
One-Time Start-Up Costs	5,000

Total Expenditures for Program Enhancements and Administration				
All Funds			66,442,660	Surplus/(Shortage)
State General Funds	FMAP	70%	19,932,798	3,195,702

Fiscal Impact Analysis

NF Program/Provider Fiscal Impact Analysis

Total Increase to NF Program Expenditures	66,312,254				
Net Increase to NF Program Expenditures	43,183,754				
Average Provider Impact	125,534				
Number of Providers with Net Gain	324	Avg Gain	135,090	Max Gain	762,789
Number of Providers with Net Loss	19	Avg Loss	-30,804	Max Loss	-159,000
Number of Providers with 0 Impact	1				

Attachment 2-1
Date 8-16-10
Joint Committee on Home and Community Based Services Oversight

Estimated Facility Impact -- Nursing Home Provider Assessment
(Revised Modeling Projections as of 8-6-10)

Provider Name	City	Assmt	Restore 10% Cut	Rebase & Inflate	Mdcd Pass-Thru	Net Impact
Village Manor	Abilene	-112,500	60,210	143,267	57,988	148,965
Alma Manor	Alma	-9,250	36,924	72,134	3,821	103,629
Life Care Center of Andover	Andover	-231,000	101,268	76,233	86,185	32,686
Anthony Community Care Center	Anthony	-10,000	58,057	120,228	7,371	175,656
Arkansas City Presbyterian Manor	Arkansas City	-15,000	47,973	87,652	7,177	127,802
Medicalodges Arkansas City	Arkansas City	-87,000	79,112	91,050	56,202	139,364
Deseret Nursing & Rehab at Arma, Inc	Arma	-90,000	57,731	73,684	65,499	106,914
Ashland Health Center - LTCU	Ashland	-5,750	18,377	86,273	3,858	102,758
Medicalodges Atchison	Atchison	-105,000	46,439	84,295	53,247	78,981
Atchison Senior Village	Atchison	-84,000	54,878	94,074	46,879	111,831
Dooley Center	Atchison	-69,000	94,118	150,794	65,815	241,727
Attica Long Term Care	Attica	-90,000	57,067	73,683	57,608	98,358
Good Samaritan Society-Atwood	Atwood	-11,250	32,169	106,024	4,160	131,103
Lake Point Nursing Center	Augusta	-171,000	84,947	181,269	97,661	192,877
Baldwin Care Center	Baldwin City	-90,000	50,190	38,235	39,589	38,014
Quaker Hill Manor	Baxter Springs	-90,000	52,272	53,627	59,963	75,862
Catholic Care Center Inc.	BELAIRE	-44,500	140,665	164,357	18,140	278,662
Belleville Health Care Center	Belleville	-108,000	45,493	53,148	51,200	41,841
Great Plains of Republic County, Inc	Belleville	-9,500	44,972	145,392	5,872	186,736
Hilltop Lodge Nursing Home	Beloit	-150,000	72,397	103,751	73,719	99,867
Great Plains of Mitchell County, Inc	Beloit	-10,000	26,528	177,560	5,009	199,097
Bonner Springs Nursing and Rehabilit	Bonner Springs	-75,000	57,652	48,336	53,194	84,182
Hill Top House	Bucklin	-7,500	32,169	27,849	3,741	56,259
Buhler Sunshine Home, Inc.	Buhler	-13,750	41,002	86,725	6,358	120,335
Life Care Center of Burlington	Burlington	-115,500	61,987	44,159	63,543	54,189
Caney Nursing Center	Caney	-87,000	35,907	74,819	73,037	96,763
Eastridge Nursing Home	Centralia	-9,750	27,188	135,300	5,388	158,126
Heritage Health Care Center	Chanute	-79,500	49,300	69,724	44,167	83,691
Applewood Rehabilitation	Chanute	-69,000	32,168	65,998	65,835	95,001
Chanute Health Care Center	Chanute	-115,500	66,721	104,068	61,841	117,130
Chapman Valley Manor	Chapman	-78,000	33,499	57,571	30,972	44,042
Cheney Golden Age Home Inc.	Cheney	-90,000	49,871	85,484	41,005	86,360
Cherryvale Care Center	Cherryvale	-88,500	52,060	43,979	62,502	70,041
Chetopa Manor	Chetopa	-9,500	30,195	77,457	5,722	103,874
The Shepherd's Center	Cimarron	-8,000	32,226	80,083	4,833	109,142
Clay Center Presbyterian Manor	Clay Center	-7,500	20,971	55,847	3,304	72,622
Medicalodges Clay Center	Clay Center	-76,500	55,988	61,385	38,764	79,637
Clearwater Ret. Community	Clearwater	-96,000	47,941	251,121	52,973	256,035
Community Care, Inc.	Clifton	-6,250	14,037	28,460	3,277	39,524
Park Villa Nursing Home	Clyde	-9,000	22,976	74,332	4,368	92,676
Coffeyville Regional Medical Center	Coffeyville	-5,000	485	733	70	-3,712
Medicalodges Coffeyville	Coffeyville	-10,000	35,583	139,715	6,613	171,911
Windsor Place	Coffeyville	-40,750	182,176	391,642	27,270	560,338
Prairie Senior Living Complex	Colby	-102,000	62,807	115,330	55,867	132,004
Deseret Nursing & Rehab at Colby	Colby	-90,000	38,765	154,240	45,523	148,528
Pioneer Lodge	Coldwater	-6,750	30,447	121,965	4,847	150,509
Medicalodges Columbus	Columbus	-72,000	47,918	59,868	37,204	72,990
Sunset Nursing Center	Concordia	-75,000	28,003	66,644	31,755	51,402
Mt Joseph Senior Village, LLC	Concordia	-112,500	55,078	78,479	71,331	92,388
Spring View Manor	Conway Springs	-79,500	25,565	72,871	36,683	55,619
Golden Living Center-Chase Co.	Cottonwood Falls	-76,500	37,001	75,320	45,383	81,204
Council Grove Healthcare Center	Council Grove	-120,000	58,292	111,046	65,958	115,296
Hilltop Manor	Cunningham	-106,500	44,219	91,408	49,018	78,145
Derby Health and Rehabilitation	Derby	-111,000	26,120	29,777	47,276	-7,827
Westview Manor, Inc.	Derby	-180,000	71,324	246,377	125,815	263,516
Hillside Village	DeSoto	-73,500	32,807	23,257	34,583	17,147
Dexter Care Center	Dexter	-10,000	34,529	28,772	6,162	59,463
Lane County Hospital - LTCU	Dighton	-3,500	14,190	40,259	1,575	52,524
Manor of the Plains	Dodge City	-12,500	31,144	25,783	4,937	49,364
Trinity Manor	Dodge City	-88,500	65,441	87,115	51,370	115,426
Good Samaritan Society-Dodge City	Dodge City	-90,000	64,220	93,830	55,908	123,958
Medicalodges Douglass	Douglass	-10,500	29,980	29,123	5,966	54,569
Golden Living Center-Downs	Downs	-76,500	30,878	39,015	33,219	26,612
Country Care Home	Easton	-75,000	35,299	51,828	33,235	45,362
Golden Living Center-Parkway	Edwardsville	-75,000	64,494	77,834	63,671	130,999
Golden Living Center-Kaw River	Edwardsville	-75,000	58,138	105,916	59,701	148,755
Golden Living Center-Edwardsville	Edwardsville	-25,000	105,294	427,589	23,211	531,094
Lakepoint Nursing Center-El Dorado	El Dorado	-160,500	80,052	88,981	101,582	110,115
Golden Living Center-El Dorado	El Dorado	-82,500	45,920	111,566	57,792	132,778
Morton County Hospital	Elkhart	-120,000	49,874	91,637	62,099	83,610
Woodhaven Care Center	Ellinwood	-84,000	39,920	46,949	45,704	48,573
Good Samaritan Society-Ellis	Ellis	-78,000	46,726	50,277	39,245	58,248
Good Sam Society-Ellsworth Village	Ellsworth	-90,000	30,502	48,904	34,338	23,744
Flint Hills Care Center, Inc.	Emporia	-100,500	64,504	38,375	68,725	71,104
Holiday Resort	Emporia	-180,000	114,455	88,883	95,492	118,830
Emporia Presbyterian Manor	Emporia	-15,000	31,168	130,813	4,736	151,717
Enterprise Estates Nursing Center, I	Enterprise	-69,000	37,442	80,841	41,765	91,048
Golden Living Center-Eskridge	Eskridge	-90,000	58,919	91,205	79,789	139,913
Medicalodges of Eudora	Eudora	-111,000	51,982	21,248	57,178	19,408
Eureka Nursing Center	Eureka	-114,000	69,522	64,010	70,774	90,306
Kansas Soldiers Home	Fort Dodge	0	10,985	86,724	0	97,709

Estimated Facility Impact -- Nursing Home Provider Assessment
(Revised Modeling Projections as of 8-6-10)

Provider Name	City	Assmt	Restore 10% Cut	Rebase & Inflate	Mdcd Pass-Thru	Net Impact
Fort Scott Manor	Fort Scott	-78,000	65,727	51,977	50,376	90,080
Medicalodges Fort Scott	Fort Scott	-91,500	73,117	68,400	60,368	110,385
Fowler Nursing Home	Fowler	-7,000	19,225	46,160	2,475	60,860
Frankfort Community Care Home, Inc.	Frankfort	-69,000	32,887	70,995	29,025	63,907
Golden Living Center-Fredonia	Fredonia	-70,500	31,706	108,061	46,506	115,773
Sunset Manor, Inc	Frontenac	-180,000	94,667	98,335	107,376	120,378
Galena Nursing & Rehab Center	Galena	-87,000	59,294	45,844	53,827	71,965
Emerald Pointe Health & Rehab Centre	Galena	-72,000	49,755	49,065	61,673	88,493
Garden Valley Retirement Village	Garden City	-108,000	60,832	41,062	56,381	50,275
Homestead Health & Rehab	Garden City	-75,000	52,388	75,262	42,650	95,300
Meadowbrook Rehab Hosp., LTCU	Gardner	-10,250	72,186	93,932	5,143	161,011
Medicalodges Gardner	Gardner	-123,000	156,766	93,910	102,481	230,157
Golden Heights Living Center	Garnett	-76,500	37,773	58,362	38,946	58,581
Anderson County Hospital	Garnett	-8,000	49,955	97,690	7,237	146,882
The Heritage	Girard	-75,000	36,414	65,727	42,299	69,440
The Nicol Home, Inc.	Glasco	-7,000	7,410	7,073	2,273	9,756
Medicalodges Goddard	Goddard	-90,000	71,411	64,288	57,027	102,726
Bethesda Home	Goessel	-14,250	86,365	190,103	8,924	271,142
Good Samirtan Society-Sherman Co.	Goodland	-90,000	56,617	71,417	55,248	93,282
Great Bend Health & Rehab Center	Great Bend	-204,000	91,175	65,249	99,282	51,706
Cherry Village Benevolence	Great Bend	-69,000	28,643	115,316	47,718	122,677
Halstead Health and Rehab Center	Halstead	-90,000	50,123	41,697	42,119	43,939
Lakewood Senior Living of Haviland	Haviland	-75,000	44,703	70,229	73,157	113,089
Good Samaritan Society-Hays	Hays	-109,500	41,081	104,788	43,924	80,293
St. John's of Hays	Hays	-90,000	46,557	128,395	46,886	131,838
Haysville Healthcare Center	Haysville	-178,500	137,332	270,745	114,592	344,169
Medicalodges Herington	Herington	-87,000	44,500	102,744	55,562	115,806
Schowalter Villa	Hesston	-26,250	114,084	366,114	13,572	467,520
Maple Heights of Hiawatha	Hiawatha	-91,500	57,743	50,511	60,414	77,168
Highland Care Center	Highland	-11,000	32,673	48,596	5,116	75,385
Dawson Place, Inc.	Hill City	-9,250	31,344	187,406	6,484	215,984
Parkside Homes, Inc.	Hillsboro	-19,750	51,891	89,609	7,178	128,928
Salem Home	Hillsboro	-84,000	35,329	133,765	52,765	137,859
Medicalodges Jackson County	Holton	-105,000	57,587	34,491	60,744	47,822
Tri County Manor Living Center, Inc.	Horton	-75,000	33,465	92,008	45,285	95,758
Howard Twilight Manor	Howard	-10,000	41,767	29,587	5,386	66,740
Sheridan County Hospital	Hoxie	-9,500	19,288	60,762	2,813	73,363
Pioneer Manor	Hugoton	-87,000	53,576	357,690	41,062	365,328
Pinecrest Nursing Home	Humboldt	-72,000	25,124	72,613	45,505	71,242
Hutchinson Hospital SNF	Hutchinson	-3,750	0	0	0	-3,750
Ray E. Dillon Living Center	Hutchinson	-90,000	57,559	182,328	50,989	200,876
Golden Plains	Hutchinson	-160,500	137,607	106,204	120,713	204,024
Deseret Nursing & Rehab at Hutchinso	Hutchinson	-90,000	55,236	195,918	70,762	231,916
Wesley Towers	Hutchinson	-32,500	95,526	224,051	10,562	297,639
Good Sam Society-Hutchinson Village	Hutchinson	-135,000	96,967	286,057	77,020	325,044
Regal Estate	Independence	-82,500	40,857	33,232	49,994	41,583
Windsor Place at Independence	Independence	-10,750	24,777	47,613	4,703	66,343
Pleasant View Home	Inman	-31,000	129,829	125,049	16,996	240,874
Iola Nursing Center	Iola	-78,000	54,744	62,255	57,865	96,864
Windsor Place at Iola, LLC	Iola	-97,500	59,765	109,600	57,610	129,475
Hodgeman Co Health Center-LTCU	Jetmore	-7,750	11,027	40,599	2,662	46,538
Stanton County Hospital- LTCU	Johnson	-6,500	21,778	73,304	3,055	91,637
Valley View Senior Life	Junction City	-154,500	111,586	77,856	83,421	118,363
Providence Place	Kansas City	-105,000	0	0	0	-105,000
Lifecare Center of Kansas City	Kansas City	-123,000	84,360	86,397	78,685	126,442
Medicalodges Kansas City	Kansas City	-11,250	83,679	46,793	8,685	127,907
Medicalodges Post Acute Care Center	Kansas City	-183,000	140,686	181,492	120,490	259,668
Kansas City Presbyterian Manor	Kansas City	-40,250	207,373	550,615	30,549	748,287
Deseret Nursing & Rehab at Kensingto	Kensington	-75,000	30,802	42,065	45,547	43,414
The Wheatlands	Kingman	-81,000	32,787	55,079	35,342	42,208
Medicalodges Kinsley	Kinsley	-10,500	39,849	130,492	6,447	166,288
Kiowa Hospital District Manor	Kiowa	-9,250	22,425	82,601	3,960	99,736
Rush Co. Memorial Hospital	La Crosse	-5,000	18,638	108,265	2,461	124,364
Rush County Nursing Home	Lacrosse	-72,000	44,967	85,770	33,554	92,291
High Plains Retirement Village	Lakin	-10,000	50,530	166,447	5,976	212,953
Golden Living Center-Lansing	Lansing	-90,000	31,048	87,787	41,965	70,800
Larned Healthcare Center	Larned	-120,000	59,161	60,608	83,411	83,180
Lawrence Memorial Hospital SNF	Lawrence	-3,000	0	0	0	-3,000
Lawrence Presbyterian Manor	Lawrence	-12,500	21,270	34,779	4,280	47,829
Pioneer Ridge Retirement Community	Lawrence	-19,000	44,620	38,118	7,468	71,206
Brandon Woods at Alvamar	Lawrence	-210,000	91,257	105,704	95,533	82,494
Medicalodges Leavenworth	Leavenworth	-120,000	72,455	53,940	77,366	83,761
Lakeview Village	Lenexa	-30,000	15,900	42,674	2,711	31,285
Delmar Gardens of Lenexa	Lenexa	-62,500	189,903	103,921	43,277	274,601
Leonardville Nursing Home	Leonardville	-82,500	27,028	84,544	31,691	60,763
Wichita County Health Center	Leoti	-3,000	19,587	64,857	2,659	84,103
Southwest Medical Center SNF	Liberal	-4,500	0	0	0	-4,500
Wheatridge Park Care Center	Liberal	-82,500	40,423	69,466	32,351	59,740
Good Samaritan Society-Liberal	Liberal	-105,000	68,125	98,259	58,707	120,091
Lincoln Park Manor	Lincoln	-10,000	20,667	61,801	3,486	75,954
Bethany Home Association	Lindsborg	-29,500	89,629	274,612	11,657	346,398

Estimated Facility Impact -- Nursing Home Provider Assessment
(Revised Modeling Projections as of 8-6-10)

Provider Name	City	Assmt	Restore 10% Cut	Rebase & Inflate	Mdcd Pass-Thru	Net Impact
Linn Community Nursing Home	Linn	-97,500	38,254	39,645	45,343	25,742
Sandstone Heights	Little River	-10,000	39,939	124,215	5,308	159,462
Logan Manor Community Health Service	Logan	-9,000	17,708	80,173	3,188	92,069
Louisburg Care Center	Louisburg	-90,000	57,657	40,195	49,818	57,670
Good Samaritan Society-Lyons	Lyons	-75,000	38,976	63,790	34,998	62,764
St. Joseph Village, Inc.	Manhattan	-144,000	91,666	89,523	63,503	100,692
Meadowlark Hills Retirement Communit	Manhattan	-33,250	77,483	219,175	9,840	273,248
Stoneybrook Retirement Community	Manhattan	-17,500	66,441	232,598	11,245	292,784
Jewell County Hospital	Mankato	-4,750	23,056	225,454	2,228	245,988
St. Luke Living Center	Marion	-8,000	26,749	43,119	4,302	66,170
Riverview Estates, Inc.	Marquette	-10,000	29,100	85,910	4,988	109,998
Cambridge Place	Marysville	-174,000	65,873	105,365	75,293	72,531
Deseret Nursing & Rehab at McPherson	Mcpherson	-75,000	50,652	79,198	33,631	88,481
The Cedars, Inc.	Mcpherson	-26,250	83,174	112,551	14,544	184,019
Meade District Hospital, LTCU	Meade	-90,000	28,587	217,818	29,065	185,470
Trinity Nursing & Rehab Ctr	Merriam	-180,000	120,308	98,779	98,307	137,394
Great Plains of Ottawa County, Inc.	Minneapolis	-4,250	13,935	23,980	1,581	35,246
Good Samritan Society-Minneapolis	Minneapolis	-102,000	54,047	81,334	56,299	89,680
Minneola Nursing Home	Minneola	-9,000	27,677	226,704	3,600	248,981
Bethel Home, Inc.	Montezuma	-78,000	73,496	38,772	53,060	87,328
Moran Manor	Moran	-11,250	50,036	46,693	6,871	92,350
Memorial Home for the Aged	Moundridge	-18,500	57,150	116,974	7,830	163,454
Moundridge Manor, Inc.	Moundridge	-115,500	91,512	162,271	69,986	208,269
Mt. Hope Nursing Center	Mt. Hope	-75,000	45,122	43,092	39,071	52,285
Villa Maria, Inc.	Mulvane	-96,000	44,503	35,743	40,314	24,560
Golden Living Center-Neodesha	Neodesha	-75,000	49,012	87,411	50,305	111,728
Ness County Hospital Dist.#2	Ness City	-10,750	42,592	81,093	5,653	118,588
Newton Presbyterian Manor	Newton	-15,000	38,659	116,988	7,139	147,786
Kansas Christian Home	Newton	-23,000	86,782	126,028	13,986	203,796
Asbury Park	Newton	-24,750	117,967	187,455	13,532	294,204
Bethel Care Center	North Newton	-15,000	42,135	108,915	6,865	142,915
Andbe Home, Inc.	Norton	-105,000	54,279	43,012	43,971	36,262
Village Villa	Nortonville	-9,750	43,636	36,775	6,148	76,809
Logan County Manor	Oakley	-69,000	30,045	106,407	33,153	100,605
Good Samaritan Society-Decatur Co.	Oberlin	-11,250	24,820	72,118	4,169	89,857
Decatur County Hospital	Oberlin	-9,250	19,716	85,254	2,739	98,459
The Plaza Health Services at Santa Mar	Olathe	-8,000	0	0	0	-8,000
Hoeger House	Olathe	-4,250	0	0	0	-4,250
Pinnacle Ridge Nursing and Rehabilit	Olathe	-141,000	85,272	72,447	87,495	104,214
Aberdeen Village, Inc.	Olathe	-15,000	37,794	108,035	5,327	136,156
Royal Terrace Nrsg. & Rehab. Center	Olathe	-36,750	185,389	125,419	23,647	297,705
Villa St. Francis	Olathe	-42,500	171,387	329,977	22,395	481,259
Johnson County Nursing Center	Olathe	-28,000	171,584	394,067	20,984	558,635
Good Samaritan Society-Olathe	Olathe	-35,000	163,892	448,225	20,723	597,840
Deseret Nursing & Rehab at Onaga	Onaga	-69,000	44,385	30,065	37,793	43,243
Osage Nursing & Rehab Center	Osage City	-84,000	47,523	51,748	45,056	60,327
Peterson Health Care, Inc.	Osage City	-81,000	43,566	88,921	61,877	113,364
Life Care Center of Osawatomie	Osawatomie	-165,000	103,824	81,011	88,332	108,167
Parkview Care Center	Osborne	-93,000	48,511	37,307	41,310	34,128
Hickory Pointe Care & Rehab Ctr	Oskaloosa	-90,000	36,880	96,766	51,919	95,565
Deseret Nursing & Rehab at Oswego	Oswego	-10,000	36,848	34,384	7,952	69,184
Ottawa Retirement Village	Ottawa	-157,500	76,683	107,286	80,269	106,738
Brookside Manor	Overbrook	-105,000	49,804	36,497	48,689	29,990
The Sweet Life at Grand Court	Overland Park	-150,000	0	0	0	-150,000
The Forum at Overland Park	Overland Park	-15,000	0	0	0	-15,000
Garden Terrace at Overland Park	Overland Park	-244,500	94,278	139,446	79,928	69,152
Overland Park Nursing & Rehab	Overland Park	-153,000	82,319	103,055	73,094	105,468
Indian Meadows Healthcare Center	Overland Park	-78,000	142,117	12,277	43,666	120,060
Village Shalom, Inc.	Overland Park	-19,000	46,474	161,452	6,088	195,014
Villa Saint Joseph	Overland Park	-174,000	80,559	270,036	79,043	255,638
Indian Creek Healthcare Center	Overland Park	-30,000	156,659	148,008	20,871	295,538
Manorcare Hlth Services of Overland	Overland Park	-55,750	147,386	229,431	20,990	342,057
Delmar Gardens of Overland Park	Overland Park	-30,000	133,288	243,470	20,874	367,632
Riverview Manor, Inc.	Oxford	-75,000	42,142	52,891	46,176	66,209
North Point Skilled Nursing Center	Paola	-88,500	53,993	43,208	48,828	57,529
Medicalodges Paola	Paola	-23,250	114,381	57,054	22,358	170,543
Elmhaven East	Parsons	-87,000	31,041	88,705	41,882	74,628
Parsons Presbyterian Manor	Parsons	-10,750	31,598	72,722	6,146	99,716
Elmhaven West	Parsons	-75,000	33,598	95,717	47,002	101,317
Good Samaritan Society-Parsons	Parsons	-84,000	49,140	154,507	55,864	175,511
Westview Manor of Peabody	Peabody	-78,000	37,020	1,490	77,697	38,207
Legacy Park	Peabody	-82,500	59,413	57,560	58,849	93,322
Phillips County Retirement Center	Phillipsburg	-90,000	52,843	128,961	53,070	144,874
Mt. Carmel Regional Medical Ctr. SNF	Pittsburg	-4,000	2,129	9,550	124	7,803
Medicalodges Pittsburg South	Pittsburg	-90,000	63,302	38,956	63,767	76,025
Cornerstone Village, Inc.	Pittsburg	-144,000	91,799	123,199	71,537	142,535
Golden Livng Center-Pittsburg	Pittsburg	-120,000	82,790	116,059	82,643	161,492
Rooks County Senior Services, Inc.	Plainville	-9,250	41,216	43,106	5,966	81,038
Brighton Gardens of Prairie Village	Prairie Village	-11,250	0	0	0	-11,250
Somerset-Claridge Court	Prairie Village	-8,750	0	0	0	-8,750
Lakewood Senior Living of Pratt, LLC	Pratt	-105,000	48,370	86,483	61,476	91,329

Estimated Facility Impact -- Nursing Home Provider Assessment
(Revised Modeling Projections as of 8-6-10)

Provider Name	City	Assmt	Restore 10% Cut	Rebase & Inflate	Mdcd Pass-Thru	Net Impact
Pratt Regional Medical Center	Pratt	-76,500	45,774	184,755	48,369	202,398
Prescott Country View Nursing Center	Prescott	-90,000	23,257	52,357	45,945	31,559
Prairie Sunset Manor	Pretty Prairie	-8,500	26,875	25,546	3,130	47,051
Protection Valley Manor	Protection	-10,500	52,786	121,054	8,259	171,599
Gove County Medical Center	Quinter	-73,500	53,411	116,052	35,117	131,080
Grisell Memorial Hosp Dist #1-LTCU	Ransom	-8,000	28,083	91,128	4,945	116,156
Richmond Healthcare and Rehabilitati	Richmond	-90,000	28,469	25,182	42,310	5,961
Lakepoint Nursing Ctr-Rose Hill	Rose Hill	-84,000	36,932	75,574	42,703	71,209
Rossville Healthcare & Rehab Center	Rossville	-114,000	78,342	57,907	64,743	86,992
Wheatland Nursing & Rehab Center	Russell	-88,500	61,564	137,867	54,615	165,546
Russell Regional Hospital	Russell	-7,250	13,978	261,641	2,794	271,163
Sabetha Nursing Center	Sabetha	-11,250	38,037	52,706	7,028	86,521
Apostolic Christian Home	Sabetha	-21,500	59,902	86,561	8,989	133,952
Smokey Hill Rehabilitation Center	Salina	-150,000	101,287	45,362	104,940	101,589
Holiday Resort of Salina	Salina	-90,000	45,167	50,765	38,307	44,239
Windsor Estates	Salina	-90,000	47,816	34,972	53,578	46,366
Salina Presbyterian Manor	Salina	-15,000	28,145	74,632	2,967	90,744
Pinnacle Park Nursing and Rehabilita	Salina	-90,000	60,093	76,094	57,621	103,808
Kenwood View Nursing Center	Salina	-123,000	78,206	105,515	77,150	137,871
Satanta Dist. Hosp. LTCU	Satanta	-11,000	30,133	158,060	5,397	182,590
Park Lane Nursing Home	Scott City	-111,000	82,582	227,795	67,294	266,671
Pleasant Valley Manor	Sedan	-120,000	62,365	63,926	74,705	80,996
Sedgwick Healthcare Center	Sedgwick	-93,000	81,893	65,010	54,090	107,993
Country View Estates Care Home	Seneca	-73,500	29,864	28,764	33,057	18,185
Crestview Manor	Seneca	-8,500	26,881	36,038	4,988	59,407
Good Samaritan Society	Sharon Springs	-7,000	15,313	40,005	4,018	52,336
The Sweet Life at Rose Hill	Shawnee	-159,000	0	0	0	-159,000
Shawnee Gardens Nursing Center	Shawnee	-217,500	124,398	104,846	113,251	124,995
Sharonlane Nursing Home	Shawnee	-144,000	90,195	169,634	90,852	206,681
Deseret Nursing & Rehab at Smith Ctr	Smith Center	-10,000	19,265	17,378	4,945	31,588
Smith County Memorial Hospital LTCU	Smith Center	-7,000	18,844	96,708	2,906	111,458
Mennonite Friendship Manor, Inc.	South Hutchinsor	-31,500	123,738	361,096	15,028	468,362
Golden Living Center-Spring Hill	Spring Hill	-70,500	29,526	122,994	53,386	135,406
Good Sam Society-St. Francis Village	St. Francis	-75,000	55,498	99,846	45,546	125,890
Leisure Homestead at St. John	St. John	-7,500	25,887	60,396	4,823	83,606
Community Hospital of Onaga, LTCU	St. Mary's	-9,750	46,084	156,766	6,382	199,482
Prairie Mission Retirement Village	St. Paul	-75,000	30,950	35,336	38,321	29,607
Leisure Homestead at Stafford	Stafford	-11,250	26,214	50,369	5,099	70,432
Sterling Presbyterian Manor	Sterling	-13,750	51,685	146,637	7,721	192,293
Solomon Valley Manor	Stockton	-9,000	40,147	83,908	5,391	120,446
Seasons of Life Living Center	Syracuse	-11,000	39,861	100,546	5,866	135,273
Tonganoxie Nursing Center	Tonganoxie	-135,000	58,862	45,082	78,253	47,197
Westwood Manor	Topeka	-81,000	55,631	137,299	65,707	177,637
McCrite Plaza Health Center	Topeka	-150,000	26,724	49,376	60,129	-13,771
The Kansas Rehabilitation Hospital LTC	Topeka	-3,000	0	0	0	-3,000
Brewster Place	Topeka	-19,750	15,630	59,311	2,505	57,696
Lexington Park Nursing and Post Acut	Topeka	-22,500	48,878	30,547	5,178	62,103
IHS of Brighton Place	Topeka	-75,000	44,266	41,465	55,216	65,947
Brighton Place North	Topeka	-8,500	29,737	73,058	8,083	102,378
Providence Living Center	Topeka	-114,000	68,066	52,981	106,014	113,061
Countryside Health Center	Topeka	-102,000	67,025	114,317	88,658	168,000
Eventide Convalescent Center, Inc.	Topeka	-123,000	65,519	141,971	83,545	168,035
Manorcare Health Services of Topeka	Topeka	-180,000	136,794	133,027	111,012	200,833
Topeka Community Healthcare Center	Topeka	-123,000	116,725	124,483	96,876	215,084
Plaza West Care Center, Inc.	Topeka	-37,750	162,780	267,932	23,226	416,188
Rolling Hills Health Center	Topeka	-25,500	99,376	370,506	15,629	460,011
Topeka Presbyterian Manor Inc.	Topeka	-30,000	130,931	365,202	18,065	484,198
Aldersgate Village	Topeka	-52,250	244,405	542,215	28,419	762,789
Greeley County Hospital, LTCU	Tribune	-8,000	22,469	99,420	3,576	117,465
Western Prairie Care Home	Ulysses	-90,000	79,349	178,112	58,537	225,998
Valley Health Care Center	Valley Falls	-10,000	56,213	41,306	9,325	96,844
St. Johns Victoria	Victoria	-105,000	58,490	112,105	57,476	123,071
The Lutheran Home - Wakeeney	Wakeeney	-10,000	28,662	77,138	5,847	101,647
Trego Co. Lemke Memorial LTCU	Wakeeney	-9,250	59,824	112,263	5,266	168,103
Golden Living Center-Wakefield	Wakefield	-72,000	26,848	83,019	44,136	82,003
Good Samaritan Society-Valley Vista	Wamego	-75,000	45,920	67,924	32,516	71,360
The Centennial Homestead, Inc.	Washington	-10,250	22,841	90,933	5,051	108,575
Wathena Nursing & Rehab Center	Wathena	-90,000	38,329	106,187	43,924	98,440
Coffey County Hospital	Waverly	-10,500	33,161	272,057	4,371	299,089
Sumner Regional Medical Center SNF	Wellington	-3,250	0	0	0	-3,250
Golden Living Center-Wellington	Wellington	-82,500	52,736	57,778	53,770	81,784
Deseret Nursing & Rehab at Wellingto	Wellington	-11,000	40,868	54,495	6,843	91,206
Wellsville Manor	Wellsville	-76,500	36,492	21,885	46,995	28,872
Westy Community Care Home	Westmoreland	-85,500	48,760	78,325	42,926	84,511
Wheat State Manor	Whitewater	-97,500	55,917	94,505	58,623	111,545
Family Health & Rehabilitation Cente	Wichita	-108,000	13,173	25,217	7,391	-62,219
Sandpiper Healthcare and Rehab Cente	Wichita	-217,500	98,815	85,277	109,217	75,809
Park West Plaza	Wichita	-10,000	0	0	0	-10,000
Riverside Village Inc	Wichita	-9,000	0	0	0	-9,000
Via Christi Hope	Wichita	-6,000	0	0	6,000	0
Life Care Center of Wichita	Wichita	-180,000	62,348	74,540	59,754	16,642

Estimated Facility Impact -- Nursing Home Provider Assessment
(Revised Modeling Projections as of 8-6-10)

Provider Name	City	Assmt	Restore 10% Cut	Rebase & Inflate	Mdcd Pass-Thru	Net Impact
The Health Care Center@Larksfield Pl	Wichita	-22,500	20,285	22,004	2,856	22,645
Lakepoint Nursing and Rehabilitation	Wichita	-165,000	83,187	62,011	78,974	59,172
Wichita Presbyterian Manor	Wichita	-15,000	28,447	68,523	4,054	86,024
Lakewood Senior Living of Seville	Wichita	-127,500	66,967	80,590	75,194	95,251
Medicalodges Wichita	Wichita	-109,500	111,662	70,130	82,341	154,633
Abal Home	Wichita	-105,000	87,599	77,052	95,308	154,959
Meridian Nursing & Rehab Center	Wichita	-26,500	93,624	80,485	21,103	168,712
Deseret Nursing & Rehab at Wichita	Wichita	-139,500	129,140	105,068	89,964	184,672
Golden Living Center-Wichita	Wichita	-88,500	91,445	158,845	77,687	239,477
College Hill Nursing and Rehab Cente	Wichita	-144,000	140,352	129,004	118,447	243,803
Homestead Health Center, Inc.	Wichita	-120,000	60,874	248,216	67,140	256,230
Kansas Masonic Home	Wichita	-30,000	131,395	194,707	16,357	312,459
Manorcare Health Services of Wichita	Wichita	-29,750	170,672	304,446	20,617	465,985
Golden Living Center-Wilson	Wilson	-75,000	38,731	64,994	39,780	68,505
Jefferson Co. Memorial Hospital-LTCU	Winchester	-10,750	40,837	63,007	6,742	99,836
Winfield Rest Haven, Inc.	Winfield	-75,000	47,663	71,757	39,072	83,492
Good Samaritan Society-Winfield	Winfield	-105,000	43,398	80,961	66,229	85,588
Cumbernauld Village, Inc.	Winfield	-10,500	30,855	85,963	3,350	109,668
Kansas Veterans Home	Winfield	0	0	220,205	0	220,205
Deseret Nursing & Rehab at Yates Ctr	Yates Center	-75,000	30,765	24,435	34,568	14,768
Totals		-23,128,500	19,208,570	34,176,120	12,927,564	43,183,754
Affected Providers		342	327	328	327	344
Providers with Net Gain						324
Providers with Net Loss						19
Providers with Neutral Impact						1

KANSAS
DEPARTMENT ON AGING

Mark Parkinson, Governor
Martin Kennedy, Secretary
www.agingkansas.org

Joint Committee on
Home and Community Based Services Oversight
Aug. 16, 2010

Update on Provider Assessment Implementation
Dave Halferty, Reimbursement Manager
Nursing Facility and CARE Division

Nursing Facility Reimbursement Changes for Fiscal Year 2011

- Rebase to 2007-2009 cost data
  - Since July 1, 2008 rates have been based on 2005-2007 cost data
- Inflate data to December 31, 2010
  - Since July 1, 2008 costs have been inflated to December 31, 2008
- Remove private pay limit
  - Rates have previously been limited to the lesser of the calculated Medicaid rate or the average private pay rate
- Increase Direct Health Care limit to 130% of the median
  - Previously the Direct Health Care limit was 120% of the median
- Increase the Incentive Factor per diems 150%
  - Each per diem was increased to 2.5 times its previous amount. The maximum per diem is now $6.51
- Transition rates to insure at least 3.22% rate increase
  - Many providers cut costs in 2008 and 2009 due to reduced Medicaid funding and other economic pressures
- Pass-through Medicaid share of the Quality Care Assessment

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- The Medicaid share of any assessment expense will be paid back to providers soon after they pay their assessment. For example, a home that has 50% of its residents enrolled in Medicaid and that pays a quarterly assessment of $10,000 will be paid back $5,000 as soon as a payment can be processed to them. (Federal rules require that two transactions take place rather than netting the Medicaid share out of the assessment payment.)

- Repay the 10% cut imposed between January 1, 2010 and June 30, 2010
  - These payments will be made on a pro-rated basis as assessment payments are collected. For example, a home that pays 50% of its annual assessment by February 28, 2011, will be repaid for 50% of the Jan-Jun cut as soon as a payment can be processed.

KANSAS
DEPARTMENT ON AGING

Joint Committee on Home and Community Based Services Oversight

Aug. 16, 2010

Update on Provider Assessment Implementation

Kansas Department on Aging
Dave Halferty, Reimbursement Manager
Nursing Facility and CARE Division

Nursing Facility Provider Assessment As Passed & Submitted

Current Status:

- S Sub for S Sub for Sub HB 2320 passed by legislature and signed by Governor June 3, 2010
- Submitted to CMS July 28, 2010
- Estimated review time = 6-9 months
- Retroactive to July 1, 2010 once approved
- KAR 129-10-31, drafted and being reviewed

Nursing Facility Provider Assessment As Passed & Submitted

Provisions of the Bill:

- Licensed Bed Assessment up to $1,950
- 1/6 Rate for Small Homes, High Medicaid, CCRC
- Rebase and Inflate Rates for FY 2011
- Other Quality Enhancements
- Payback 10% Cut (from FY 2010)
- Pass-through of Medicaid Share of Assessment
- Removes Private Pay Limit
- Sunset

Nursing Facility Provider Assessment As Passed & Submitted

Licensed Bed Assessment:

- Annual general fee of $1,500 per bed
- Lower fee, $250 per bed, for small homes, high Medicaid, and CCRC
- Small homes = less than 46 beds
- High Medicaid > 25,000 Medicaid days
- CCRC = registered with KID before 7/1/10
- Estimated Revenue = $23.1 million

Nursing Facility Provider Assessment As Passed & Submitted

Reimbursement Rate Changes for FY 2011:

- Rebase to 2007-2009 costs
- Inflate to December 31, 2010
- Increase Direct Health Care Limit to 130%
- Increase Incentive Factor Add-ons 150%
- No Private Pay Limit
- Transition rates to ensure at least a 3.22% rate increase for all providers

Nursing Facility Provider Assessment As Passed & Submitted

Payback of 10% Cut:

- The 10% cut was restored July 1, 2010

  All claims for dates of service after that date will be paid in full

- Bill provides for a payout for the Jan-Jun 2010 reimbursement cut

Nursing Facility Provider Assessment As Passed & Submitted

Pass-Through of Medicaid Share:

- Bill makes assessment an allowable expense
- Provides for pass-through of Medicaid share
- Medicaid share = Medicaid % of assessment
- Medicaid % = Medicaid Days/Total Days
- Per Home Pass-Through

  = (Medicaid %) x (Assessment Total)

Nursing Facility Provider Assessment As Passed & Submitted

Provider Impact:

Out of 344 nursing homes in Kansas

324 will have a Net Gain, average $135K

19 will have a Net Loss, average $31K

1 will have No Impact

Nursing Facility Provider Assessment As Passed & Submitted

Program Impact:

Cut Restoration = $19.2 million

Rebase/Inflation = $34.2 million

Pass-Through = $12.9 million

Agency Administration = $130,000

Total Increase = $66.4

Nursing Facility Provider Assessment As Passed & Submitted

Other Provisions:

- Quality Care Assessment Panel
  - 2 persons by KAHSA & KHCA
  - 1 person by KABC, KFMC & KHA
  - 4 persons appointed by the Governor
    - 1 each from KACE, KDOA, & KHPA
    - 1 resident/family member

    (KDOA & KHPA non-voting)

HUMAN SERVICES

Approved FY 2011 Expenditures

Agency	State General Fund	All Funds	FTE Positions
Social and Rehabilitation Services:			
Department of SRS	$ 558,374,399	$ 1,577,060,096	3,669.1
Hospitals:			
Parsons State Hospital and Training Center	$ 10,399,233	$ 25,534,663	495.2
Kansas Neurological Institute	11,207,006	29,569,200	546.7
Larned State Hospital	43,696,401	58,867,083	976.2
Osawatomie State Hospital	14,384,174	28,696,646	441.4
Rainbow Mental Health Facility	4,524,059	8,613,982	122.2
Subtotal-Hospitals	$ 84,210,873	$ 151,281,574	2,581.7
Other Human Services			
Department on Aging	$ 148,860,621	$ 495,619,197	214.0
KDHE–Health	22,920,672	169,588,275	363.4
Dept. of Labor	439,481	1,066,201,111	552.0
KS Guardianship Progr.	1,158,265	1,158,265	11.0
Comm. Veterans Affairs Soldiers/Veterans' Homes	8,330,373	22,052,894	498
Kansas Health Policy Authority	384,122,423	1,466,652,575	294.7
Subtotal Other Human Services	$ 565,831,835	$ 3,221,272,317	1,933.1
TOTAL-Human Services	$ 1,208,417,107	$ 4,949,613,987	8,183.9
Percentage of Total State Budget	21.5 %	36.1 %	

Attachment 5-1
Date 8-16-10
Joint Committee on Home and Community Based Services Oversight

Home and Community Based Service Waivers (HCBS) Expenditures from all funding sources FY 2000 to FY 2011 Approved

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010 Approved	FY 2011 Approved
Department on Aging												
HCBS/FE	$ 44,748,114	$ 49,527,953	$ 58,223,782	$ 53,529,370	$ 45,069,948	$ 54,125,403	$ 55,706,959	$ 63,264,442	$ 68,765,887	$ 72,096,548	$ 69,772,881	$ 71,735,084
Senior Care Act	2,079,265	2,074,134	7,865,402	6,774,547	6,523,513	6,258,229	6,624,094	6,783,690	7,560,059	7,584,588	6,601,412	6,285,928
Deparment of Social and Rehabilitation Services												
HCBS/DD	170,350,998	175,759,758	189,467,567	194,605,709	204,954,171	217,398,123	221,149,613	248,145,859	279,254,523	293,283,426	$ 306,478,431	315,226,304
HCBS/PD	52,369,330	57,604,827	60,528,414	60,457,651	59,736,010	70,857,648	80,980,683	94,423,948	102,144,039	139,059,707	130,864,410	124,111,645
HI/TBI	4,847,074	3,607,662	3,883,033	4,593,058	5,455,886	5,703,934	3,400,107	8,277,479	6,844,597	10,882,090	11,432,012	11,524,845
TA	125,885	153,178	121,642	166,401	181,244	182,470	112,115	179,712	240,806	18,189,216 *	24,182,778	24,194,773
Autism									744,417	531,301	1,220,762	1,207,786
TOTAL	$ 274,520,666	$ 288,727,512	$ 320,089,840	$ 320,126,736	$ 321,920,772	$ 354,525,807	$ 367,973,571	$ 421,075,130	$ 465,554,328	$ 541,626,876	$ 550,552,686	$ 554,286,365

* In FY 2009, all expenditures for the Attendant Care for Independent Living Program were shifted to the Technology Assistance Waiver.
Staff Note: Prior to FY 2009 numbers also included Targeted Case Management Services.

Home and Community Based Service Waivers (HCBS) Expenditures from the State General Fund FY 2007 to FY 2011 Approved

	FY 2007	FY 2008	FY 2009	FY 2010 Approved	FY 2011 Approved
Department on Aging					
HCBS/FE	$ 25,123,026	$ 26,246,366	$ 25,151,011	$ 21,214,819	$ 21,554,366
Senior Care Act	2,431,200	3,385,000	3,210,157	2,101,612	1,785,928
Deparment of Social and Rehabilitation Services					
HCBS/DD	98,535,965	109,519,509	97,967,491	$ 88,782,473	87,039,926
HCBS/PD	37,494,203	44,229,044	48,121,139	39,763,397	37,625,608
HI/TBI	3,286,755	3,542,533	3,795,393	2,615,644	2,159,810
TA	71,363	48,919	6,056,066	6,528,145	6,156,119
Autism		6,526	176,132	370,929	366,151
TOTAL	$ 166,942,512	$ 186,977,897	$ 184,477,389	$ 161,377,019	$ 156,687,908

Staff Note: The FMAP rate for Kansas Medicaid programs was increased beginnning October 2008 due to the federal American Recovery and Reinvestment Act of 2008 (ARRA). This increased the federal share and decreased the state portion for Medicaid expenditures.

Actions by 2010 Legislature regarding Home and Community Based Services Waivers

Department on Aging

Added $1.3 million, including $311,835 from the State General Fund, to fund telehealth services for 500 individuals on the Home and Community Based Services-Frail Elderly waiver program for FY 2011.

Added language specifying that any expansion of the Home and Community Based Services-Frail Elderly waiver program for telehealth services in FY 2011 be distributed geographically statewide. In addition, no funds generated from Senate Substitute for Senate Substitute for Substitute for House Bill 2320, which authorizes an annual, uniform assessment on all skilled nursing facility licensed beds, are allowed to be expended for any telehealth program.

Department of Social and Rehabilitation Services

Added $2.4 million in State General Fund moneys to restore the 10.0 percent Medicaid provider reduction for Home and Community Based Services for individuals with developmental disabilities and deleted the same amount from grants and state aid payments to Community Developmental Disability Organizations in FY 2010. This resulted in the addition of $5.5 million, all from federal funds, in FY 2010 to reflect the amount received in federal matching funds associated with the increased state Medicaid expenditures for the waiver. The 10.0 percent Medicaid provider reduction was included in the Governor's November 2009 allotment and reduced reimbursement rates for most Medicaid providers by 10.0 percent for dates of service from January 1, 2010 to June 30, 2010. The allotment affected the Department of Social and Rehabilitation Services, the Kansas Health Policy Authority, the Department on Aging, and the Juvenile Justice Authority.

Added $10.9 million, including $3.3 million from the State General Fund, for FY 2011 to increase funding for the Home and Community Based Services Waiver for individuals with Developmental Disabilities to ensure all individuals in crisis are able to access waiver services and allow approximately 145 individuals currently not receiving services (on the waiting list) to begin receiving services.

Added $11.9 million, including $3.6 million from the State General Fund, for FY 2011 to increase funding for the Home and Community Based Services Waiver for Individuals with Physical Disabilities, to implement a rolling waiting list policy to provide services for one new individual for every individual who stops receiving services.

Home and Community Based Services Waiting List

	July 2010	Omnibus 2010	October 2009	Omnibus 2009	Omnibus 2008
Department on Aging					
HCBS/FE	-	-	-	-	-
Senior Care Act	121	152	269	215	146
Deparment of Social and Rehabilitation Services					
HCBS/DD					
Unserved	2,414	2,246	1,863	1,650	1,345
Underserved	1,024	915	985	1,036	730
Total HCBS/ DD	*3,438*	*3,161*	*2,848*	*2,686*	*2,075*
HCBS/PD	2,108	1,975	1,382	552	-
HI/TBI	-	-	-	-	-
TA	-	-	-	-	-
Autism	247	243	275	224	141

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

HCBS Oversight Committee

August 16, 2010

Home and Community Based Services Waivers

For Additional Information Contact:
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Attachment 6-1
Date 8-16-10
Joint Committee on Home and
Community Based Services Oversight

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Home and Community Based Services Waivers

HCBS Oversight Committee

August 16, 2010

Chairman Bethell and members of the Committee, thank you for the opportunity to appear before you today to discuss the Home and Community Based Services (HCBS) waivers and the Money Follows the Person (MFP) grant. I will present information today regarding six Home and Community Based Service Waivers that provide services to persons with disabilities, including the number of individuals served and funding for each of the programs. I will also provide information regarding the MFP grant which impacts the HCBS waivers. I have included a chart with more detail on the waivers impacted by the MFP grant in Attachment A.

Background

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. Many of the community supports and services provided to persons with disabilities such as respite care, attendant care services, and assistive services, are not covered by the regular federal Medicaid program. HCBS waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. The Centers for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions.

Developmental Disability (DD) Waiver

The DD waiver serves individuals with significant developmental disabilities. At this time there are 2,444 people on the waiting list receiving no waiver services, and another 1,047 people receiving some services who are waiting for additional services. In FY 2010 there were 295 individuals who left waiver services. These positions were filled by individuals in crisis situations. SRS maintains one statewide waiting list for HCBS-DD services which includes both the unserved and the underserved. A person's position on the waiting list is determined by the request date for the service(s) for which the person is waiting. Each fiscal year, if funding is made available, people on the statewide waiting list are served, beginning with the oldest request dates at the top of the list. An additional $3.3 million SGF was allocated to the DD waiver for FY 2011. SRS is in the process of working with the Community Developmental Disability Organizations to offer services to individuals on the waiting list. At this time we know at least 145 individuals will be served with this funding. The exact number taken off of the waiting list will be determined by the projected annualized cost to serve each person that is offered and accepts services.

On January 1, 2010 and on February 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- On January 1, 2010, Oral Health Services were eliminated.
- On February 1, 2010, Temporary Respite Care services were eliminated.

Physical Disability (PD) Waiver

During FY 2008 the rate of growth in the waiver increased significantly and on December 1, 2008, SRS implemented a waiting list for the PD waiver. The waiting list was implemented not to cut the budget, but to avoid further overspending. With the implementation of a waiting list approximately 7,300 individuals have been able to continue receiving services. In December 2008 when the waiting list was implemented only persons in a crisis situation were allowed to access new waiver services. On March 2, 2009, the "rolling" waiting list methodology was implemented whereby one consumer was offered services for every two terminations. On January 1, 2010, due to the budget situation, the rolling waiting list methodology was terminated and only persons meeting the crisis criteria were allowed to access PD waiver services (the only other opportunity to access these services was through the MFP grant). As of August 1, 2010, there were 2,286 individuals on the PD Waiver waiting list.

The PD waiver received an additional $3.6 million SGF, which will allow for the start of a rolling waiting list in October 2010. The rolling waiting list will be implemented in this way: for every two people leaving the waiver, one person from the waiting list will be added. It is anticipated that through implementing this rolling waiting list approximately 321 people can be put into service from the waiting list. 153 people would be removed from the waiting list, in the chronological order in which they were placed on the waiting list. Approximately 168 people would be removed from the waiting list and added to the PD waiver in other than waiting-list order, due to crisis situations. The actual number that could be added will be dependent on several variables, including the service needs and resulting average cost per person, and the number of people added to the PD waiver other than in waiting-list order, due to crisis situations.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Eliminating Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.
- Limiting assistive services to crisis situations only, with approval by the program manager.
- A change in the crisis criteria was made to eliminate the criteria that a person could enter services if the individual was at significant, imminent risk of serious harm because the primary caregiver(s) were no longer able to provide the level of support necessary to meet the consumer's basic needs due to the primary caregiver(s): own disabilities, return to full time employment, hospitalization or placement in an institution, moving out of the area in which the consumer lived, or death.

Traumatic Brain Injury (TBI) Waiver

The TBI waiver is designed to serve individuals who would otherwise require institutionalization in a Head Injury Rehabilitation Hospital. The TBI waiver services are provided at a significant cost savings over institutional care and provide an opportunity for each person to live and work in their home communities. Each of these individuals is provided an opportunity to rebuild their lives through the provision of a combination of supports, therapies and services designed to build independence.

A significant difference in this program is that it is not considered a long term care program. It is considered a rehabilitation program and consumers are expected to transition off the program or to another program upon completion of rehabilitation. Individuals currently receive up to four years of therapy and, if by that time progress in rehabilitation is not seen, the individual is transitioned to another program. In FY 2010 the average length of stay in this program was 1.9 years. This number is based on the consumers who transitioned from services during FY 2010. There is currently no waiting list for this program.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Elimination of Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.
- Limiting assistive services to crisis situations only, with approval by the program manager.
- Moving third year continuation of service review to program manager as opposed to committee.

Technology Assisted (TA) Waiver

The TA waiver is designed to serve children ages 0 to 22 years who are medically fragile and technology dependent, requiring intense medical care comparable to the level of care provided in a hospital setting, for example, skilled nursing services. The services provided through this waiver are designed to ensure that the child's medical needs are addressed effectively in the child's family home, thereby eliminating the need for long term and or frequent hospitalization for acute care reasons. There is no waiting list for this program. The TA waiver served 483 (unduplicated) children in FY2010 at a total cost of $ 24,594,116 and an average monthly cost per person of $ 5,418.

Serious Emotional Disturbance (SED) Waiver

The HCBS waiver for youth with a Serious Emotional Disturbance allows federal Medicaid funding for community based mental health services for youth who have an SED and who are at risk of being placed in a state mental health hospital. The SED waiver determines the youth's Medicaid eligibility based on his/her own income separate from that of the family. Once the youth becomes a Medicaid beneficiary he/she may receive the full range of all Medicaid covered services including the full range of community mental health services. In addition, the youth is eligible for specific services only available to youth on the SED Waiver. The services

offered through the SED waiver and other community mental health services and supports are critical in assisting the youth to remain successfully in his/her family home and community. During FY 2010, $48,448,927 was paid through the SED waiver to serve a total of 6,021 children.

Autism Waiver

The autism waiver is the newest of our HCBS waivers with the first funding approved for FY 2008. The target population for the autism waiver is children with autism spectrum disorders (ASD), including autism, Aspergers' Syndrome, and other pervasive developmental disorders. The diagnosis must be made by a licensed medical doctor or PhD psychologist using an approved autism specific screening tool. Children are able to enter the program from the age of diagnosis through the age of five. Children receiving services through this waiver would be eligible for placement in a state mental health hospital if services were not provided through the waiver. A child will be eligible to receive waiver services for a time period of three years with an exception process in place to allow children who demonstrate continued improvement to continue services beyond the three year limit.

The autism waiver was implemented on January 1, 2008. At that time 25 children were selected through a random process to receive services. The other applicants were placed on the waiting list. The 2008 Legislature approved funding for an additional 20 children to be served by the autism waiver in FY 2009. The waiver is now serving 45 children. There are 247 children waiting for services through this waiver. Since this waiver was implemented, 166 children have aged off of the waiting list before services could begin. The total expenditure for the waiver in FY2010 was $743,673 with the average monthly cost per person being $1,546.

SRS Fee Fund

Over the past several years SRS fee fund balances have been used to fill the gap between available SGF and waiver spending and the funds allocated for the HCBS Waivers. The fee fund balance has now been depleted and SRS will be $11 million short for FY 2012. SRS will be requesting an enhancement to replace the $11 million shortfall with the next budget submission. SRS's options regarding changes that may be made to fill this gap are limited by federal regulations that have been implemented through the Recovery Act and the Affordable Care Act. These regulations do not allow states to change the waiver eligibility requirements without loss of federal funding. Under the Recovery Act the number of persons served by the waivers may not drop below the number of individuals that were being served on July 1, 2008. The only options that are available to SRS to control spending are through serious rate reductions and then to evaluate what additional service limitations could be implemented.

Money Follows the Person (MFP) Grant

The federally funded Money Follows the Person (MFP) demonstration grant is designed to enhance participating states' ability to increase the capacity of approved HCBS programs to serve individuals that are currently residing in institutional settings. The benefit for Kansas is enhanced federal funding to create additional community capacity, facilitate private Intermediate Care Facilities for people with Mental

Retardation (ICFs/MR) voluntary bed closure, train staff, and ensure individuals have the supports in their homes to be successful, reducing the risk of re-institutionalization.

Target populations for this grant include persons currently residing in nursing facilities and ICFs/MR. Individuals must have resided in the facility for a minimum of 90 days, which is a decrease from a minimum of six months. The federal Affordable Care Act reduced the length of stay in order to enhance the program and decrease the cost of institutional placement. Persons must also have been Medicaid eligible for a minimum of 30 days to be eligible to move into the community through this program.

SRS and Kansas Department on Aging (KDOA) are working together with the LTC Ombudsman office to identify individuals that are currently residing in qualified institutional settings and assist them to move into home settings of their choice.

SRS, as the lead agency for the demonstration grant, has partnered with the KDOA to develop benchmarks and implementation strategy. Additionally, Kansas Health Policy Authority is an integral partner as the Single State Medicaid Agency.

The individuals transitioning into the community are representing the mentally retarded/developmentally disabled, traumatic brain injury, physically disabled and elderly population groups. Kansans who have chosen community living in FY 2010 include 38 persons with physical disabilities, 4 persons with a traumatic brain injury, 25 individuals with developmental disabilities, and 40 persons that are elderly.

The MFP movement report, which includes data on numbers of individuals transferred from institutions to community based care and the resultant costs is attached as Attachment B.

Executive Order 10-01; Kansas Neurological Institute and Parsons State Hospital Consolidation

On January 28, 2010, after considerable review and thought, Governor Parkinson responded to the report of the Kansas Facilities Realignment and Closure Commission by issuing Executive Order 10-01. That order set the stage for focused work that will eventually lead to the downsizing and consolidation of the two remaining state developmental disability hospitals in Kansas: Kansas Neurological Institute (KNI) and Parsons State Hospital (PSH).

Since the Executive Order was issued SRS has been working both internally and with stakeholder representatives to implement the 11 directives of the order, all designed to enhance opportunities for Kansans with developmental disabilities to experience effective community services.

One of the first activities conducted was convening parent and guardian listening sessions. In order to effectively capture a broad array of information and input from the parents and guardians of people currently receiving state hospital services, SRS worked with the Wichita State University Center for Community Support and Research to conduct listening sessions with the parent/guardian groups at both KNI and PSH. The concerns and suggestions identified in these sessions were provided to the Executive Order Advisory Group to

consider as they developed recommendations, and also will be used by SRS as the implementation of consolidation continues.

The second action taken by SRS was to convene an advisory group which was charged with assessing and developing recommendations regarding the directives in the Executive Order. The PSH/KNI Executive Order Advisory Group was comprised of parents/guardians, CDDO Directors, community service providers, the hospital superintendents, and SRS representatives.

After working from March 4, 2010 through May 13, 2010, the advisory group developed 15 recommendations that will significantly support the consolidation of KNI/PSH services and the successful transition to community services for people who are well prepared to make that change. In summary, the recommendations include robust information/education processes for people who currently receive state hospital services; effective transition planning and the safety net features that will help ensure strong and person-centered community services for each person making the change; and post-move monitoring processes that will support long-term success for each person and their parents/guardians.

The Executive Order Advisory Group report has been presented to Governor Parkinson and SRS will continue to use the report as a guide for implementation of the Executive Order.

This concludes my testimony; I will stand for questions.

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

8-9

Attachment A - Overview of Medicaid Home & Community Based Services Waivers Operated by DBHS/CSS and KDOA

Updated 8-11-10

Long Term Care Services	DEVELOPMENTAL DISABILITY WAIVER	PHYSICAL DISABILITY WAIVER	TRAUMATIC BRAIN INJURY WAIVER	FRAIL ELDERLY WAIVER (operated by KS dept. on Aging)
Institutional Equivalent	Intermediate Care Facility for Persons with Mental Retardation	Nursing Facility	Head Injury Rehabilitation Facility	Nursing Facility
Eligibility	▯ Individuals age 5 and up ▯ Meet definition of mental retardation or developmental disability ▯ Eligible for ICF/MR level of care	▯ Individuals age 16-64* ▯ Determined disabled by SSA ▯ Need assistance with the activities of daily living. ▯ Eligible for nursing facility care **Those on the waiver at the time they turn 65 may choose to stay on the waiver*	▯ Individuals age 16-65 ▯ Have traumatic, non-degenerative brain injury resulting in residual deficits and disabilities ▯ Eligible for in-patient care in a Head Injury Rehabilitation Hospital	▯ Individuals age 65 or older ▯ Choose HCBS ▯ Functionally eligible for nursing care ▯ No waiver constraints
Point of Entry	Community Developmental Disability Organization	Case management Entities	Case management Entities	Case management Entities
Financial Eligibility Rules	▯ Only the individual's personal income & resources are considered ▯ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ▯ Income over $727 per month must be contributed towards the cost of care	▯ Only the individual's personal income & resources are considered ▯ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ▯ Income over $727 per month must be contributed towards the cost of care	▯ Only the individual's personal income & resources are considered ▯ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ▯ Income over $727 per month must be contributed towards the cost of care	▯ Only the individual's personal income & resources are considered ▯ Income over $727 per month must be contributed towards the cost of care

	DEVELOPMENTAL DISABILITY WAIVER	PHYSICAL DISABILITY WAIVER	TRAUMATIC BRAIN INJURY WAIVER	FRAIL ELDERLY WAIVER (operated by Kansas Department on Aging)
Services/ Supports Additional regular Medicaid services are provided	☐ Assistive Services ☐ Day Services ☐ Medical Alert Rental ☐ Sleep Cycle Support ☐ Personal Assistant Services ☐ Residential Supports ☐ Supported Employment ☐ Supportive Home Care ☐ Wellness Monitoring	☐ Personal Services ☐ Assistive Services ☐ Sleep Cycle Support ☐ Personal Emergency Response ☐ Personal Emergency Response Installation	☐ Personal Services ☐ Assistive Services ☐ Rehabilitation Therapies ☐ Transitional Living Skills ☐ Sleep Cycle Support ☐ Personal Emergency Response ☐ Personal Emergency Response Installation	☐ Adult Day Care ☐ Assistive Technology* ☐ Attendant Care Services ☐ Comprehensive Support* ☐ Medication Reminder ☐ Nursing Evaluation Visit ☐ Oral Health* ☐ Personal Emergency Response ☐ Sleep Cycle Support* ☐ Wellness monitoring *demotes suspended service; must meet crisis exception
Average Monthly Number Persons Served FY 10	7669	6964	323	5813
FY 10 Expenditures (All funds)	$311,275,963	$140,511,241	$13,085,895	$74,476,067
Estimated Average Waiver expenditure Mo/year	$3,382 / $40,589	$1,681 / $20,176	$3,376 / $40,514	$ 1,068/ $12,812
Institutional Setting Total Cost / Annually Per Person	Private ICF/MR $13,606,580 / $79,571 Public ICF/MR (combined)* $54,088,890 / $154,540	Nursing Facilities $358,545,585/ $33,863 (Includes persons who are aging)	Head Injury Rehab Facility $10,047,478 / $257,628	Nursing Facilities $358,545,585/ $33,863 (Includes persons with Physical disabilities)

*KNI/Parsons FY 2010 Expenditures & Daily Census Data

Kansas Department of Social and Rehabilitation Services
LONG-TERM CARE SUMMARY
August 2010

DD INSTITUTIONAL SETTINGS	Number Served Start of SFY 2010	Average Cost Per Person	Estimated Costs	
			All Funds	SGF
Private ICFs/MR	178	$79,028.00	$14,067,024.00	$4,274,265.00
State DD Hospitals - SMRH	358	$154,540.00	$55,325,207.00	$16,189,327.00
MFP (# persons discharged into MFP program) **Private ICFs/MR**	7			
MFP (# persons discharged into MFP program) **Public ICFs/MR SMRH**	14			
(# persons discharged NOT into MFP) **Private ICFs/MR**	6			
(# persons discharged NOT into MFP) **Public ICFs/MR SMRH**	12			
Sub-Total - **Private ICFs/MR**	165			
Sub-Total - **Public ICFs/MR -SMRH**	332			
New Admissions **Private ICFs/MR**	7			
New Admissions **Public ICFs/MR**	18			
Sub-Total - **Private ICFs/MR**	172	$79,028.00	$13,592,855.00	$4,130,189.00
Sub-Total - **Public ICFs/MR -SMRH**	350	$154,540.00	$54,088,890.00	$15,827,554.00
Net TOTAL Changes **Private ICFs/MR**	-6		($474,169.00)	($144,076.00)
Net TOTAL Changes **Public ICFs/MR**	-8		($1,236,317.00)	($361,773.00)
TOTAL DD Institutional Changes	-14		($1,710,486.00)	($505,809.00)
DD WAIVER SERVICES	**Number Served Start of SFY 2010**	**Average Cost Per Person**	**Estimated Costs**	
			All Funds	**SGF**
DD Waiver Community Services	7,596	$40,123.80	$304,780,365.00	$92,607,514.00
MFP	25			
Subtotal	7,621			
*1 Change due to OTHER reasons	173			
Subtotal	7,794	$40,800.16	$310,938,034.00	$94,462,975.00
TOTAL NET CHANGES DD Waiver	198		$7,899,108.00	$2,399749.00
TOTAL NET CHANGES DD SYSTEM	184		$6,188,621.00	$1,880,413.00

FE / PD / TBI INSTITUTIONAL SETTINGS	Number Served Start of SFY 2010	Average Cost Per Person	Estimated Costs	
			All Funds	SGF
Nursing Homes – Avg Mo Caseload SFY 08	10,817	$33,863.00	$366,296,071.00	$111,295,398.00
FE MFP	-40			
PD MFP	-38			
TBI MFP	-4			
Additional people–Net Admissions/Discharges	-229			
Nursing Homes-Avg Mo Caseload SFY 09	10,588	$33,863.00	$358,545,585.00	$108,940,491.00
TOTAL ADDITIONAL INSTUTUTIONAL COST	-229		($7,750,486.00)	($2,354,907.00)
FE / PD / TBI COMMUNITY SERVICES	Number Served Start of SFY 2010	Average Cost Per Person	Estimated Costs	
			All Funds	SGF
FE WAIVER	5,706	$12,812.00	$73,105,272.00	$22,172,071.00
PD WAIVER	7,400	$20,269.00	$149,983,200.00	$45,564,896.00
TBI WAIVER	294	$33,132.00	$9,740,762.00	$2,959,243.00
FE MFP	40			
PD MFP	38			
TBI MFP	4			
SUBTOTAL FE	5,746			
SUBTOTAL PD	7,438			
SUBTOTAL TBI	298			
*2 Change due to OTHER reasons FE	67			
*3 Change due to OTHER reasons PD	-511			
*4 Change due to OTHER reasons TBI	79			
SUBTOTAL FE	5,813	$12,812.00	$74,476,156.00	$22,587,873.00
SUBTOTAL PD	6,927	$20,269.00	$140,401,529.00	$42,653,984.00
SUBTOTAL TBI	377	$33,132.00	$12,490,705.00	$3,794,676.00
TOTAL NET CHANGES FE/PD/TBI	-283		($5,460,844.00)	($1,907,036.00)
Total Net Changes FE/PD/TBI and Institution	-512		($13,211,330.00)	($4,613,661.00)
GRAND TOTAL - NET CHANGES	-328		($7,022,709.00)	($2,452,470.00)

*1 Change due to OTHER reasons	Net number of persons added to waiver due to crisis, movement from other eligible programs
*2 Change due to OTHER reasons FE	Net number of persons added to waiver due to crisis, movement from other eligible programs
*3 Change due to OTHER reasons PD	Net number of persons added to waiver due to crisis, movement from other eligible programs
*4 Change due to OTHER reasons TBI	Net number of persons added to waiver due to new applications for services, crisis, movement from other eligible programs
ICFs/MR Private	Intermediate Care Facility for Persons with Mental Retardation - Privately Operated
ICFs/MR Public	Intermediate Care Facility for Persons with Mental Retardation - Public (Operated by the State of Kansas) also known as SMRH
SMRH	State Mental Retardation Hospital also known as a Public ICF/MR
DD Waiver	Community Services for persons with developmental disabilities funded by Medicaid
PD Waiver	Community Services for persons with physical disabilities funded by Medicaid
FE Waiver	Community Services for persons that meet the aging criteria funded by Medicaid
TBI Waiver	Community Services for persons with traumatic brain injuries funded by Medicaid
MFP	Money Follows the Person - federally funded grant that serves persons moving from qualified institutional settings into qualified community settings
MFP - State	Money Follows the Person - state funded program
Non-MFP Community	Persons that exited institutional settings to live in the community - DID NOT qualify for MFP services
Other Discharges	Persons that exited institutional settings for other reasons (death, transfer, non-qualifying stay - there are many possible reasons
Additional general notation	These data may not precisely match other program reporting information due to variable reporting cycles

INDEPENDENCE
INCLUSION
INNOVATION

INTERHAB

August 16, 2010

TO: Senator McGinn & Representative Bob Bethell, Vice Chairs
Members, Joint Committee on Home and Community Based Services

FR: Tom Laing, Executive Director
InterHab

RE: Home and Community Based Services for Kansans with Developmental Disabilities

The 2010 Legislative Session was important in that both parties, both Houses and the administration spoke out about the crisis facing human services. The crisis could have deepened, but it didn't thanks to your efforts.

The dialog you initiated on the needs of Kansans with developmental disabilities was long overdue as an acknowledgement of the importance of these issues. It was a message that a significant number of Kansas citizens had longed to hear from the Statehouse. It was a message that all of Kansas needed to hear. For your work last session, and for the funds appropriated to begin whittling down the State's DD waiting lists, we are appreciative.

However, the community network of supports for Kansans with developmental disabilities is still in crisis.
In particular, the legislature must not ignore the reimbursement crisis which threatens to destroy decades of collaborative work by the State and community partners in building supports for the developmentally disabled.

Reimbursement for community services continues to be funded at a rate far behind the costs providers now face. HCBS reimbursement has been allowed to fall behind every economic indicator, and virtually no adjustments have been made to enable us to keep pace with the basic costs of doing business. Utility, transportation, insurance, and so on ... all costs have gone up and next to nothing has been done to respond to this annually identified concern.

Direct Support Professional wages in the community are the largest cost of providing service, and they continue to lag more than $3.00/hour behind the standard you have set for wages in the State's institutional settings. Nationally compiled data underscores this fact. MSN recently reported that direct support positions were among the 8 lowest paying jobs in America.

While this is a national crisis, we cannot ignore that, among all the states, our relative standing has fallen perhaps further than any other state, when one considers our per-person investment in DD programs (for persons not in institutions). In 1993 we were 23rd in the nation. When these

Attachment 7-1
Date 8-16-10
Joint Committee on Home and Community Based Services Oversight

numbers were last compiled in 2008, we had fallen to 40th in the nation. Since 2008, we have continued to serve more persons, but at the same reimbursement rate, so our relative standing has almost certainly fallen further.

Fundamental to making this matter right is the need, which we and the State are addressing, to revamp our nearly 20-year-old rate setting methodology which has become irrelevant in the face of a changing service demographic.

Q-Base:

We have discussed the reimbursement crisis and you have heard today from the Director of the DD Council regarding the waiting list crisis. We strongly believe that these two issues must be considered as one, because the issues are interlinked.

To address the challenges facing the State in the DD arena requires not just serving more persons, and not just more money for reimbursement rates, but a investment in both, simultaneously, to create a quality-based approach to community expansion. We call the concept ***'Q-Base'***.

Quality Based Community Expansion (Q-Base) is predicated on the fact that, to provide services to more persons also requires an expanded investment into the community system that is being asked to continue to expand. Our approach recognizes that it must be a multi-year effort. It is unrealistic and almost certainly unwise to attempt to restore these losses hurriedly.

We will continue to advocate that legislators consider this ***Q-Base*** approach in rebuilding the DD system, and in doing so, we call out the need for quality enhancement as a part of that goal. We are ready and willing to invest new funding in an expanded commitment - not just to wages - but to meet the training and service needs of our workers as well. This is necessary in order that they can better serve the growing numbers of persons with DD entering the service system who have challenging behaviors and other highly specialized, challenging needs. We also will advocate for a renewal of the State's commitment to employment and training services for so many of the men and women we serve who want to work in the community, but who need assistance to make that happen.

It would be misleading, however, if we talked only of the HCBS funding issues we face:

The cuts from outside the HCBS funding stream have been significant. Among the most damaging is the continued trend to cut SGF-only programs.

These numbers illustrate it adequately: In FY2010, roughly $14.1 million was invested in SGF grants for persons in the community who do not qualify for the HCBS program. In FY2011, that amount will have fallen to $3.5 million. Persons who were served by these dollars included hundreds of children and families, as well as persons who only needed a little bit of help to maintain their independence.

Add to these cuts the loss of funding from many counties, from many charitable donors, from business contractors who assist the persons we serve in employment training settings, from many United Way efforts in many communities, categorical aid from schools to our infant and toddler programs, and so on. The downturn in the economy has affected all these funding sources, some more than others.

So how did we judge the outcome of the 2010 session? We evaluated it in the only fair manner, by the facts that have been presented to you.
From the thousands still on the State's waiting lists, now totaling more than 4,500 children and adults with developmental disabilities, the 2010 session found funds for less than 200. That number is smaller than the number of new persons who will be eligible for service in FY 2011. In other words, we are still going backwards, slower perhaps, but backward.

For the thousands of community workers whose principal funding stream is the HCBS waiver, the legislature and the Governor provided zero relief. Though the current economy shows only modest attrition in spending power, it is a fact that the DD system continues to lag behind. Community service providers have had to cut benefits, or pass benefit costs onto employees, or both. Health Care Reform has created a further hurdle regarding benefits, by mandating that employers must provide benefits at current level with no further cuts.

We continue to call these matters a crisis because they constitute an ongoing and unresolved crisis.
It's a personal crisis, a program crisis, a constitutional crisis and a moral crisis:

- *For families and persons waiting for service.*
- *For community workers who are being forced to find other careers where there is some promise of at least some modest growth in financial opportunity.*
- *For community leaders, who are left holding a very heavy bag of liability – both moral and legal – for promises made by this State that are not being kept.*

Last session you showed great determination to slow down the avalanche of growing need and to rekindle a dialog that more honestly discussed the challenges we have raised today. We thank you for that.

Nevertheless, in this coming session (no matter what is said during the election campaigns) you need to lead with a renewed legislative determination to support these programs more adequately and more reasonably. We ask only that you show the same determination that has been shown by persons with disabilities, their families, and community service leaders, who have all kept up their end of the deal.

American Network of Community Options and Resources

A National Network of Providers Offering Quality Supports to People with Disabilities

Direct Support Professional Wage Facts-2009[1]
KANSAS

NATIONAL FACTS:

Medicaid is the largest source of financing for disabilities services in the United States. For people with disabilities and for those who provide their care, Medicaid serves as a safety net for the provision of services and directly tied to this are the wages paid to Direct Support Professionals (DSPs).

Direct Support Professionals (DSPs) are healthcare professionals who provide "hands on" daily supports, training and habilitative services to persons with developmental and physical disabilities. This workforce is responsible for the health, safety and emotional support of the individuals being served. DSPs ensure compliance with state regulatory requirements for the delivery of these critical supports, as well as provider policies and procedures. For purposes of this study, DSPs employed by private providers are compared with those who work for State-Run programs.

NATIONAL IMPACT:

NATIONAL	ENTRY WAGE	ANNUALIZED ENTRY WAGE	FEDERAL POVERTY LEVEL	DOLLAR VALUE($) DIFFERENCE	PERCENT (%) DIFFERENCE
PRIVATE PROVIDER	$9.37	$19,498.00	$18,454.00	$1,041.00	6.00%
STATE PROVIDER	$12.57	$26, 143.00	$18,454.00	$7,654.00	41.00%
DIFFERENCE BETWEEN STATE AND PRIVATE PROVIDER	$3.20	$6,645.00		$6,613.00	35.00%

KANSAS IMPACT:

KANSAS	ENTRY WAGE	ANNUALIZED ENTRY WAGE	FEDERAL POVERTY LEVEL	DOLLAR VALUE($) DIFFERENCE	PERCENT (%) DIFFERENCE
PRIVATE PROVIDER	$8.29	$17,243.00	$18,310.00	-$1,607.00	-6.00%
STATE PROVIDER	$11.13	$23,150.00	$18,310.00	$4,840.00	26.00%
DIFFERENCE BETWEEN STATE AND PRIVATE PROVIDER	$2.84	$5,907		$6,447.00	32.00%

In Kansas, a DSP working for a Private Provider who is a single parent of three would earn $1.607 below the federal poverty level. This compared to a State employed DSP who earns $4,840 a year more. This means a State employed DSP earns 32% more above the federal poverty level as compared to private providers. In addition, a DSP working for a private provider would earn only $1.04 an hour more as compared to the $7.25 minimum wage in Kansas.

Research shows that better pay is critical to ensuring the adequacy and stability of the direct-care workforce. There is nothing inherent about these jobs that make them low quality. In fact, they are the jobs of the future...they can't be outsourced; they are recession-proof and they can be powerful economic drivers improving the lives of many low-income families and spurring community revitalization.

Providing decent paying jobs for direct-care workers is the key to ensuring quality of life and quality of care for millions of Americans with disabilities and chronic illnesses.

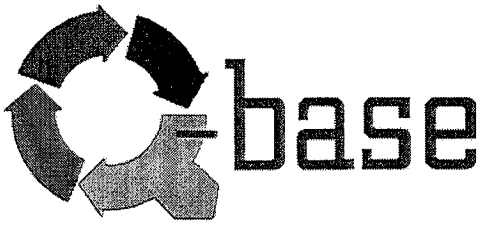
Our long-term care system faces a huge recruitment challenge – a challenge made more difficult by the poor pay of many direct-care jobs. On average vast majority of Direct Support Professionals earn wages around $9.37 per hour . Coupled with the national average for high turnover of 38.2%, Direct Support Professionals leave the field for better compensated, more stable work that is less emotionally and physically demanding.

The future of intellectual and developmental disability services hinges on the recruitment and retention of quality direct support professionals. Without these qualified staff no provider will be able to serve.

1 ANCOR 2009 Direct Support Professionals Wage Study: A report on national wage, turnover and retention comparisons. Prepared for the ANCOR National Advocacy Campaign by the Mosaic Collaborative for Disabilities Public Policy and Practice

Table 3.14 Medicaid ICF-MR, HCBS and Combined Per Person Expenditures in FY 1993 and FY 2008

State	1993					2008				
	ICF/MR Expenditures	ICF/MR Residents	HCBS Expenditures	HCBS Recipients	Combined Per Person Costs	ICF/MR Expenditures	ICF/MR Residents	HCBS Expenditures	HCBS Recipients	Combined Per Person Costs
AL	$79,030,041	1,266	$22,182,047	2,184	$29,337	$36,179,938	236	$267,362,504	5,670	$51,396
AK	10,362,069	85	0	0	121,907	0	0	76,806,107	1,061	72,390
AZ	16,911,180	298	114,161,800	6,071	20,580	15,370,880	209	619,467,289	20,154	31,176
AR	89,553,111	1,724	10,391,122	453	45,909	147,860,176	1,601	97,104,703	3,360	49,378
CA	356,304,904	11,025	92,414,694	11,085	20,295	610,506,432	9,379	1,709,007,000	75,867	27,210
CO	50,704,123	737	63,448,347	2,407	36,308	22,289,078	128	311,354,728	7,275	45,069
CT	181,959,971	1,272	139,890,550	2,069	96,334	236,997,479	1,116	475,540,000	7,905	78,987
DE	26,574,433	370	9,667,487	290	54,912	29,834,083	138	83,576,384	817	118,754
DC	63,961,219	804	0	0	79,554	82,083,747	533	54,469,781	1,203	78,660
FL	192,151,682	3,207	38,671,466	6,009	25,046	338,699,599	3,129	945,063,427	30,939	37,682
GA	116,223,419	1,933	15,068,108	359	57,283	103,532,026	984	381,689,803	11,296	39,513
HI	6,155,659	117	8,620,253	450	26,060	9,027,307	86	104,462,436	2,531	43,366
ID	38,497,578	494	2,700,000	174	61,673	62,009,912	535	68,119,007	2,233	47,012
IL	531,667,554	12,160	34,477,962	2,850	37,718	659,781,238	9,023	461,700,000	14,496	47,684
IN	283,528,589	6,213	483,489	447	42,644	304,804,854	4,099	443,949,814	10,247	52,193
IA	160,959,092	1,890	2,477,295	170	79,338	288,092,999	2,134	303,613,019	13,205	38,575
KS	106,648,757	1,837	36,813,107	1,066	49,418	63,193,294	584	274,843,524	7,373	42,483
KY	69,885,596	1,053	24,505,668	855	49,471	111,177,567	524	226,531,475	3,161	91,644
LA	324,034,343	4,678	13,087,458	1,134	58,004	480,841,734	5,059	322,451,876	6,834	67,543
ME	59,821,344	630	23,606,982	509	73,247	65,103,006	210	248,956,942	2,867	102,067
MD	60,767,020	894	64,502,005	2,437	37,607	55,148,164	279	517,577,519	10,831	51,550
MA	315,569,399	3,520	74,222,387	3,288	57,255	234,838,072	901	583,547,891	11,381	66,633
MI	149,187,111	3,342	78,234,680	2,885	36,522	16,728,240	81	381,731,216	7,987	49,388
MN	288,650,678	5,072	107,234,621	3,408	46,685	178,358,058	1,832	925,198,681	14,563	67,311
MS	79,043,314	2,038	0	0	38,785	285,877,979	2,623	38,013,057	1,975	70,442
MO	113,792,154	1,709	75,838,414	2,622	43,784	129,144,945	965	392,751,282	8,729	53,837
MT	10,387,598	165	13,515,850	504	35,730	13,044,028	55	78,281,028	2,268	39,313
NE	34,216,508	721	24,169,388	991	34,104	68,217,464	510	147,500,141	3,589	52,627
NV	26,810,867	208	2,295,417	186	73,874	18,993,803	105	65,416,400	1,591	49,770
NH	5,364,387	74	53,026,255	1,032	52,794	3,005,371	25	155,729,108	3,580	44,032
NJ	286,201,207	3,892	113,719,749	4,191	49,477	633,120,543	2,878	505,880,000	10,048	88,117
NM	42,832,979	681	7,552,177	612	38,968	23,171,893	181	267,982,051	3,777	73,561
NY	1,927,559,462	21,850	163,595,442	3,398	82,825	2,675,003,359	7,752	3,825,876,515	58,560	98,035
NC	316,571,784	4,662	16,223,347	1,190	56,869	461,931,336	4,176	457,750,000	9,700	66,279
ND	37,077,368	618	20,585,690	1,362	29,123	70,722,378	585	77,570,212	3,657	34,958
OH	449,570,809	8,222	26,512,352	1,120	50,962	691,974,985	6,418	813,795,687	18,106	61,400
OK	132,075,921	2,415	43,728,032	1,287	47,489	126,917,256	1,486	267,877,651	5,548	56,127
OR	80,043,415	468	86,645,986	2,023	66,917	12,240,527	32	438,537,585	10,879	41,314
PA	500,105,694	6,768	169,500,650	3,795	63,392	578,710,845	3,854	1,224,627,946	29,357	54,299
RI	105,169,194	457	74,432,864	1,192	108,916	8,737,800	40	251,288,605	3,217	79,836
SC	165,306,409	3,232	14,702,477	586	47,147	154,255,458	1,477	213,200,000	5,652	51,544
SD	29,613,205	504	20,474,218	923	35,100	22,366,550	150	86,921,676	2,733	37,908
TN	117,122,556	2,328	10,133,905	587	43,656	241,018,741	1,180	553,899,151	7,467	91,930
TX	508,053,498	12,143	10,741,860	968	39,569	890,443,032	11,177	698,358,386	18,409	53,701
UT	45,245,234	938	29,537,055	1,476	30,979	69,802,718	797	126,595,282	4,062	40,419
VT	11,213,196	79	28,628,023	598	58,850	979,000	6	121,270,835	2,270	53,713
VA	148,246,524	2,669	12,350,227	537	50,093	273,332,795	1,627	443,732,502	8,106	73,674
WA	206,468,229	1,650	79,960,529	1,711	85,221	150,434,481	760	352,550,599	9,205	50,475
WV	14,607,955	640	38,188,818	637	41,344	60,128,913	477	222,657,003	3,891	64,740
WI	207,826,034	3,887	50,139,752	2,017	43,693	128,508,098	946	504,234,866	13,405	44,091
WY	6,224,937	90	17,308,645	459	42,866	18,312,242	82	93,970,241	2,082	51,887
US Total	9,185,859,310	147,729	2,180,368,650	86,604	48,505	11,962,854,423	93,164	22,310,392,935	525,119	55,433



Quality-Based Community Expansion - "Q-Base"

The Kansas Developmental Disabilities (DD) Reform Act (KSA 39-1806), passed in 1995, mandates development of a community network of supports that foster independence, inclusion, integration and productivity for Kansans with developmental disabilities. Significant and sustained efforts must be undertaken by the State of Kansas, in partnership with community providers, in order to build the infrastructure required to carry out this commission.

While small increases in needed resources have been championed by the legislature in recent years, no organized effort has been initiated by policy makers to either address the glaring needs of the community DD system or meet the mandates of the KS DD Reform Act. Strong leadership is now needed to steer the State into a new era of sustained investment in a community-based system of supports for Kansans with developmental disabilities that will finally answer the call of the KS DD Reform Act.

The beginning steps of such a sustained effort must include the elimination of the State's waiting lists for DD services, which now number more than 4,000 children and adults with developmental disabilities.

However, policy makers must understand that in order to end the State's waiting lists, community service capacity must be dramatically enhanced - both programmatically and in terms of human resources infrastructure.

The following is a broad proposal that we believe must be embraced if we are to meet the mandates of the DD Reform Act. This proposal is based on a simple but critical premise, i.e. waiting lists and rate increases must be addressed in combination if the State and its Community partners are to significantly expand community services for persons with developmental disabilities.

Proposing new resources to fund "stand alone items" ignores the reality that waiting list funding alone will not enable community service providers (CSP) to meet the needs of persons on the waiting list, e.g.:

- In several areas of the State CSPs are unable to hire staff to serve new consumers due to low starting wages.
- Other CSPs are without enough supervisory staff, due to turnover, to safely oversee a business expansion.

- Requests that a CSP serve a person with challenging behavioral issues may be turned down due to the relative inexperience of existing staff, or

- Other requests that a CSP serve a person with challenging medical issues may be turned down due to a shortage of persons on staff with adequate training to safely provide the ancillary support tasks of tube feeding or tracheotomy-cleaning.

To provide increasing amounts of services requires the State/Community partnership to expand service capacity and enhance service quality in amounts commensurate with the needs of persons to be served, ahead of the curve of service expansion.

To increase service without this consideration invites quality erosion and exacerbates safety risks to all consumers, not just the consumers funded by new waiting list dollars.

Only with sufficient rate increases, in combination with creative and flexible program management, can the State/Community partnership insure a quality-based approach to community service expansion.

InterHab proposes that any new system dollars – for waiting list reduction and rate increases – be creatively utilized to address four program components:

- Stewardship
- Quality enhancement
- Capacity expansion
- Waiting lists

Community Stewardship:

Community leadership have long been tasked with combining state/federal resources with local resources to make community DD programs work to the maximum attainment of the statutory and regulatory expectations of the participating funding authorities. To that extent, the following are the stewardship activities that we believe are vital to assure the long term financial sustainability for the coming years:

- State and community efforts must be increased to assure an expanded effort in the community to promote employment and employment related training for persons with developmental disabilities.

- Programs such as 'tiny-k' infant and toddler services which perform vital early intervention for children with disabilities and their families must be enhanced, thereby ensuring a better quality of life for thousands of Kansas children who could be diverted from further need of State-funded assistance.

- State and community efforts must collaboratively develop new family service models that satisfy basic family needs, in order that families are not diverted into the most available funding stream (the current HCBS DD Waiver) but are assisted by options (including the Family Subsidy model, a new Family Services waiver, or other models).

- State and community efforts must be redoubled to increase the maximization of freedom and control that someone can bring to their life.

- State oversight must position its structure, within the philosophical framework of the Developmental Disability Reform Act, to be supportive of community flexibility in adjusting programs, services and staffing to suit the wide spectrum of both proven current needs and possible future needs of populations served.

Quality Enhancement:

The State and community collaboration of the past, which ushered in a high degree of professionalism and expertise in all areas of the delivery of community services and supports, has taken a back seat to a struggle to maintain 21st century quality enhancement momentum with 20th century resources. This trend must be reversed.

Further, additional emphasis and resources must be brought to bear on the State's efforts to encourage self-advocacy among Kansans with Developmental Disabilities.

Finally, in order to fill a vital community education and oversight role, the State should pursue creation of a Kansas DD Ombudsman. This ombudsman would provide information to persons served and their families regarding community service and provider options, as well as collect needed data on community provider customer service, quality of service and service access issues.

A significant resource commitment must be made in the following areas of training:

- Training initiatives to assist in the delivery of high-quality services to the increasing numbers of persons with health, behavioral or age-related challenges,

- Training initiatives to upgrade the skill-set of every supervisor of community direct care staff, and

- A comprehensive review must be undertaken to assess the core quality related proficiencies of the current network of service providers.

The expansion of services, the expansion of non-licensed providers, and the lack of adherence to core standards among newly licensed providers – all of these factors give rise to a concern among community leadership that standards of service intended to safeguard the interests of consumers have been sacrificed due to resource shortages. Minimum standards must be established, and reimbursement rate structures must reflect a commitment to such standards.

In the era of increased self-sufficiency among persons receiving service, ensuring the adherence to statutory and departmental quality benchmarks such as the core components of the DDRA (integration, inclusion, independence and productivity) is vital. The State must undertake a development process to implement full oversight of these new service choices, in order to determine that established statutory and departmental outcomes are met.

The State's Waiting Lists:

State and community leaders must better assess and present the characteristics of persons' needs who are waiting for services. Merging the two lists into one list would acknowledge that individuals' needs cannot be arbitrarily prioritized by who is and who isn't currently receiving some services.

State and community leaders must also re-emphasize the generic community supports that do exist, and persons waiting for services, and their advocates, must be assisted in accessing such generic supports. Generic supports can, and often do, mitigate some of the negative effects of waiting for service, and sometimes can become a non-paid alternative to paid services.

Capacity Expansion:

Community service providers have few tools with which to develop the human resource capacity needed to serve significant new numbers of persons, given that the principal energy of human resource professionals in the system is spent in the constant battle to overcome high-turnover and staff shortages that arise as a direct result of low wages.

True capacity building can only result from significant upward adjustments in the wage base to reduce the stigmatization of such jobs as low-wage, no-advancement jobs. Reducing such stigma removes the initial barrier faced by HR staff, i.e. that persons entering the job market routinely do not apply for our jobs because they are known to be hard jobs with low pay.

Obviously, the foundation of HR capacity building is the foundation upon which the community service policies rise or fall. It is critical, but still woefully under-addressed, that the State must provide resources adequate to enable service providers to recruit, train, and retain high-quality

direct care staff. Current reimbursement rates are neither adequate nor reasonable to make better wages and benefits possible.

HR capacity building is additionally needed to enable focusing in the following ways:

- To ensure that community developmental disability service providers are reimbursed at a rate which allows them to offer wages and benefits commensurate with attracting and retaining quality direct support staff.

- To utilize higher qualified and/or more experienced staff for the increasing numbers of consumers served whose diagnostic characteristics include (a) significant health needs, (b) increases of the early onset of age-related illness, principally Alzheimer's and other forms of dementia, (c) behavioral challenges of such significance that the failure to provide adequate staff to serve such persons could easily constitute risks to the consumers or the community at large;

- To increase the development of community generic support to help meet individual needs with non-paid services; and,

- To better educate community employers to see workers with DD as a resource to be utilized, and to provide the informal short term assistance to make that happen, as well as the intermittent long-term follow up to assure the viability of those employment experiences.

- To fully-fund supported employment services for persons with developmental disabilities in order to assist them in becoming independent, contributing members of their communities.

DISABILITY RIGHTS CENTER of KANSAS
EQUALITY • LAW • JUSTICE

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JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

August 16, 2010

Thank you for the opportunity to speak before you, my name is Nick Wood, I am a disability rights advocate at the Disability Rights Center of Kansas (DRC). The DRC is a public interest legal advocacy agency, part of a national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. As such, DRC is the officially designated protection and advocacy organization for Kansans with disabilities. DRC is a private, 501(c)(3) nonprofit corporation, organizationally independent of state government and whose sole interest is the protection of the legal rights of Kansans with disabilities.

In a climate of fears of further budget cuts to Medicaid programs in Kansas, the DRC has continued to investigate and review the policies and practices the State of Kansas uses to administer these important programs in an effort to continuously monitor and zealously advocate for the rights of individuals with disabilities to live in most integrated, community based environments.

In 1999, the US Supreme Court decided that "unjustified isolation of individuals with disabilities is properly regarded as discrimination based on disability" and therefore a violation of rights guaranteed under the Americans with Disabilities Act (ADA). Since the Olmstead Decision, the US Department of Justice (DOJ) and President Bush's New Freedom Commission have reinforced the spirit of the court's decision by further delineating the responsibilities of every state to ensure the legal rights of its citizens with disabilities in Institutions.

Before I go over the DOJs position, it is our understanding that one purpose of today's meeting is to discuss the impact of the actions and subtractions in the budget. In short, we believe that the Legislature's actions on the budget leave the state vulnerable in regard to the standards set out by the DOJ.

A legal complaint against the state of Arkansas, filed by the Department of Justice on May 6th 2010, has defined what an Olmstead violation looks like. It is important to stress that these are the arguments of the DOJ, and therefore these are some of the standards that Kansas will be

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held accountable to if it finds itself in a similar position as Arkansas, which has been sued by the DOJ. The DOJ is aggressively enforcing the ADA and the right to live in the community.

The following are excerpts from the DOJ's complaint (with some edits):

BACKGROUND:

"The State segregates hundreds of individuals with ... disabilities in institutions that are not the most integrated setting appropriate to their needs, and fails to provide adequate community supports and services to individuals who are discharged from the institutions or who are at risk of institutionalization." [Note: This applies to people who are either in institutions, or discharged from institutions, or at risk of going into an institution.]

"The State gives individuals with ... disabilities the draconian choice of receiving services in segregated institutions or receiving no services at all."

"Congregate institutions ... segregate individuals with ... disabilities from the community." These institutional "settings discourage its residents from engaging independently in activities of daily living, fosters dependence on institutional supports, and erodes the skills necessary for community living."

PERSONS CONFINED TO INSTITUTIONS:

"Most, if not all, of the residents confined to the institution can handle or benefit from community settings, and therefore can be served successfully in a more integrated setting in the community."

"State's treatment professionals agree that many of the residents currently confined could be served in the community with appropriate supports and services."

"The State has not given many residents, and/or their family/guardian, the opportunity to make an informed objection to receiving services in a setting less-restrictive than the institution."

STATE FAILS TO TRANSITION PERSONS TO THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS:

"Typically, the State does not meaningfully consider a resident for a more integrated setting unless the resident or their family/guardian proactively requests a more integrated setting.

"Most residents do not proactively request a more integrated setting because the State does not properly educate residents on what community resources are available, or the possible benefits of community placements.

"The States does not adequately assess whether residents could be served in a more integrated setting appropriate to their needs."

"The States does not properly educate staff at the institution on how to appropriately assess a resident for community placement.

"Institution staff typically tailor an assessment of a resident's appropriateness for community placement based upon their limited understanding of what community resources are available (or not available), rather than specifically what supports and services a resident needs in order to be adequately supported in the community."

"While confined in the institution, residents do not receive appropriate treatment to support their eventual discharge to a less restrictive setting in the community."

"Residents who have been confined for many years are not actively reassessed for opportunities to move to a less restrictive setting appropriate to their needs."

"The State fails to properly evaluate individuals with disabilities for a more integrated setting before these individuals become residents of the institution. Institutionalizing these individuals fosters their dependence on institutional supports, and erodes the skills necessary for community living."

THE STATE'S INADEQUATE COMMUNITY SERVICES:

"The State fails to provide services in the community in sufficient quality, quantity, and geographic diversity to enable individuals with disabilities to be served in the most integrated setting appropriate to their needs."

"The State has not conducted an adequate assessment of the needs of its disability services system, including, particularly, those services necessary in order to provide services to all residents in the most integrated setting appropriate to their needs."

"Numerous residents are confined to institutions because the services necessary to address their needs in the community are not offered by the State in sufficient quality, quantity, and geographic diversity to serve residents' needs."

"Many individuals with disabilities are segregated in institutions for no reason other than they are waiting for funding to become available to support their placement in a Home and Community-based waiver slot under the federal Medicaid Waiver Program."

"The current wait list for a Home and Community-based waiver slot total approximately 1,400 people waiting for community services. This wait list moves at an extremely slow pace, with most people waiting several years for funding for community services. Individuals currently at the bottom of the wait list will likely wait more than a decade to receive community services."

The Kansas Picture

- The waiting lists have grown.
    - MR/DD 'Access List' has grown up to 2444.
    - Physical Disabilities list has grown to 2286.
- We are currently serving about 158 people in KNI and up to 200 at Parsons.
- There are reportedly no children at KNI. The number of children has Parsons has risen from 12 in fall of 2009 to 17 as of July of 2010. Of those children being served at Parson, several have been in the facility for more than one year.
- Extent and Type of Disability. According to data published in 2004, the average *"tier rate"* (determining extent of disability and the level of services and supports needed) is 2.0 at KNI and 3.0 at Parsons. Within the community based system, the average tier rate was 3.07. There was no significant difference between institutionalized and community-served individuals in the extent of their disabilities and need for support.

Funding cuts

Cuts in funding to HCBS Waiver programs have meant more of the responsibilities that belong to the State of Kansas to provide supports that allow people with disabilities to live in the community have been borne by families. At the DRC we see this trend of cutting services and putting more pressure on families as the primary reason for unnecessary institutionalization. Below are a set of trends we have seen since the cuts began to be implemented:

- Financial difficulties increased by cutting dental services.

- No guarantee of a Positive Behavior Support Plan to anyone who needs them.
- Failure to adequately review all of the community based service options available to families under Medicaid AND/OR needed services are not provided in a coordinated fashion.
- No 'check and balance' to ensure that families facing institutionalization are fully informed of all community based supports and services.

Recommendations to prevent unnecessary institutionalization

- Immediately develop a process ensures everyone in institutions and those facing institutionalization are fully evaluated and the parent/guardian is fully informed about community based supports and services. Essentially a plan should be developed that would be provided to the family/guardian that is a breakdown of the "7 day week" complete with identified service provider, as well as time, duration and frequency of each service. It is not a real option when we don't have this picture.
- Review this plan with each individual and their family/guardian on a regular basis. This can and should take place at 30, 60, or 90 day intervals.
- If institutionalization is not avoided, then provide high levels of services in the facility are focused on returning individuals to the community. Goals for Occupational Therapy, Speech Therapy, Physical Therapy, Family Therapy, education and training for families are essential. Much of the research about individual with Dual Diagnosis says that many behaviors that develop are a result of frustration with communication. Electronic Speech augmentation devices are now less expensive and easier to use than ever before. Every person with significant speech issues should be able to begin working with these devices during a stay in the Institution.

Kansas Council on Developmental Disabilities

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

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

August 16, 2010

Testimony in Regard to the unmet needs of the Kansas Developmental Disabilities system.

Mr. Chairman, Members of the Committee, I am appearing today on behalf of the Kansas Council on Developmental Disabilities regarding the Kansas Developmental Disabilities System.

The Kansas Council is federally mandated and federally funded under the Developmental Disabilities Assistance and Bill of Rights Act of 2000, we receive no state funds. It is composed of individuals who are appointed by the Governor, including representatives of the major agencies who provide services for individuals with developmental disabilities. At least 60 percent of the membership is composed of individuals who are persons with developmental disabilities or their immediate relatives. Our mission is to advocate for individuals with developmental disabilities to receive adequate supports to make choices about where they live, work, and learn.

Specifically, I will discuss the impact of state budget cuts on persons with Developmental Disabilities and provide recommendations that impact funding both to assist the many individuals who are and have been waiting for several years for services. And in maintaining current services

First, how many people are waiting for services? Attached in bright yellow are both the numbers and a chart showing how the waiting list for the Developmental Disabilities HCBS Waiver has grown. All 2011 numbers are as of August 1, 2011 and reflect requested dates of services on or before that date.

There are two different Waiting Lists – the **Unserved** List includes adults and families with children who receive no services. These individuals have been waiting, some for as long as three

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years or more, for necessary services. They include persons who have exited education, either through graduation or by "aging out." Others are individuals who have moved to Kansas during that period or whose families have been their caregiver and are no longer able to provide care. The reasons are many – aging parents, parents who themselves have incurred a disability that prevents them from providing care, and other diverse reasons.

The second list, the **Under Served,** includes adults and families with children who receive some services but who, due to some major event, need additional care. This list could also include persons who receive some services but have now excited education and need daytime services and others who also receive some but not all needed services. The latter may be persons with Down's Syndrome who are now in their 30's and have developed Alzheimer's.

As a former special education specialist, I am aware of the large sums spent education children with disabilities. I am equally aware that those skills taught in school soon disappear if they are not used. The State pays for students with Developmental Disabilities to be taught employment related skills only to have them lose those skills, as they graduate to their parent's living room, because we have not adequately funded waiver services. We also have many adults with Developmental Disabilities who can and want to work but, again, there are not enough funds to provide supported employment, job search, and other services needed for them to find and remain employed. Finally, research has shown that the earlier we diagnose and serve persons with DD, the greater their likelihood for success in life. Reductions in funding to the Community Developmental Disabilities Organizations leads to reductions in programs for the Infant Toddler (Tiny K) programs resulting in the need for increased services as these children reach school age and adulthood.

<u>Suggested Areas for Improvement</u>

Employment - *The Case For Inclusion 2010, An Analysis of Medicaid for Americans with Intellectual and Developmental Disabilities,* a study done by United Cerebral Palsy, shows Kansas ranks 46th in supporting meaningful work (column 4 on the attached chart). We must change the attitude of the DD community – employment should be the first item considered for persons seeking service. Employment is not an option for the vast majority of Kansans when they exit school and it should not be an option for persons with a disability. Schools, vocational rehabilitation services,

community service providers, and most important, parents and consumers should seek employment for persons with a disability. We have many examples of persons, even those with severe disabilities, who are gainfully employed. Some of them own their own very successful business. Several of them were here to testify at a hearing for the Employment First Bill this past Session. The House passed this bill 121-1 and we applaud you for doing that. Unfortunately, the Senate did not even hold a hearing. Kansas needs a law that states that employment first is our priority!

Institutional Closure

Kansas spends approximately **$154,000 per person** for each individual in Parsons State Hospital (PSH) or Kansas Neurological Institute (KNI) for a total of over $55,000,000. We spend approximately **$40,000 per person** in the community or approximately. We serve approximately 358 persons in the two institutions and close to 9,000 in community settings. There are **2,444 adults and children who receive no services**. The waiting list for Developmental Disabilities (DD) Home and Community Based Services keeps growing. Each year for many years the number taken off the list and provided services is smaller than the number seeking services. The Topeka Capitol Journal reports that Kansas is a desirable place to live. It does not appear to be desirable to the 2,444 persons with DD on the waiting list! If we closed KNI and moved their population of 160 to the community, even estimating an average cost of $80,000 per person, we would still save **$11,840,000,** KNI total cost of $24,640,000, minus $12,800,000 (for 160 persons at $80,000). These potential savings would current DD waiting lists and help maintain current services for those in the community. Savings could be even greater depending upon specific costs for former KNI residents and the use of federal grant monies such as Money Follows the Person. One other very important item – those who move out of an institution have improved health, more inclusion in the community, increased interaction with their families, and overall a better life.

We successfully closed Winfield State Hospital (WSH) in the mid 1990s and used that savings to bring our DD waiting list to almost nothing. An outside study commissioned by the Legislature and Developmental Disabilities Council showed that overall health and welfare of WSH residents improved after their movement to the community. Closure of another state DD hospital would greatly benefit both persons with Developmental Disabilities and the State. Alaska, Hawaii, Indiana, Kentucky, Maine, Minnesota, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and West Virginia have no state institutions. Illinois recently closed an institution and in the past five years, Louisiana went from 9 institutions to 3 and closed another one this year.

Money Follows the Person

Kansas has a federal Money Follows the Persons Grant – the federal funds from that grant are to be used to assist persons with disabilities to move into the community. We suggest it is time to reexamine the grant's goals and use more funds to move consumers from PSH and KNI into the community.

Your time and interest and is very much appreciated and I would be happy to answer any questions.

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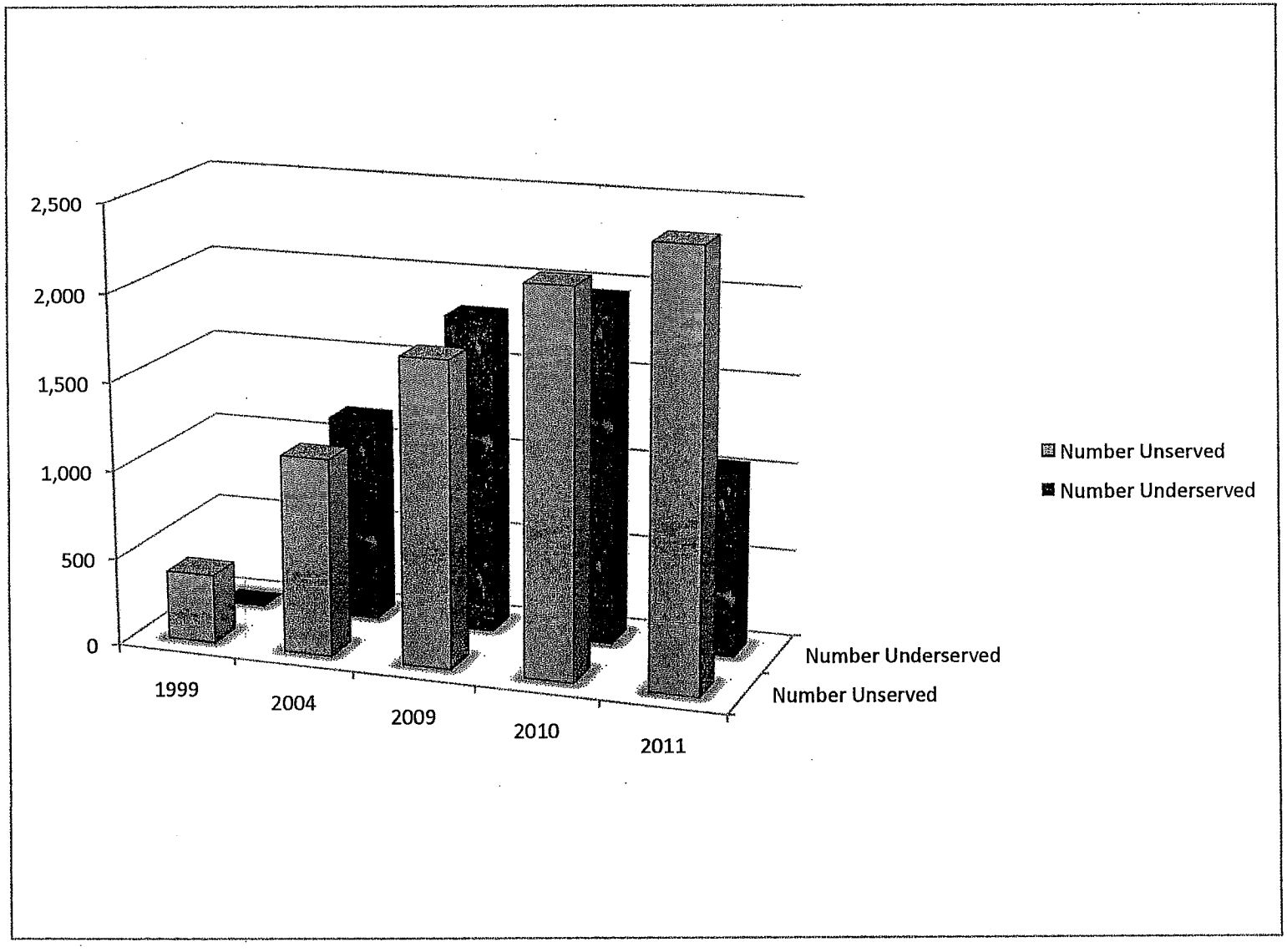
9-4

Kansans with Developmental Disabilities -
Unserved and Underserved



Kansans with Developmental Disabilities - Unserved and Underserved

Year	Number Unserved	Number Underserved	Totals
1999	393	0	**393**
2004	1,120	1,169	**2,289**
2009	1,733	1,812	**3,545**
2010	2,182	1,957	**4,139**
2011	2,444	1,047	**3,491**

Subrankings of States in Four Key Outcomes And Data Elements

Allocating Resources to Those in the Community (Non-ICF-MR)

% of ID/DD Expenditures on non-ICF-MR		Rank
100%	Alaska	1
99%	Vermont	2
99%	New Hampshire	3
99%	Michigan	4
98%	Oregon	5
98%	Arizona	6
97%	Rhode Island	7
95%	Colorado	8
94%	Hawaii	9
94%	New Mexico	10
93%	Maryland	11
90%	Minnesota	12
90%	Montana	13
89%	Alabama	14
88%	California	15
87%	Kansas	16
86%	Nevada	17
86%	Wisconsin	18
86%	Wyoming	19
84%	Maine	20
84%	Georgia	21
84%	South Dakota	22
83%	West Virginia	23
82%	Missouri	24
82%	Connecticut	25
82%	Massachusetts	26
82%	Washington	27
82%	Delaware	28
80%	Florida	29
78%	Pennsylvania	30
78%	Idaho	31
75%	Ohio	32
75%	Nebraska	33
75%	Oklahoma	34
75%	Tennessee	35
74%	Dist. of Columbia	36
73%	Indiana	37
73%	South Carolina	38
72%	Utah	39
70%	Kentucky	40
70%	New York	41
70%	Virginia	42
70%	North Carolina	43
66%	North Dakota	44
66%	Arkansas	45
63%	Iowa	46
61%	Illinois	47
61%	New Jersey	48
59%	Texas	49
53%	Louisiana	50
30%	Mississippi	51
77%	US Average	

Supporting Individuals in the Community and Home-like Settings

% Living in Settings with 1-3 Residents		Rank
98%	Nevada	1
98%	Vermont	2
95%	Arizona	3
95%	New Hampshire	4
93%	Idaho	5
90%	California	6
90%	Kentucky	7
89%	Washington	8
88%	New Mexico	9
88%	Alaska	10
88%	Hawaii	11
87%	Georgia	12
85%	West Virginia	13
85%	Colorado	14
81%	Delaware	15
81%	New Jersey	16
81%	Florida	17
81%	Ohio	18
80%	South Carolina	19
80%	Maryland	20
80%	Tennessee	21
80%	Montana	22
79%	Alabama	23
79%	Oregon	24
79%	Virginia	25
78%	North Carolina	26
78%	Michigan	27
78%	Massachusetts	28
77%	Missouri	29
76%	Iowa	30
76%	Utah	31
74%	Connecticut	32
73%	Maine	33
73%	New York	34
72%	Kansas	35
71%	Louisiana	36
71%	Indiana	37
69%	Pennsylvania	38
68%	Oklahoma	39
67%	North Dakota	40
67%	Nebraska	41
66%	Wisconsin	42
66%	Dist. of Columbia	43
65%	South Dakota	44
65%	Minnesota	45
63%	Texas	46
62%	Rhode Island	47
59%	Wyoming	48
54%	Arkansas	49
50%	Illinois	50
44%	Mississippi	51
81%	US Average	

Keeping Families Together through Family Support

Families Supported with Family Support per 100k of Population		Rank
537	New Mexico	1
343	New Hampshire	2
309	Arizona	3
308	Montana	4
261	South Dakota	5
229	Alaska	6
228	New Jersey	6
227	Connecticut	8
224	California	9
216	Massachusetts	10
216	New York	10
214	Vermont	12
213	Hawaii	13
211	South Carolina	14
206	Delaware	15
199	Wisconsin	16
199	Wyoming	16
185	Pennsylvania	18
181	Louisiana	19
157	Minnesota	20
139	Maryland	21
139	Mississippi	21
131	Oklahoma	23
129	Kansas	24
129	Missouri	24
123	West Virginia	26
117	Washington	27
113	Florida	28
113	Michigan	28
105	Ohio	30
105	Tennessee	30
103	Nevada	32
100	Texas	33
95	North Dakota	34
87	Illinois	35
76	Georgia	36
74	Colorado	37
69	Rhode Island	38
67	Iowa	39
66	Indiana	40
62	Alabama	41
52	Utah	42
50	Idaho	43
49	North Carolina	44
42	Kentucky	45
41	Maine	46
38	Virginia	47
35	Oregon	48
32	Nebraska	49
28	Arkansas	50
0	Dist. of Columbia	51
144	US Average	

Supporting Meaningful Work

% in Supportive or Competitive Employment		Rank
77%	Oklahoma	1
61%	Washington	2
51%	Connecticut	3
48%	Vermont	4
45%	Louisiana	5
44%	Massachusetts	6
38%	Maryland	7
38%	Pennsylvania	7
36%	Alaska	9
35%	Colorado	9
34%	New Mexico	11
34%	Oregon	11
32%	Utah	13
30%	South Dakota	14
29%	Nebraska	15
29%	New Hampshire	15
28%	Iowa	17
26%	Delaware	18
26%	Georgia	18
24%	Michigan	20
23%	Virginia	21
22%	Florida	22
22%	Indiana	22
22%	Ohio	22
21%	Kentucky	25
21%	Maine	25
21%	Wyoming	25
20%	Rhode Island	28
20%	Tennessee	28
20%	Texas	28
19%	North Carolina	31
16%	Nevada	32
16%	Wisconsin	32
15%	Idaho	34
15%	Minnesota	34
15%	Mississippi	34
15%	North Dakota	34
14%	Arizona	38
14%	Montana	38
14%	New Jersey	38
13%	California	41
13%	Illinois	41
12%	New York	43
12%	South Carolina	43
11%	West Virginia	45
10%	Dist. of Columbia	46
10%	Kansas	46
9%	Missouri	48
8%	Hawaii	49
5%	Alabama	50
2%	Arkansas	51
21%	US Average	

Statewide Independent Living Council of Kansas **SILCK**

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Testimony to
HCBS Oversight Committee
Rep. Bob Bethell, Chairman
August 16, 2010

Mr. Chairman and Members of the Committee:

My name is Shannon Jones. I am the director of the Statewide Independent Living Council of Kansas, (SILCK). The SILCK envisions a world in which people with disabilities are valued equally and participate fully. To realize that vision, the SILCK works closely with the 12 Centers for Independent Living to promote productivity and economic self sufficiency for people with all types of disabilities.

In response to this committee's request to report on the impact of the 10% Medicaid rate reductions applied to all Medicaid services delivered on or after January 1, 2010, in one word; it has been ***devastating***. Every service delivered under Kansas Department of Social and Rehabilitation Services (SRS) Home and Community Based Services (HCBS) Medicaid waiver program was reduced by 10%. That includes personal care attendant services, assistive services, sleep cycle support and others.

To date, we know of at least ***70 people who have died*** while waiting for services.

- The 10% cut and previous state budget reductions have resulted in a ***PD Waiver waiting list of 2,286 people as of August 1, 2010.*** These individuals on the waiting list need attendant services due to conditions such as: congestive heart failure, chronic obstructive pulmonary disease, muscular dystrophy, degenerative disk disease, cancer and arthritis, kidney failure and diabetes, stroke, spinal cord injury, leukemia, seizure disorder, lung disease and multiple sclerosis.

- On January 1, 2010 SRS also began limiting PD Waiver attendant services to no more than 10 hours per day. Statewide, there are approximately 200 people with significant disabilities who receive personal care attendant services over 10 hours per day based on real needs. This includes people with quadriplegia, some of whom rely on breathing-assist technology. They have active minds and do not belong in a nursing home. Many are in the process of appealing this reduction in service based on the significant impact it will have on health and safety.

- The $35 a night salary rate for night support (i.e. assisting a person with a significant disability to turn in bed during the night, take medication, use the restroom) was cut 10%. Once we pay the attendant $30 for night support, there is not enough money to cover our costs of Workers Comp and FICA. So we're forced to decide whether to run a deficit, cut attendant pay for night support, or drop night support services.

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- Night support was completely eliminated for people on the Frail Elderly Waiver.

- Assistance with instrumental activities of daily living (IADL's) such as meal preparation, laundry and shopping has also been reduced.

- Assistive Services, such as grab-bars in the bathroom, ramps, etc., will be limited to those individuals whose situations meet the "critical" condition definition.

- Chore Services, such as snow removal, lawn care, etc., no longer available.

- Loss of Meals-on-Wheels service because providers won't accept the lower reimbursement rate.

- Cuts to wages of personal attendants makes it much more difficult for a person on the PD Waiver to find individuals willing to provide PA services to them.

- The recent series of state cuts to social services has placed the health and safety of people with disabilities who rely on Medicaid services in serious jeopardy. It also forces people with disabilities to decide whether to remain living in their homes in the community with reduced attendant services or to move into nursing homes where they can receive attendant services without a waiting period based on the entitlement in Title XIX of the Social Security Act.

- Home and Community Based Services Medicaid waiver services are ⅓ to ½ the cost of nursing home and other forms of institutional care. Home and Community Based Services show positive results for state money well spent, and the services are consistent with the Supreme Court's *L.C. v. Olmstead* decision.

The Centers for Independent Living (CILs) are gate keepers for the Physically Disabled (PD) home and community based waiver (HCBS). All of the CILs made cuts internally, rather than put their consumer's health and safety at risk. CIL's also looked to absorb as much of the cut as possible in order to stave off, as long as possible, reducing the wages of personal care attendant, who are already making below poverty wages. Following are the operational cuts most CIL members initiated as of January 1, 2010.

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

Beyond the 10% Medicaid cut and its affect on all the consumers CILs serve, the 2011 budget cuts base funding for CILs by $350,000

There are better ways to balance the budget than cutting social services that are essential to the health and well being of Kansans with disabilities.

The SILCK supports including Home and Community Based Services (HCBS) Medicaid waiver programs in the SRS caseload estimating process. This would insure that people eligible for long-term care services have a choice to receive such services either in their homes in the community or in a nursing home/institution.

Currently, Title IXX of the Social Security Act entitles (i.e., guarantees) that a person who is eligible to receive state-funded personal care attendant services in a nursing home or institution can move into such facility and receive services in a timely manner. There is no state law that provides a similar guarantee for eligible individuals who prefer to receive attendant services in their homes in the community.

The nursing home/institution entitlement reflects an out-of-date historical bias in favor of nursing homes and institutions in an era when the vast majority of people with disabilities (of all ages) have a strong preference to receive attendant services in their homes in the community. Sound fiscal policy would favor HCBS attendant services, which are ⅓ to ½ the cost of nursing home and other forms of institutional care.

The Affordable Care Act (ACA) also offers numerous opportunities for seniors and people with disabilities, including new options for states to deliver on the promise of the ADA and adhere to the principles of the Supreme Court's Olmstead decision.

The SILCK will urge the 2011 legislature to take advantage of incentives and new opportunities in the Affordable Care Act to strengthen home- and community-based services (HCBS), so that people who want to live in the community have the ability to make that choice.

These incentives include an increased federal Medicaid matching rate for new home and community based attendant care services, and establishes the Community First Choice Option (CFCO) to provide attendant support services for seniors and PWD.

It also extends the Money Follows the Person (MFP) program to support state efforts to transition individuals from institutional living back to the community.

We encourage policy makers to explore new ways to leverage federal resources to help our states create new opportunities that promote choice and self-determination for individuals with disabilities.

The SILCK stands ready to work side by side with advocates and it's state's partners to deliver on the Affordable Care Act's promise of access to health care and long term care regardless of disability.

KANSAS
AREA AGENCIES
ON AGING
ASSOCIATION

Meeting the Needs of Older Kansans

2910 SW TOPEKA BOULEVARD • TOPEKA, KS 66611 • 785-267-1336 • FAX - 785-267-1337

Joint Committee on Home and Community Based Services Oversight

August 16, 2010

The Kansas Area Agencies on Aging Association (K4A) represents the 11 Area Agencies on Aging (AAA) in Kansas that collectively serve all 105 counties in the state.

The Area Agencies on Aging in Kansas are part of a national network of 629 AAAs and 246 Title VI organizations. Area Agencies on Aging established under the Older Americans Act (OAA) in 1973 to respond to the needs of seniors and caregivers in every local community. The services available through the Area Agencies on Aging fall into five broad categories: Information and Access services, Community Services, In-Home services, Housing and Elder Rights. Within each category a range of programs are available.

Whether you are an older Kansan or a caregiver concerned about the well-being and independence of an older adult, Area Agencies on Aging are ready to help. Area Agencies on Aging in communities across the country plan, coordinate and offer services that help older adults remain in their home - if that is their preference. Services such as home delivered meals and a range of in-home services make independent living a viable option. Area Agencies on Aging make a range of options available so that seniors choose the services and living arrangement that best suits them.

Area Agencies on Aging offer programs that make a difference in the lives of all older adults from the frail older person who can remain at home if they receive the right services to those who are healthy and can benefit from social activities and volunteer opportunities provided by community-based programs.

Budget cuts to in-home service system over the last two sessions threaten even the minimal services many frail elderly need to remain living in their communities.

Below are budget cuts over the last two years and their impact on community programs for Kansas seniors.

Home and Community Based Services - Frail Elderly Waiver

- **$5-$6 Million projected shortfall in HCBS-FE waiver funding in FY 2011.** Likely resulting in a waiting list for services. Roughly 400 individuals based upon annual cost.
- $750,000 - Elimination of ALL Core Services funding for Kansas Area Agencies on Aging in fiscal year 2010.
- January 1, 2010 - Four in-home services were eliminated for low income seniors including sleep cycle support, assistive technology, comprehensive supports and oral health care. **$2,084,541 reduction ($625,362 SGF).**
- SRS Funded Targeted Case Management Rate Study Shows Reimbursement Shortfall

- A recently released SRS study indicated in FY 2010 an unreimbursed shortfall of $10.20 hr
- The projected shortfall in FY 2011 is $12.00 hr

Senior Care Act - Senior Care Act program provide services for seniors that assist seniors to remain living in their home.

- $1,258,588 - 17% reduction in Senior Care Act in state fiscal year 2010. **Cut from roughly $7.8 million to $6.6 million**
- $315,484 - Additional cut in Senior Care Act in state fiscal year 2011. **Cuts Senior Care Act from $6.6 million to $6.3 million**
- **121 seniors on the waiting list as of July 31st.**

There is simply no question that, given the magnitude of budget reductions, access to health care and in-home services in our state have been impaired, resulting in Kansas seniors receiving care in more expensive settings or not receiving care at all.

We would appreciate the opportunity to discuss these issues with you. Inquiries may be directed to:

Craig Kaberline, Executive Director
Kansas Area Agencies on Aging Association
(785) 267-1336

email: Craig@k4a.org
website: www.k4a.org

Statewide Toll-Free Resource Line
1-866-457-2364

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Joint Committee on Home and Community -Based Services
August 16, 2010
Cindy Luxem, CEO, President
Kansas Health Care Association/Kansas Center for Assisted Living

Mr. Chairman, Ladies and Gentlemen of the Committee, I appreciate the opportunity to give you the some thoughts on the budget reductions to HCBS as seen through the eyes of our residents and providers.

The impact of the budget reductions to the HCBS program affects our members in two ways.

Nursing home participation goes up when things like sleep support cycle is eliminated. And alternately, when services are reduced the number of providers needed to accommodate the discharge of residents from nursing homes keeps people from going back home.

Assisted living homes are also HCBS providers but not much changes for those residents but there are major changes for providers. Assisted living providers operate under a standard of care and a regulatory environment that does not allow for disruption in care. Residents who are living independently are really the ones who suffer if the provider does not provide HCBS in their facility. Providers take into account a $1500-2000 loss a month.

The trouble we have from the association view is providers are all treated differently. If you are a facility you would have one form to fill out, a survey to worry about and reduction in reimbursements. A HCBS client who lives in your own home...different form ... no survey and very little follow-up from the people paying the tab...the state of Kansas

We have recently worked with the state of Kansas and stakeholders to have assisted living homes a choice for the Money Follows the Person program.

Lastly, a suggestion on how to bring more Assisted Living providers to the table...how about a tax credit...It might work like this. .. the average room rate and let the provider subtract the patient liability and the amount they receive for HCBS and whatever is left can be written off on taxes. Currently the providers are gifting the money to the state without any credit.

Just a thought. I believe it is time to start acting and stop talking.

Now I would like to introduce Carol Feaker, Midwest Health Consulting.

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Facility	%HCBS
Atchison	25
Baldwin	11
Gardner	35
Lenexa	57
Stanley	50
Paola	24
Osawatomie	34
Louisburg	49
Ottawa	33
Tonganoxie	16
Waterfront	8
Eureka	32
Neodesha	33
Fredonia	32
Osage City	25
Wamego	36
Holton	37
Hiawatha	38

KHCA
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kcal ahca

August 20, 2009

Ms. Cindy Mann
Director, Center for Medicaid and State Operations
Washington, DC 20201]

Dear Ms. Mann,

The Kansas Health Care Association and Kansas Center for Assisted Living represents nearly 200 for profit and nonprofit providers throughout the state. All Kansas providers are committed to the delivery of person-centered care in whatever setting the frail elder chooses.

I write to you today to comment on the proposed adding to **42 CFR subpart G about the requirement of not allowing home and community based services to be provided in an home or apartment owned by a provider of any health-related treatment or support services.**

The Kansas Department of Aging has been operating under an approved qualifying definition for HCBS settings for sometime without any problems. In fact, in checking with state, currently 25% of their clients receive services in assisted living, and residential health care settings. And these consumers have chosen this setting...exercising their personal choice. I further submit any Kansas provider will tell you that KDOA expects the least costly setting to be used and it appears in 25% of the time it is the assisted living setting. What perplexes us is why CMS would want to place limitations on residence settings when the reason for keeping people in the assisted living home and community based setting saves the state of Kansas and the federal government significant monies versus what it would cost in a nursing or skilled nursing setting such as a nursing home.

After a survey in preparation for these comments, we asked our providers and more than 70% serve consumers on the home and community based service frail elderly waivers. And because Medicaid does not pay room and board in assisted living settings, a payment gap is created that makes it even more difficult on providers, but they make it work so the resident can still have their choice in where they live. Many time what the providers share is, a resident who has lived beyond their personal financial means, who might need a higher level of care, with the appropriate health and social supports can continue to live where they call home under the frail elderly waiver. It would be a travesty to not offer this choice to those residents.

Another concern we have is the quality assurance issue. Assisted living and residential health care communities must meet care and regulatory standards under state law that help ensure resident safety and in Kansas, these standards do not apply to beneficiaries receiving services in their own homes. If fact due to budget constraints, there is less oversight to those receiving services in their own home.

KHCA/KCAL believes that all Kansans should have access to the entire array of long term care services and settings based on their individual preferences. Assisted living communities emphasize person-centered care and provide care while promoting independence, dignity, privacy and choice. In Kansas because of our vast difference in rural and urban settings, most being rural settings, services are very limited as you move away from the more populated regions. So, to deny any setting for services to be delivered would be an injustice to many parts of the state.

In closing, we just request that you not implement this rule change. As consumers review their choices in where they receive their care to limit these settings. Thank you for allowing us to comment.

Sincerely,

Cindy Luxem
CEO, KHCA/KCAL

Joe Perkin
Chair, Kansas Center for Assisted Living

12-3

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HCBS Oversight Committee

Testimony on
Impact of Budget Cuts and Temporary Suspension of Voluntary Admissions to State Psychiatric Hospitals

August 16, 2010

Presented by:

Michael J. Hammond, Executive Director
Association of CMHCs

Mr. Chairman and members of the Committee, my name is Mike Hammond, I am the Executive Director of the Association Community Mental Health Centers of Kansas, Inc. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs, collectively serving over 131,000 Kansans with mental illness.

It is my understanding you wanted to hear from the CMHC system on the impact of budget cuts on the State's public mental health system, as well as the impact of temporarily shutting off admissions to our State Psychiatric Hospitals. I have presented you with comprehensive written testimony on these two issues. I will provide some key highlights and then Walt Hill, Executive Director of High Plains Mental Health Center in Hays; and Robbin Cole, Executive Director of Pawnee Mental Health Services in Manhattan, will follow me in presenting you with specific information about how these two issues have impacted their respective CMHC and those they serve. Also present today is Sue Claridge, a member of the Governing Board of East Central Mental Health Center. Sue would like to speak to the Committee from the perspective of a family member.

Highlights of funding reductions sustained by the CMHC system:

1. $20 million reduction in Mental Health Reform grants since FY 2008 – a 65 percent reduction.
2. $7.8 million all funds in Medicaid rate reductions during FY 2010 as a result of the 10% rate reduction.
3. $3.1 million in MediKan funding in FY 2010 – a 45 percent reduction.
4. $560,000 SGF in Community Support Medication Program funding during FY 2010 – a 53 percent reduction.

Cuts in Mental Health Reform Funding

Mental Health Reform grants allow CMHCs to serve the uninsured and underinsured who do not qualify for Medicaid and do not have resources to pay for their mental health treatment. It is this funding which essentially ensures every Kansan has universal access to mental health treatment. The CMHCs have a State mandate to serve everyone regardless of their ability to pay. If those living with mental illness do not receive timely treatment, they could easily end up being admitted into a State psychiatric hospital - the most costly level of care. It is the grant funding which has allowed Mental Health Reform to be a success.

Those served by the CMHCs who are not Medicaid eligible (the non-target population) are the largest population segment served, yet the CMHCs have limited resources available to cover the cost of providing those services. For example, 30 percent of individuals served by the CMHCs (or 39,300) have Medicaid as their sole payor source. The remaining 70 percent (or 91,700) are non-Medicaid eligible and benefit in some way from state grant funding.[1] We also know that of those served by the CMHC system who are non-Medicaid, and reporting income information, 69% earn less than $20,000 a year.

Without treatment and care, many will end up in contact with law enforcement, jails, hospital emergency rooms or State psychiatric hospitals. Individuals who are able to be treated in the community will have improved quality of life for themselves and their families, and ultimately be more productive citizens.
Budget cuts are placing the public mental health system at a breaking point. Every Kansan who walks through the doors of a CMHC is impacted by these budget cuts. Our workforce is also impacted by these cuts.

The response of the State is to impose deep cuts to the public mental health system, walking away from a longstanding commitment to ensuring Kansans have access to quality community-based treatment when they need it. The chart below details this trend.

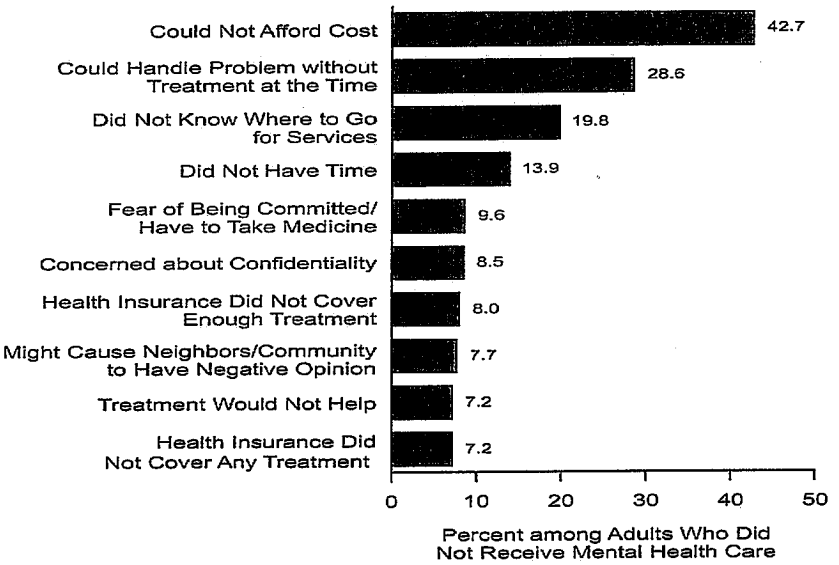
Mental Health Reform Funding

FY	Amount	Impact	Cumulative Impact	% Difference	Cumulative Difference
FY07	$31,066,330				
FY08	$21,874,340	-$9,191,990	-$9,191,990	-29.59%	-29.59%
FY09 (Base)	$21,874,340	-	-$9,191,990	-	-29.59%
FY09 (Revised - Governor's 3% cut to SRS)	$20,074,340	-$1,800,000	-$10,991,990	-8.23%	-35.38%
FY10 Budget Bill	$17,374,340	-$4,500,000	-$13,691,990	-20.57%	-44.07%
FY10 Omnibus Bill	$14,874,340	-$2,500,000	-$16,191,990	-14.39%	-52.12%
FY10 Governor's Allotments	$10,874,340	-$4,000,000	**-$20,191,990**	-26.89%	**-65.00%**

The impact on those we serve and on the CMHC system is devastating and is already being felt throughout this State.

- **Increased admissions to hospitals - local emergency rooms and psychiatric hospitals.**
- **Increased suicide calls.**
- **Increased demand for services (90% of CMHCs are experiencing increased demand for services).**
- **Delayed access to services for the uninsured - outpatient, therapy limits, crisis services, reduced/capped benefits.**
- **Waiting lists for some services, longer wait times for appointments.**
- **Raising monthly fee payment arrangements.**
- **Elimination of programs and closing of local offices (75% of CMHCs have done so).**
- **Reduced staff hours.**
- **Reduced operating hours.**

According to the 2008 National Survey on Drug Use and Health (NSDUH), among the 5.1 million adults aged 18 or older who reported an unmet need for mental health care and did not receive mental health services in the past year, several barriers to care were reported, which are outlined in the bar chart below. **The top reason (43%) was they could not afford the cost of treatment.**



In these distressing economic times, mental health needs are on the rise and individuals negatively impacted by the economy turn to our public mental health system for help. With these difficult times come increased drinking, domestic violence and marital problems linked to financial stress, as well as children trying to cope with extreme anxiety within the home. Research shows rates of depression and suicide tend to climb during times of economic tumult.[2]

Mental Health Reform funding helped our system close state hospital beds and helps support services that are essential in keeping individuals out of inpatient settings. Reducing these funds puts at risk an already overstretched state hospital capacity. Without Mental Health Reform funding, there would be no universal system; no safety net; no 24 hour emergency care; increasing demands for mental health care in emergency rooms and in-patient setting; and a growing number of persons in our jails.

Given these facts, in addition to the State mandate placed on CMHCs to serve everyone regardless of their ability to pay, the Association continues to request the Administration and/or the Legislature begin restoring cuts to Mental Health Reform funding.

Community Based Mental Health Services are the Best Value for the State

In the face of budget shortfalls, severe cuts have been imposed on CMHCs that will impact the public mental health system and individuals with mental illness and their families. Policy makers must understand that paying for the costs of treating mental illness is unavoidable. Our only decision is how we as a State pay for it. The State can either invest in the public mental health system or pay a greater price through increased psychiatric hospitalization and primary care costs, greater reliance correctional facilities, homelessness, and other costs to society including lost productivity and suicide.

We know it costs on average, $428 per day for treatment at one of our State psychiatric hospitals; $80 per day on average to be incarcerated at Larned Correctional Mental Health Facility; $10 per day on average for Medicaid expenditures for community-based mental health treatment; and $22 per day on average for Medicaid expenditures for the most chronic mental health conditions. This is consistent with other data which confirms community-based treatment for mental illness is the best value.

It is also important to note that investing in community-based mental health services directly lowers healthcare costs. Treatment for mental disorders is associated with a 20 percent reduction in the overall use of health care services.[3] Budget gains from reducing access to pharmaceuticals are more than offset by increases in spending on services elsewhere in the system (such as increased hospitalization and emergency room care).[4] At a time when the State is struggling with containing the costs of health care, paying for the cost of community-based mental health treatment is part of the solution to our State's budget crisis.

Why Investing in Mental Health is Important

- Good mental health enhances the workplace; a high percentage of lost productivity, staff absences and errors on the job is due to emotional problems, alcohol and/or drug abuse.
- Children learn better in a school environment where early intervention of mental health services is available.
- Effective community-based mental health treatment and support services, as well as newer medications, promote economic stability by permitting thousands of persons with serious mental illness to hold meaningful jobs and maintain productive lives in their own communities.
- Families stay healthier and grow stronger when affordable access to mental health services is readily available.
- The treatment success rates for such disorders as depression (more than 80%), panic disorder (70-90 percent) and schizophrenia (60 percent), surpass those of other medical conditions such as heart disease (45-50 percent).
- Evidence is being identified that the occurrence of severe psychiatric disorders may be increasing. The number of individuals on SSI/SSDI between 2000 and 2008 increased by 33 percent, while persons who have a mental disorder who are on SSI and SSDI, increased by 57 percent during the same time frame. The U.S. population increased by only 8 percent in this same time period.
- A growing number of employers have dropped health insurance for their employees and in some cases their dependents – many of whom show up on the doorsteps of community providers seeking services that we must provide, regardless of their ability to pay. These are men, women and children who will turn to community providers for help, when untreated problems build and result in a behavioral healthcare emergency. And we know from experience that, in crisis, care is more expensive to deliver. When they walk through our doors, for whatever reason, our challenge and commitment is to serve them.

MediKan

The Governor's FY 2010 November Allotment reduced the time limit for MediKan benefits from 18 months to 12 month; FY 2011 continues that policy. MediKan is a State-funded program that provides medical benefits to people awaiting determination for federal disability benefits (SSI/SSDI), approximately 3,000 adults in total. MediKan provides limited medical services and is generally considered interim coverage. MediKan is funded by State General Fund (SGF) dollars with no federal matching funds. The chart below highlights the cuts imposed on the MediKan (mental health) program.

MediKan (Mental Health)

FY	Amount	Impact	Cumulative Impact	% Difference	Cumulative Difference
FY09 (24 months)	$6,836,999				
FY10 Reduction (reduction from 24 months to 18 months)	$4,176,257	-$2,660,742	-$2,660,742	-38.92%	-38.92%
FY10 Allotment (reduction from 18 months to 12 months)	$3,710,705	-$465,552	**-$3,126,294**	-11.15%	**-45.73%**

For FY 2010, the MediKan time limit was reduced from 24 months with a hardship provision (allows the most ill to continue receiving benefits beyond the limit) to 18 months, placing a firm lifetime limit on the recipient of MediKan benefits (no hardship provision). This resulted in a reduction of $2.6 million SGF. For FY 2011, the MediKan time limit is being reduced from 18 months to 12 months. This results in an additional reduction of $465,000.

At the beginning of FY 2009, there were 3,155 individuals on MediKan. At the end of December 2009, that number was reduced to 1,928. We can clearly see the impact of the time limit by the number of individuals served by MediKan.

Many of the individuals who don't qualify for SSI/SSDI have a mental health diagnosis. **Without MediKan as a payor source or without additional funding provided to meet the needs of those previously served on MediKan who will not become eligible for SSI or Medicaid, the burden falls on existing resources within the public mental health system to meet their mental health needs. Those existing resources are the Mental Health Reform funds which have been significantly reduced since FY 2008.** While we understand the necessity in making this policy decision, we are concerned about accessibility of physical and mental health care for those individuals who are ultimately unsuccessful in pursuing SSI/SSDI benefits, regardless of what the time limit is set at. Again, these individuals will turn to safety net clinics and CMHCs to access the necessary care.

Community Support Medication Program

The Community Support Medication Program (CSMP) is for the purchase of atypical anti-psychotics, antidepressants, and other medications for the treatment of mental illness for those who are at risk of hospitalization and who meet income requirements. The CSMP is legislatively mandated as the "payment of last resort."

For FY 09, the CSMP was appropriated at a little over $1 million. In FY 2010, that amount was reduced by 54 percent, or by almost $500,000. Based on expenditures through December 2009, over $325,000 has already been spent. If spending continues at this rate, we will run out of funding before the next fiscal year begins. This clearly shows the great need for this program.

FY	Amount	Impact	% Difference
FY09	$1,050,000		
FY10 Omnibus Bill	$489,715	**-$560,285**	-53.36%

This, coupled with Mental Health Reform cuts and cuts to MediKan, only further exacerbates the challenges faced by those we serve who have no resources to pay for their care.

Desired Recommendations on Funding for Community-Based Mental Health Services:

Our top priority is to, at the very least, protect all mental health funding from further reductions. That was accomplished, for the time being at least, for FY 2011. It is our hope that as the State's economy begins to improve we can impress upon the next Administration and the Legislature to begin restoring cuts in Mental Health Reform funding so that our Centers can effectively meet the mental health needs of the uninsured and underinsured without having to reduce critical services or turn people away.

Temporary Suspension of Voluntary Admissions to State Psychiatric Hospitals

As has been previously testified by SRS, the State Psychiatric Hospitals – Osawatomie State Hospital (OSH), Larned State Hospital (LSH) and Rainbow Mental Health Facility (RMHF) serve persons experiencing serious symptoms of severe mental illness who require inpatient care. The individuals referred to these hospitals are typically those that CMHCs cannot safely and effectively treat in the community.

The State Psychiatric Hospital budgets were reduced by $698,916 in FY 2010 and by $1,643,875 in FY 2011. We know that the hospitals are operating at the bare minimum staffing to ensure active treatment and the safety of staff and patients. Current staff vacancy rates at the SMHHs are running from 7 percent to 14 percent. The actual cost to operate each of these facilities is the amount which SRS has budgeted. What SRS has told us as well as policy makers is that the only choice for reductions would be to serve less people in our hospitals. **Our concern is that reductions of the hospital budgets coupled with increased demand for inpatient care has resulted in the agency temporarily suspending voluntary admissions – once on May 20, 2010 (lasting until May 26, 2010), and again on July 16, 2010 (lasting until July 20, 2010). Without reducing patient census at critical times, the agency indicates it could put the hospitals at risk of losing their license and certification. This is further complicated by the fact that Mental Health Reform funding – funding dedicated to keeping individuals out of our State Psychiatric Hospitals has been reduced by 65 percent over the last three years. This collectively is a recipe for disaster in our public mental health system.**

If Kansans cannot voluntarily admit themselves to a State Psychiatric Hospital, then their only choice is to ensure a worsening of their psychotic episode, decompensate further, and to put themselves or others at risk of harm or even death. In that event, it may be necessary for a court to order them to be admitted involuntarily to the hospital. However, by that time they may have spiraled out of control and would be significantly harder to treat successfully. Alternatively, they may have ended p in a jail or prison, at a much higher cost to both taxpayers and the person in need of treatment.

I can stand here today and report that there was no tragedy in any of our communities as a result of these two occasions where voluntary admissions were temporarily suspended. Both occasions were very short in duration. However, what happens in the future if the frequency increases as does the duration? To be honest, I think we as a system are pressing our luck and it remains very concerning to us and those we serve that in a critically important situation where a person with mental illness is in crisis and require psychiatric inpatient care, they may not have access to inpatient care when they need it and there will be dire consequences.

Examples of what occurred at the community-level during these periods of suspension of voluntary admissions when the need arose:

- Extra staff were placed on call to provide support and services in the community if at all possible.
- Continued utilization of crisis services as best possible to attempt to support the client until inpatient resources were available.
- High risk clients were sent to community inpatient facilities who then in turn were asked to hold them until a State Psychiatric Hospital bed became available, increasing the burden of uncompensated care on local hospitals and in some cases, asking them to take on more challenging and difficult clients than they would normally accept.
- SRS did open up 11 beds at LSH that were not budgeted for.

- SRS turned to two community hospital partners – Via Christi in Wichita and Prairie View in Newton, who agreed to help overflow at OSH and LSH. SRS agreed to pay for all uncompensated care they incurred. SRS did not have these funds budgeted. These two agreements were key to the short duration of the temporary suspension of voluntary admissions.

It is important to note that approximately 40 percent of all admissions to CMHC crisis services and consequently then to our State Psychiatric Hospitals are new to the Kansas mental health system. It is also noteworthy that over 50 percent of those admitted to State Psychiatric Hospitals do not have Medicaid as a payor source.

For a number of years, our State Psychiatric Hospitals have reached their maximum capacity and are often significantly over census on a continual basis – sometimes at very alarming rates. This situation has forced the philosophy of the use of SMHHs in Kansas to change. The utilization of these hospitals has evolved from serving as long-term residential treatment facilities to the role of short-term acute care treatment facilities.

To help alleviate such overcrowding, in 2007, the Kansas Legislature funded SRS's budget for facility improvements at OSH to prepare for expansion with a new 30-bed adult psychiatric unit. The 2008 Legislature appropriated $1.4 million to staff the expanded unit beginning in FY 2009, however, the Governor's Revised FY 2009 Budget recommended delaying the opening of this unit for the remainder of FY 2009 and for FY 2010. The Legislature accepted that recommendation. For FY 2011, it was yet again not recommended for opening and the Legislature accepted that recommendation. We need this unit to come online.

In FY 2010, SRS contracted out the adolescent unit at LSH. The unit freed up by this action had 30 beds available to the system, but the SRS budget only called for 19 of those 30 beds to be opened back up to serve adults. During the 2010 Legislature, we also asked for funding to bring those 11 beds online. That request was not funded.

It is important to note that the agency did submit to the Governor as part of their enhancement request for FY 2010, a proposal for establishing local private mental health inpatient beds across Kansas, with a request of $7.8 million, including $5 million in SGF. This would reimburse private hospitals for additional days of psychiatric treatment for people who would otherwise be transferred to State Psychiatric Hospitals. This would occur in two different ways: the first part would allow adjustments to the Medicaid reimbursement methodology to fund extended lengths of stay for people who need more time to complete their treatment in the local hospital. The second part would provide a state only payment for inpatient psychiatric hospital treatment for persons who have no private or public insurance and no other method to pay for their treatment. While the situation has not changed at all, the agency, due to the State's continued financial crisis, did not submit this budget enhancement for FY 2011.

<u>The Importance of Inpatient Resources</u>

The vast majority of persons treated in the CMHC system are either indigent or low income with few resources to pay for private care. Because CMHCs function as an out-patient safety net resource for large numbers of persons with the most severe forms of mental illness, it is vitally important that we, in turn, have access to a safety net resource for those consumers whose illness simply cannot be managed in a community setting, and who have no resource to pay for private care. For us, and those consumers, the State Psychiatric Hospital is the safety net.

There is a longstanding partnership between the State Psychiatric Hospitals and CMHCs. Each CMHC designates a liaison to their respective State Psychiatric Hospital. Liaisons work with hospital staff to coordinate services upon discharge. This coordination helps to reduce the length of stays by ensuring that community based services are available. In addition, CMHCs are required to plan for and implement mechanisms to deal with emergency service needs. Throughout Kansas, CMHCs work to quickly respond to mental health emergencies by stabilizing crisis situations and providing follow-up services.

As outlined in the charts on the following page, which is also included in the SRS testimony, inpatient capacity of our State Psychiatric Hospital system can be at critical stages of maximum utilization several times throughout the year. The mental health system did not anticipate the explosion of need for State Psychiatric Hospital beds in the past few years. That explosion is in part due to the continued decline of private psychiatric hospital beds – resources the CMHCs relied upon at the community level.

OSH Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2005	73	20%
FY 2006	81	22%
FY 2007	100	28%
FY 2008	64	17%
FY 2009	82	23%
FY 2010	123	34%

Source: SRS

RMHF Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2007	19	5%
FY 2008	36	10%
FY 2009	27	7%
FY 2010	131	36%

Source: SRS

LSH Psychiatric Services Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2006	31	8%
FY 2007	34	9%
FY 2008	259	71%
FY 2009	141	39%
FY 2010	302	83%

Source: SRS

As you know, State Psychiatric Hospitals are funded by state appropriations. This means they must operate at the budgeted level, even though that may not be the capacity level of the facility.

The following chart shows the number of psychiatric admissions to SMHHs in recent years, excluding the State Security Program and SPTP.

Civil Psychiatric Services Admissions								
State Hospital	**FY02**	**FY03**	**FY04**	**FY05**	**FY06**	**FY07**	**FY08**	**FY09**
LSH	819	836	929	990	1,064	1,097	1,176	1,071
OSH	1,137	1,371	1,570	1,943	2,016	1,969	2,181	2,042
RMHF	513	588	715	671	664	671	810	875
Total	**2,469**	**2,795**	**3,214**	**3,604**	**3,744**	**3,737**	**4,167**	**3,988**
Percent Change		13%	15%	12%	4%	0%	12%	-4%

Note: In FY08 RMHF began serving only adults

Source: SRS

Factors Impacting Increased Admissions at State Psychiatric Hospitals

Community providers are serving more individuals and those individuals are challenging patients with more intense needs.

- Since FY99, there has been a 47 percent increase in the total number of individuals served. This growth is consistent with national data that is outlined later in this testimony.

Funding for community-based mental health services for those who are uninsured or underinsured has been cut drastically.

- A loss of $20 million in SGF Mental Health Reform funding since FY 2008 – a 65 percent reduction.
- A loss of $3.1 million SGF in MediKan funding in FY 2010 – a 45 percent reduction.
- A loss of $560,000 SGF in Community Support Medication Program funding in FY 2010 – a 53 percent reduction.

There has been a significant decline in private psychiatric hospitals.

- Local inpatient psychiatric bed capacity statewide has been declining since 2002, from 488 beds to 324 today – a 34 percent decline. The Veterans Administration Hospitals in Kansas have only 58 psychiatric beds for adults, in two locations in Kansas. Northwest Kansas has lost the only inpatient psychiatric unit (21 beds) between Salina and Denver, Kearney, Nebraska and Wichita/ Hutchinson during this time period also. Last year, Coffeyville Regional Medical Center closed its 17 bed psychiatric unit. Just last week, Southwest Medical Center in Liberal announced they will close the hospital's 12 bed psychiatric unit, citing lose of money and difficulty recruiting psychiatrists as the reasons for the decision.

- In the May 2006 issue of *Communicator*, a newsletter of the University of Kansas School of Medicine – Wichita, Department of Psychiatry, Dr. Sheldon Preskorn, Chair of the Psychiatry Department, wrote in his article, "Mental Health Care Crisis Brewing for Kansas," that there were seven inpatient services in Sedgwick County in 1990, with more than 350 beds and today there is one, the Via Christie inpatient psychiatric facility, with approximately 100 beds. He cites the loss of this capacity is due to the eroding of financial support for that level of care over the last 15 years and the inability for many to continue supporting this level of care. He goes on to say the State needs to support inpatient beds in urban centers for its citizens suffering from acute exacerbations of psychiatric illnesses who have no means to pay for that care.

- According to national data provided by the U.S. Dept. of Health and Human Services, Center for Mental Health Services, the number of mental health organizations providing 24-hour hospital or residential treatment care private psychiatric hospitals nationwide declined by 53 percent between 1992 and 2002. The data shows that for Kansas, the decline was 89 percent.

- Based on a 2006 State Psychiatric Hospital survey conducted by the National Association of State Mental Health Program Directors (NASMHPD), 80 percent of the States report experiencing shortages in psychiatric beds as a result of hospital downsizing and the closure of general hospital psychiatric units and private psychiatric hospital beds.

The number of inpatient psychiatric beds per capita has declined substantially.

- According to the President's New Freedom Commission, the total number of inpatient psychiatric beds per capita has declined substantially between 1990 and 2000 – a 27 percent reduction. Over this same period of time, State and county psychiatric hospital beds per capita have decreased even more sharply (44 percent). Private psychiatric hospital beds per capita decreased by 43 percent, while per capita beds in psychiatric units of general hospitals showed a 32 percent decline.

The State Psychiatric Hospital capacity has remained static for a decade (with the exception of the additional 20 beds for adults that were added to the system in FY 2008, referenced earlier), though many factors in our society are driving up utilization of inpatient psychiatric capacity.

- A majority of admissions also need substance abuse treatment. Anywhere from 50 to 70 percent of people served by both OSH and LSH also need substance abuse treatment.

- In 1997, 20 inpatient beds on the Chemical Dependence Recovery Program (CDRP) unit at LSH were closed with the commitment to move funding to community based programs to treat patients with serious substance abuse disorders. That funding was never realized, and in addition to closing approximately 90 beds at LSH with mental health reform, the system capacity was reduced by another 20 beds.

- Approximately 40 percent of all admissions to our crisis services, and to our State Psychiatric Hospitals are new to the Kansas mental health system, thus constantly producing a new and different group of clients to serve.

- Evidence is being identified that the occurrence of severe psychiatric disorders may be increasing. The number of individuals on SSI/SSDI between 2000 and 2008 increased by 33 percent, while persons who have a mental disorder who are on SSI and SSDI, increased by 57 percent during the same time frame. The U.S. population increased by only 8 percent in this same time period.

- In comparing national surveys on comorbidity that were completed in 1992 and again in 2003, data shows that Americans have been increasing their use of mental health services. The proportion of the population receiving treatment in the previous year rose more than 50 percent during the decade between the two studies. Treatment has become more widespread since the early 1990s because of greater public awareness, more effective diagnosis, less stigma, more screening and outreach, and greater availability of medications (Harvard Mental Health Letter, 2005).

What is happening in Kansas is not unique to Kansas.

- State hospitals in most states are seeing increased admissions. Increasing admissions can co-exist with a shrinking bed supply because of the continued drop in the length of stay and an increase in average occupancy rates, according to the Commission. Temporarily shutting off voluntary admissions is a tool other States have used to address this same trend.

- A growing number of employers have dropped health insurance for their employees and in some cases their dependents – many of whom show up on the doorsteps of community providers seeking services that we must provide, regardless of their ability to pay. These are men, women and children who will turn to community providers for help, when untreated problems build and result in a behavioral healthcare emergency. And we know from experience that, in crisis, care is more expensive to deliver. When they walk through our doors, for whatever reason, our challenge and commitment is to serve them.

- In 34 states, the result is a shortage of acute care beds; in 16 states a shortage of long-term care beds. In response to this trend, States are reporting undertaking a variety of activities to address these problems, including: expanded contracts with private hospitals to provide acute psychiatric care; expansion of emergency and community treatment facilities; adding additional state hospital bed capacity; as well as other initiatives.

- In 2006, NASMHPD issued a report on the crisis in acute psychiatric care. The report cited that SMHAs are identifying the crisis in acute psychiatric care as one of the most troubling challenges they face.

<u>Importance of Sustaining and Expanding Local Inpatient Resources</u>

The Association believes it is very important to recognize that Mental Health Reform, the closure of Topeka State Hospital and other measures have left the state with approximately 340 state-operated psychiatric beds statewide for adults and children. With the diminished capacity of local inpatient resources in our communities, added to a 65 percent reduction in Mental Health Reform funding since FY 2008, the most critical concern we are facing is having an adequate supply of state hospital beds to provide for an inpatient safety net for the public mental health system.

We believe a major reason for the diminished capacity of local inpatient resources is in part tied to how they are funded. General hospital psychiatric specialty units may be shifting the designation of beds from psychiatric to other, more financially lucrative uses. While reimbursement for psychiatric clients has eroded, reimbursement for cardiac and other medical/surgical patients has climbed, providing a clear financial incentive to reduce availability of general hospital psychiatric unit specialty beds. The advent of the Diagnosis Related Grouping (DRG) in the 1980s led to an increase in general hospital specialty unit psychiatric beds, due to the waiver of financial constraints that subsequently permitted full reimbursement for the cost of care. The later rescinding of this exemption appears to have contributed to a drop in general hospital specialty unit psychiatric beds.

Without access to inpatient psychiatric resources, consumers and families will end up accessing emergency rooms. Because the emergency room can only provide a limited crisis response to the individual's symptoms, treatment is not very effective. The repeated use of emergency rooms in lieu of hospitalization is an expensive and ineffective means of treating individuals with mental illness.

State Hospitals as Critical and Necessary Public Safety Net

The Association and its members believe that State Psychiatric Hospitals function as a critically important safety net resource for consumers of the public mental health system who require inpatient care. The CMHCs look to local community hospitals as the first option for persons needing inpatient treatment. When private community hospitals are either not appropriate or unavailable, State Psychiatric Hospitals are frequently the only option remaining. Generally speaking, persons utilizing State Psychiatric Hospitals fall into one or more of the following four categories:

1. Indigent patients with no third-party or other resources to pay for care;
2. Involuntary admissions;
3. Forensic patients; and
4. Those patients whose symptoms or behavior management issues are such as to make community hospital admission and treatment difficult or even impossible. They may need a longer period for medication management, excess violence, behavior management that requires structured, long term attention.

The importance of the safety net role of State Psychiatric Hospitals is further underscored by the extensive range of alternative services developed by CMHCs to avert hospitalization and maintain consumers in the community. Because CMHCs are prone to push the envelope in their efforts to avert hospitalizations, ready access to inpatient resources for persons whose personal safety is often at risk due to symptoms of mental illness is essential. For the person with serious mental illness who takes longer to respond to treatment, the state hospital plays a key role in stabilization and preparation for transition to community based services.

We were unable to locate defining research that tells us with any level of confidence what the appropriate number of inpatient beds is to meet the needs of our population. However, one study of 16 metropolitan areas concluded that methods that relied on expert opinion, historical use, epidemiologic data, and social indicators predicted the need more accurately than those that relied exclusively on historical use. It is our hope that in the future the State would commission a scientific and actuarial study to make recommendations for future inpatient needs.

Conclusion and Recommendations for Psychiatric Inpatient Services

One of our most pressing immediate needs is adequate inpatient capacity to so that inpatient care is available timely. This need is further highlighted by the cuts in funding that have and continue to occur in grants to CMHCs that serve the uninsured and underinsured. Without that funding being restored, we believe it is likely the State will continue to see even greater increases in reliance on inpatient services as we face challenges in meeting all the needs of the uninsured who are mentally ill.

There is and will continue to be a renewed focus by the CMHCs in the gatekeeping function they perform for our State Psychiatric Hospitals both in controlling the "front door" and the "back door." This crisis in both funding and inpatient resources forces our CMHCs to become more innovative, to think outside the box, and to ensure strong partnerships with community organizations to ensure all resources are utilized. In visiting with the Superintendent of OSH this week, he assured me they are not seeing inappropriate admissions. It is our duty to ensure that continues. This week, my Board meets in Dodge City. We will have a focused discussion on what we can do to share resources in various communities across the State that will allow us to continue to support persons in a psychiatric emergency in our communities as best we can. However, please know there will always be a need for some level of psychiatric inpatient resources and most importantly, access to such in a timely manner.

We are pleased that the Administration and the Secretary of SRS found resources to purchase local acute care psychiatric inpatient services from two hospitals to reduce pressure on the State Psychiatric Hospitals. We are also pleased that the Administration and the Secretary of SRS have found resources to open up the remaining 11 beds at LSH that went off line. We also have urged the Administration to fund transitional housing and crisis stabilization beds.

What is Needed?

1. **Additional capacity for crisis stabilization beds. We are exploring an opportunity within the OSH catchment area where a CMHC is attempting to secure a vacant building owned by the State of Kansas, and to add 26 crisis stabilization beds. This could help us tremendously in reducing the stress on OSH and RMHF. The Association is assisting the CMHC to navigate the State bureaucracy around purchasing the building. If all goes well, we could relieve the State of the debt service on this building and there would be not cost to the State of Kansas for these 26 crisis beds to come online. It's a win-win situation.**

2. **The 30 bed unit at OSH needs to come online. That comes with a price tag of $3.1 million SGF.**

3. **An appropriation of $500,000 to pay for staffing and other operating expenditures for LSH to permanently open up the 11 beds that have not been budgeted for within SRS.**

4. **We also support funding to establish local private mental health inpatient hospital beds across Kansas, to alleviate demand for State Psychiatric Hospital beds. Given the continued increase in the number of individuals who present for admission to State Psychiatric Hospitals, it is important to plan for the future needs in strategic areas of the State. In Kansas, the urban counties of Wyandotte, Johnson, Sedgwick and Shawnee see the majority of consumers that are impacted by the lack of psychiatric inpatient resources. By contracting with local hospitals or other providers for inpatient care, youth and adults who need acute care inpatient treatment will be able to remain closer to their families and support systems.**

Mr. Chairman, I thank you and the Committee for allowing us to tell our story and for your consideration of our ideas and concerns.

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[1] Automated Information Management System (AIMS); Kansas Department of Social and Rehabilitation Services; FY 2009.
[2] National Alliance on Mental Illness; National Survey with MHA and Depression is Real. October 2009. http://www.nami.org/Content/NavigationMenu/Top_Story/Economys_Toll_on_Mental_Health.htm .
[3] Lave J. The cost offset effect. In FogelBS, Furino A, Gottlieb GL, *Mental health policy for older Americans: Protecting minds at risk.* Washington, DC: American Psychiatric Press. 1990.
[4] The Lewin Group. *Health Plan Benefit Barriers to Access to Pharmaceutical Therapies for Behavioral Health.* 1998.

HCBS Oversight Committee

Testimony on

Impact of Budget Cuts and Temporary Suspension of Voluntary Admissions to State Psychiatric Hospitals

August 16, 2010

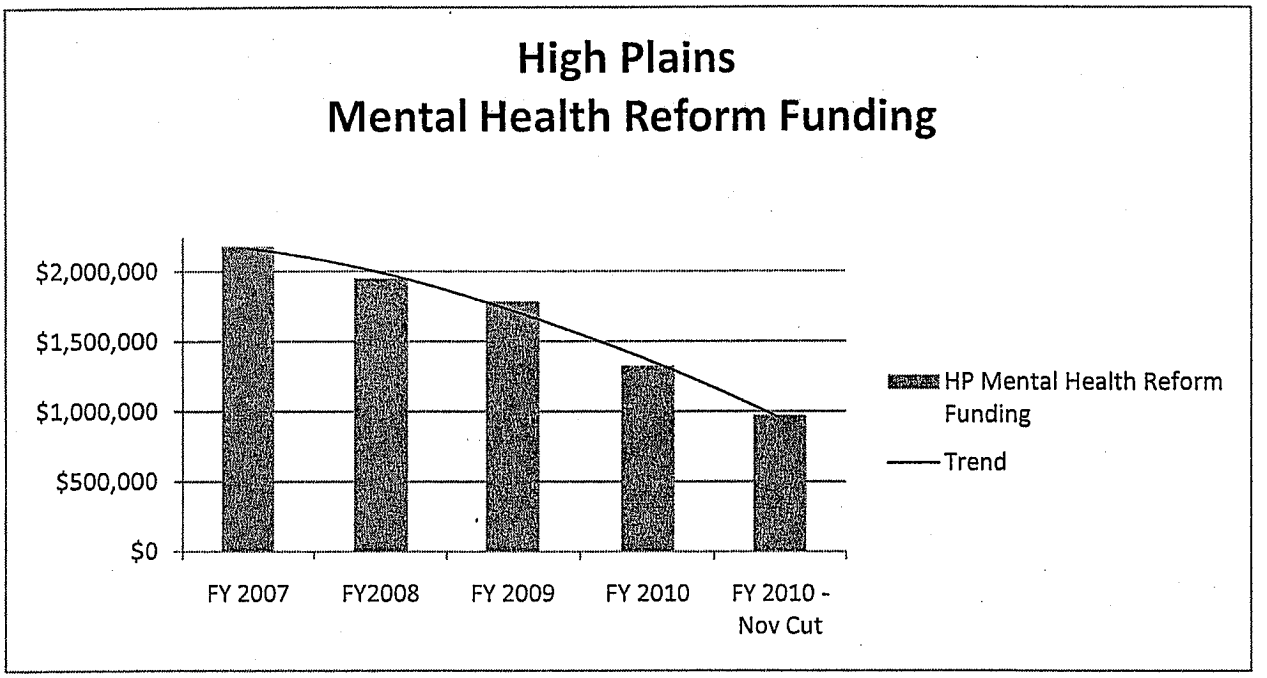
Presented by:

Walter Hill, Executive Director
High Plains Mental Health Center

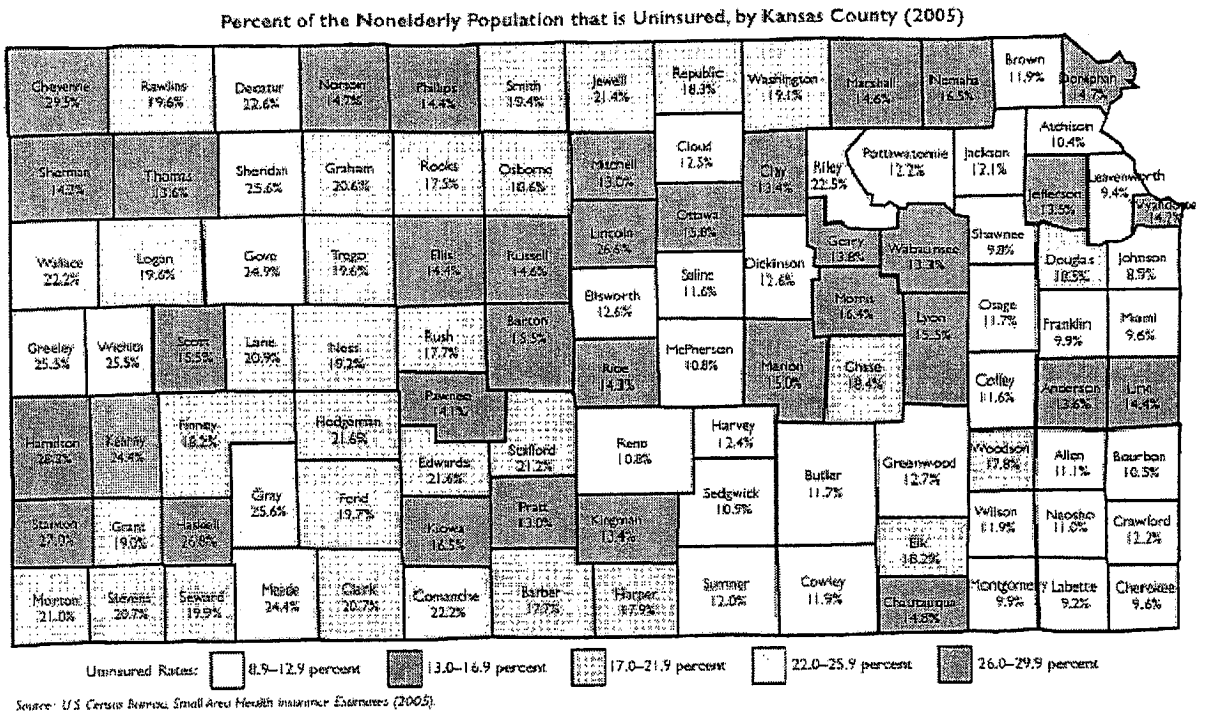
Attachment 14-1
Date 8-16-10
Joint Committee on Home and Community Based Services Oversight

Mr. Chair and members of the committee, thank you for the opportunity to speak with you about the impacts of cuts to Mental Health Reform funding to community programs and impacts on state hospitals. My name is Walter Hill and I am the Executive Director of the High Plains Mental Health Center, the licensed Community Mental Health Center providing services in the 20 counties in Northwest Kansas.

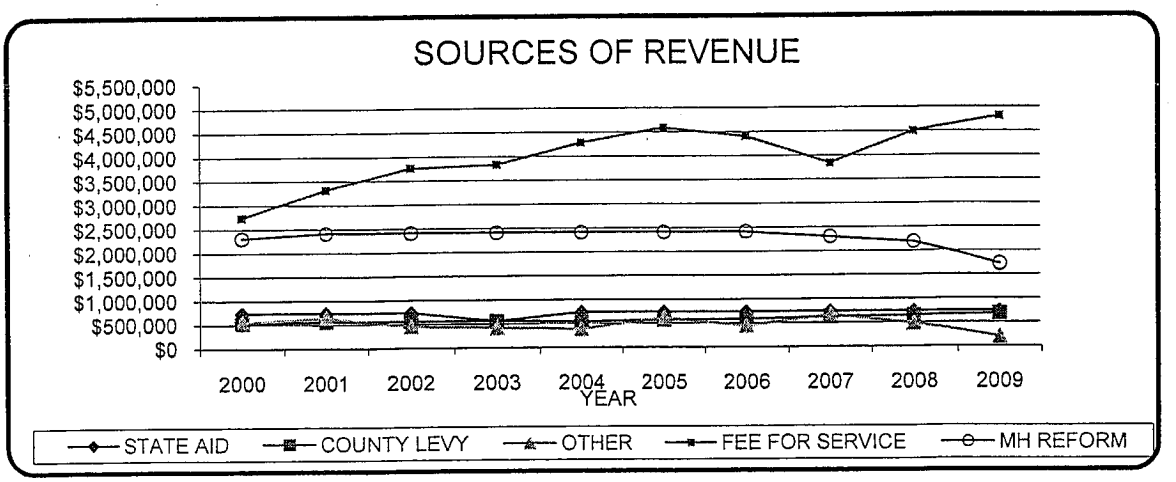
Mental Health Reform was founded on a promise of moving state dollars to communities as state hospital beds were closed and community providers cared for Kansas citizens in communities rather than in hospitals. Since 1989 our CMHC has continued our promise of Mental Health Reform, serving folks in the community and keeping thirty Larned State Hospital beds closed with no increases in that funding. Over the past several years, we have seen our Mental Health Reform Contract funding cut by nearly one half, $1.2 Million.



As you may recall, the funding cuts in the contracts for Mental Health Reform, were used to fund the repair of the Kansas Medicaid program that was in distress and under the microscope with the federal government. The theory was that Community Programs would make up the lost Mental Health Reform Contract funds with Medicaid revenues. That has not been the case in our twenty counties. The presence of Medicaid populations and uninsured is very low in Western Kansas compared to the rest of the state.



High Plains has only been able to generate the following Medicaid revenues - **$1,324,921 in CY 2007, $1,186,462 in CY 2008 , $1,217,576 in CY 2009 , and we project in CY 2010 $1,086,096. Though we have cut costs and attempted to raise other revenues, we continue to operate under a budget that is in the red nearly $40,000 each month.**



The impact of these cuts is that, though we do not have waiting lists, it is taking twice as long for a patient to be seen for medication evaluation, generally a two month wait for an appointment. Of our 5000 plus patients each year, approximatly half are treated with a combination of services that involves medications for various mental health disorders.

We have seen increases in our need to utilize the state mental health hospitals, with our utilizaiton increasing by nearly 50% over the past several years.

We have continued to provide as much service, but have maintained that level of service through reductions in number of staff, reductions of staff health, retirement and other benefits and wages.

We have reduced operating hours and reduced our travel to reach out to patients in their homes and home communities.

Over the past months that we have been discussing and dealing with cuts to our state funding, both we and others, including our auditors, board and counties, have indicated that such cuts will need to be dealt with, in addition to streamlining, by passing more of the cost of services on to service recipients.
With the removal of over $1 Million in state funding the Center is challenged to operate in historical ways with respect to the degree to which we can subsidize the cost of services. As part of considering the impact of these declines in subsidy funding, we have conducted several studies of how subsidy funding has been operating at the Center.

From April 1, 2009 through March 31, 2010 the Center provided $2,355,309 in subsidized services to patients through fee adjustments. Of those adjustments $987,718 were for self pay services.

Faced with continued cuts of over a million dollars annually in state funding, High Plains has reduced staffing levels by 20% over the past year and a half, cut office hours, reduced employee benefits, eliminated non-mandated services such as psychological evaluations, domestic violence interventions, community education and intervention and made other internal cuts to adjust to cuts in funding imposed by SRS and the legislature. Recently, without restoration of these revenues by the state and continued increases in operating costs, the High Plains Board was faced with no other options than face unsustainable levels of budget short falls, or change expectations about the share of costs that service recipients are expected to pay. In the past 30% of patients received a 96% fee discount, paying $4 or less for an hour of service that costs over $100. The base fees at High Plains have only been increased once before in the past 10 years.

On October 1, the base fees for services at High Plains will be increased approximately 25%. For the most common type of treatment appointment, the fee will increase from $100 to $125.

Many patients at High Plains receive a discount in this fee, and the Board changed the maximum discount from 96% to 90%. For an hour of therapy, the minimum fee will be $12.50. Additionally, in the past, further fee discounts were offered on a special fee consideration basis. Beginning October 1, the minimum fee will be the lowest fee and will not be discounted further unless patients are being funded by limited state funds. High Plains will work with patients to develop reasonable payment plan agreements, to carry their payment balances, without interest for up to one year.

High Plains will also begin expecting patients, who are not Severely and Persistently Mentally Ill or Seriously Emotionally Disturbed youth, to pay their fees for services in order to continue to receive regular treatment services. High Plains will provide only emergency services to individuals who are unwilling to pay their fair share of treatment cost.

Since making these announcements at the beginning of the year, we have seen self pay patients reduce the amount of services they seek by nearly 5,000 hours of treatment in six months.

We believe there is a direct correlation between the cuts in Mental Health Reform Contract funding and state hospital census, especially among non-Medicaid patients who have no where else to receive services when the community safety net can no longer serve them. The closures of state hospital beds puts patients at risk as there are no safe alternatives when the state hospital shuts its doors. The Mental Health Reform statute requires that SRS declare a moratorium when they shut the doors of the state hospitals and gain approval of the Supreme Court.

During the recent moratorium by SRS on voluntary admissions to the state mental health hospitals, we found no reduction in the number of admissions. Rather those who came to us for screening, in the absence of voluntary beds, had to be sent to the state hospital under civil commitment, due to the dangerousness.

To close just voluntary beds creates a system that jeopardizes patients and communities. I have stood before committees in this building over the past three years and warned of the looming crisis in our system because of an unaddressed shortage of state hospital beds. Several years ago the legislative proviso asked SRS to conduct a study of the number of state hospital beds we need. To date, no number of beds has been projected and we stand here today with the crisis having hit and continuing to loom before us.

Pawnee MENTAL HEALTH SERVICES

Testimony to the HCBS Oversight Committee

August 16, 2010

Good afternoon Mr. Chairman and members of the HCBS Oversight Committee. I am Robbin Cole, Executive Director of Pawnee Mental Health Services. Thank you for the opportunity to appear before you today regarding the impact of budget cuts and temporary suspension of voluntary admissions to state psychiatric hospitals.

Pawnee Mental Health Services is a licensed community mental health center and licensed substance abuse treatment center in north central Kansas serving Riley, Geary, Pottawatomie, Marshall, Clay, Cloud, Mitchell, Republic, Washington, and Jewell Counties. Pawnee was founded more than 50 years ago.

Pawnee serves over 7500 people a year, providing a full continuum of outpatient mental health and substance abuse services including individual, family and group psychotherapy, 24 hour crisis services, medication services, community support services for adults with severe and persistent mental illnesses, and community based services for children and youth with serious emotional disturbances.

Pawnee's mission is "to enhance and strengthen the wellness of our communities by providing quality mental health and substance abuse services." This mission is carried out without regard to ability to pay. As state grant funding has been cut, it has become increasingly difficult to fulfill this mission and significant adjustments have had to be made.

Since July 1, 2007, Pawnee Mental Health Services has had over $1,253,000 cut from its state funding budget as a result of the more than $20,191,000 cut from the consolidated grants to the community mental health system. This represents a 61% reduction in Pawnee's state funding and a 9% reduction in Pawnee's overall budget.

To preserve its mission to serve individuals whose lives are affected by mental illness and drug addiction, Pawnee:

- Gave no cost of living increase to its staff in the eight-and-a-half years between January 1, 2002 and June 30, 2010
- Has given no merit based raises to its staff in the six years that have passed since July 1, 2004
- Reduced mileage reimbursement to its staff to.40/mile

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- Eliminated one of nine paid staff holidays
- Eliminated sick leave, vacation leave, and health insurance benefits for employees working less than 30 hours/week
- Increased billable service expectations for direct service staff
- Closed its Regional Prevention Center
- Closed a residential house for adults whose lives are affected by severe and persistent mental illnesses
- Discontinued participation in three University of Kansas sponsored evidence based practice programs for adults whose lives are affected by severe and persistent mental illnesses
- Discontinued participation in Compeer, a friendship program for adults whose lives are affected by severe and persistent mental illnesses
- Reduced its staff from 320 to 240 (25%) through the elimination of 80 staff positions between February 1, 2009 and January 1, 2010.
- Consolidated offices resulting in the closure of one location
- Increased the number of clients served by over 500 in one fiscal year
- Implemented a "pay-as-you-go" policy for the uninsured. Clients are not allowed to schedule another appointment until/unless they pay for the last appointment they received.
- Implemented a "benefits package for the uninsured." Within that benefits package, clients have access to a limited number of individual/marital/family therapy sessions each year at their discounted fee which is based on income and family size. Once they've exhausted these sessions, they can either pay a higher fee for individual/marital/family sessions, or they can access group therapy sessions, crisis and medication services as needed at their discounted rate
- Limited the delivery of community support services for the uninsured to only those services which are necessary during periods of time when individuals demonstrate increased risk of harm to self or others, necessitating out-of-home placement. During periods of time when individuals are more stable, they can access individual/marital/family sessions according to the terms of the "benefits package for the uninsured." and can access medication and crisis services as needed at their discounted rate.

These, and other changes too numerous to mention, are the kind of changes that have been necessary to preserve community based services to individuals whose lives are affected by mental illness and substance abuse. The cuts in funding, which have necessitated these changes, when combined with the cuts in funding which have necessitated the temporary suspension of voluntary admissions to the state psychiatric hospitals, are a recipe for disaster.

We are fortunate that there were no incidents of harm to self or others that we know of that can be directly linked to the two recent suspensions of voluntary admissions to the state hospitals. We may not always be so fortunate. In the meantime, the community mental health centers and their staff, absorb the anger, anxiety and frustration of mentally ill individuals, their families and our community partners because the system that was set up to provide treatment and support to the mentally ill in our state does not work the way it was designed because it is not funded the way it was intended.

Thank you for this opportunity to speak today.

15-2

Mister Chairman and members of the committee, I am Sue Claridge of Emporia, Kansas. It is a pleasure to be here today to tell you my family's story, and how grateful we are that you are carefully studying the impact of the Medicaid cuts on mental health centers and other providers, as well as, on those of us who use services.

I am the newest Governing Board member of the Mental Health Center of East Central Kansas, a Consumer Representative. I am also a member of the Autism Steering Committee, which developed the Autism Waiver and now oversees it. Professionally, I am a flutist with a degree in music education. My current vocation and professional title is "MOM". I have two sons. Sean is 21 and Austin is 14. My husband, David, and I were foster parents for 10 years before we found out in 2005 that Austin has several diagnoses.

The first diagnosis we learned about was Anxiety. Further testing revealed Aspergers Syndrome, Pervasive Developmental Disorders – Not Otherwise Specified, and Sensory Integration Disorder. Getting that news was quite overwhelming: my son had such obstacles to overcome. I learned that my otherwise excellent insurance covered very little of what Austin needed in terms of treatment and services. My husband and I were considering drastic measures to help him, like selling our home, changing jobs, moving, doing whatever it might take to help our son. We feared that we would run out of money long before we had sufficiently helped him.

Our family doctor referred Austin to the Mental Health Center of East Central Kansas. He qualified for the HCBS Waiver to Medicaid for children with Severe Emotional Disturbance. That was a game changer for our family.

Receiving Medicaid got Austin the intensive services he needed. Austin's life began to improve. Last year, he joined an after-school and summer program called "Gateway" sponsored by the MHCECK. It has been a great place for him to develop his social skills and it has literally changed his life. Austin has friends. He is age appropriate. While he is still immature, he acts like a fourteen year old. This is the first time in his life that he has had the skills to act his age.

I asked Austin how the budget cuts with MHCECK have affected him. He told me how Gateway can no longer afford the reward system they had in place for good behavior. This is a big deal to Austin. Positive reinforcement is so important and token economies work. Austin continued that while they still had some of the cheaper rewards, the bigger prizes, for sustained good behavior, have gone away. Instead of a prize, the reward is to allow the kid to skip one day of group. A longer period of good behavior gets a kid a whole week off from group. Austin thinks this is preposterous because group is what leads to good behavior. Clearly, Gateway staff had to find a "free" method of positive reinforcement, which is really unfortunate.

My twenty-one year old son, Sean, was going through a bout of depression last year and sought help from the MHCECK. He is insured, but despite his ability to pay, he has only been able to receive counseling once a month. Budget cuts at the Mental Health Center have strained personnel. With a hiring freeze in place, employees have to do more with

less. So, my oldest son has not been able to access services as often as he would have liked. He believes he would have progressed faster with more frequent services.

I have another story to tell you about a twenty-seven year old man, who had attended my church. This young man fought depression all his life. It got bad enough for him to seek help from the MHCECK. Most people who seek counseling are in crisis, and he certainly was.

Grant funds from the state had been cut, followed by a 10% cut to Medicaid reimbursements left the Center's budget gutted. Our director, Bill Persinger, with the Board's approval, had to make some really tough decisions about how services would be delivered and how the Center would keep the doors open. In January, the Center had to develop a waiting list, which at one point numbered over 100 people: 100 people needed counseling and could not get in to a counselor.

As this young man waited for services, his despair grew. In March, he committed suicide before he was able to see a counselor. It was tragic, such a young man dying and leaving behind a wife and step-daughter. Many people at my church were greatly saddened by his death. Now, if he had gone into the emergency room, he would have received services. I wish he had done that. But, when he did reach out for help, he was not at an emergency status. I believe if he had been able to receive the counseling he needed, perhaps medication even, he might still be alive. If he had sought services during 2009 instead of a few months into 2010, he would have received services much faster. We'll never know if he could have been helped. What we do know is that these budget cuts are causing these kinds of sad stories. It is impacting my community, my family, and my children. It is impacting very vulnerable citizens indeed.

The Mental Health Center knows how to help people. These budget cuts have tied the hands of some very caring people who would like to do more and cannot. In February's Board meeting, I watched one of our valued employees tear up and get very emotional as she described the waiting list. She said it was horrible having to look someone in the eye and tell them that they could not receive the help they needed, despite their incredible personal pain.

I know that everyone on this committee cares about the man I just described, the employee who wants to help and cannot. You care about my family and have a heart for children like my son, Austin. You care about kids who have obstacles to overcome. Your very name indicates that you care about people and communities. I hope what I have shared gives you a clearer understanding about how the budget benefits these people. Please keep in mind that the budget cuts affect families and communities in a big way. Thank you for helping the state's most vulnerable citizens.

Thank you for allowing me to speak. I am glad to remain and answer questions.