MINUTES

JOINT COMMITTEE ON HOME AND COMMUNITY BASED SERVICES OVERSIGHT

September 8, 2010
Room 548-S—Statehouse

Members Present

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

Members Absent

Senator Dwayne Umbarger
Representative Brenda Landwehr

Staff Present

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

Conferees

Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services
Martin Kennedy, Secretary, Kansas Department on Aging
Scott Brunner, Chief Fiscal Officer, Kansas Health Policy Authority
Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services
Bill McDaniel, Program and Policy Commissioner, Kansas Department on Aging
Connie Hubbell, Governmental Affairs Director, Kansas Association for the Medically Underserved
Cindy Luxem, President/CEO of the Kansas Health Care Association/Kansas Center for Assisted Living

Loretta Seidl, Director of Oral Health, Kansas Health Care Association
Tanya Dorf Brunner, Executive Director, Oral Health Kansas
Sharon Rhys, Executive Director, Kansas Council on Developmental Disabilities
Sharon Bird, Consumer
Tom Laing, Executive Director, InterHab

Morning Session

Chairperson Bethell called the meeting to order at 10:00 a.m. and introduced Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services (SRS), to provide his testimony regarding agency budget plans to address the decrease in federal funds available due to reduced federal medical assistance percentage (FMAP).

Secretary Jordan presented written copy of his testimony (Attachment 1). Secretary Jordan stated SRS planned to follow the direction of the Division of the Budget regarding the submission of funding for the FMAP shortfall. The federal jobs bill includes less Medicaid funding than anticipated in the approved FY 2011 state budget. The total new federal funding received from the passage of the federal jobs bill is less than the amount assumed in the approved FY 2011 budget by $40 to $50 million. The Governor has recommended that the Legislature pass a revised FY 2011 budget which includes the replacement of State General Fund appropriations for education with funds provided through the federal education jobs fund. This would generate State General Fund dollars to fully fund the Medicaid program as originally approved by the Legislature, keeping the state budget in balance. As recommended by Governor Parkinson, SRS will factor the FMAP extension, along with up-to-date program enrollments, into fall caseload estimates for inclusion in a revised FY 2011 budget. Secretary Jordan stated SRS will be requesting an additional $15 million from the State General Fund. The Secretary addressed the questions of the Committee during his testimony.

Chairperson Bethell introduced Martin Kennedy, Secretary, Kansas Department on Aging (KDOA), to give his testimony regarding the federal Medicaid funds shortfall. Secretary Kennedy presented written testimony (Attachment 2). The Secretary stated the Kansas Department on Aging would be asking for an additional $8.5 million from the Legislature for FY 2011 in a supplemental request. A short question and answer session followed his testimony during which Senator Kelly requested that Secretary Kennedy supply the Committee with annual numbers, number of providers and cost savings. The Secretary stated he would provide the requested information.

Chairperson Bethell introduced Scott Brunner, Chief Fiscal Officer, Kansas Health Policy Authority (KHPA), to give his testimony. Mr. Brunner presented a written copy of his testimony (Attachment 3). He stated the approved FY 2011 budget was based on the state receiving $131.0 million in additional federal dollars for all Medicaid programs. This amount assumed that the enhanced Medicaid federal medical assistance percentage (FMAP) would be maintained after the original stimulus period ends in December 2010. The stimulus FMAP includes a base rate increase of 6.2 percent and an additional bonus due to Kansas' unemployment rate for a total matching percentage of 69.68 percent. KHPA's share of the additional federal share in the approved budget is $67,003,927. The extension of enhanced federal match did not provide the amount of additional federal share Kansas will receive to match Medicaid payments compared to the approved FY 2011 budget. For FY 2011, KHPA's Medical assistance budget is $1,226,228,635, including $351,204,882 from the State General Fund. This amount is the Spring 2010 consensus caseload

amount adjusted for legislative action. Applying the revised FMAP rate will result in a decreased federal share of $32.0 million for FY 2011. That amount would have to be replaced by State General Fund dollars or decreased expenditures. Upon the conclusion of Mr. Brunner's testimony, a question and answer session followed regarding the backlog of applications for services. It was noted that KHPA is making changes to speed up the process of applications, making sure no one gets lost in the process. During the discussion, Chairperson Bethell requested KHPA provide the following information as to whether:

- The prepopulating of HealthWave renewal applications is a temporary or permanent change;
- The responsibility of processing one HealthWave application falls on one employee or is divided among a team; and
- A preference is given to applications with emergency situations, and what procedure is used.

Mr. Brunner stated he would provide that information to the Committee.

Chairperson Bethell called on Martin Kennedy, Secretary, Kansas Department on Aging, to provide his testimony regarding the impact of changes in waivers and reductions in Home and Community Based Services (HCBS) on adult abuse, neglect, and exploitation (ANE). Secretary Kennedy presented written copy of his testimony (Attachment 4). He stated the Kansas Department on Aging Licensure and Certification Commission is responsible for the licensing and certification surveys of all adult care homes. In addition to annual surveys, Health Facility Surveyors conduct abbreviated or complaint surveys in response to complaints received through the Complaint Program's hotline. Surveyors investigate all allegations of abuse, neglect, exploitation and/or inadequate care and services. Investigations are conducted to assure compliance with federal nursing home and/or state adult care home regulations, as appropriate, in addition to compliance with KSA 39-1401(a)(1)(3)(b) for residents in KDOA licensed adult care homes. Secretary Kennedy reviewed the Crisis Exception Criteria and in closing, he stated a total of 245 crisis requests were made with only 15 granted for last year. A short question and answer session followed.

Chairperson Bethell introduced Ray Dalton, Deputy Secretary, SRS, to give his testimony. Deputy Secretary Dalton presented written copy of his testimony (Attachment 1-Pages 1& 2). The Deputy Secretary reviewed the crisis criteria for the Physical Disability (PD) Waiver that were implemented in December 2008, and also the criteria for the exception process used from February 27, 2009 until January 1, 2010. The number of individuals entering PD waiver services due to abuse, neglect, and exploitation (ANE) are as follows: December 2008 through December 2009 was 53, and January 2010 through July 2010 was 62. Next, he discussed the Mental Retardation/Developmental Disability (MR/DD) Waiver and reviewed the crisis situation policy. The number of individuals entering MR/DD waiver services due to ANE were as follows: July 2009 through December 2009 was 4, and January 2010 through June 2010 was 6. A short question and answer session followed. A request was made for information on ANE incidents for individuals on the Frail Elderly (FE) Waiver. Deputy Secretary Dalton stated he would provide that information.

Chairperson Bethell called on Deputy Secretary Ray Dalton once again, this time to give his testimony regarding information from providers of dental services regarding inpatient and outpatient expenditures for services related to dental problems. Secretary Dalton called the Committee's attention to Attachment 1-Page 2. He stated SRS worked with seven Community

Developmental Disabilities Organizations (CDDOs) to gather responses from providers regarding the handling of dental services since waiver coverage was discontinued. The majority of CDDOs responded that either individuals were going without oral health services, working with one of the clinics in their area that offered an income-based fee system, or the case managers were asking the CDDOs to assist through any funding to which they may have access. Some CDDOs stated that private pay was the only option. According to some CDDOs, services were being accessed through the Kansas Neurological Institute (KNI) or the Marian Clinic in Topeka; and other free clinics were assisting as much as possible. A question and answer session followed with the Committee requesting an explanation for the decrease in impatient and outpatient expenditures for services related to dental or tooth problems from FY 2007 to FY 2010 for varying age groups. Deputy Secretary Dalton was uncertain of the reason for a decrease in such expenditures from FY 2007 to FY 2008 for all age groups, and stated he would request that information from KHPA and provide it to the Committee. There was also a request for information as to the reason the 65 and older age group received less dental care than the other age groups. Deputy Secretary Dalton stated he also would provide that information to the Committee.

Chairperson Bethell introduced Bill McDaniel, Program and Policy Commissioner, Kansas Department on Aging, to give his testimony regarding the impact of removal of dental care from waiver services. Mr. McDaniel presented written copy of his testimony (Attachment 5). He reviewed the impact of reducing oral health services for individuals on the Home and Community Based Services Frail Elderly (HCBS FE) Waiver. The total expenditure for July 2008 through June 2009 was $919,494.0; for July 2009 through December 2009, $501,324.0; and for January 2010 through June 2010, $53,358.0. A short question and answer session followed.

Chairperson Bethell introduced Connie Hubbell, Governmental Affairs Director, Kansas Association for the Medically Underserved (KAMU), to provide her testimony regarding the removal of dental care from waiver services. Ms. Hubbell presented written copy of her testimony (Attachment 6). She stated that KAMU represents 39 safety net clinics in the state, including 17 that provide dental care. In 2009, there were 382,287 total medical visits and 99,945 total dental visits to safety net clinics in Kansas. In closing, she stated it is difficult to identify the exact costs for medical care and hospitalizations in Kansas due to lack of access to dental care as the healthcare industry does not have specific codes to allow for collection of that information. KAMU is aware, through experiences and outcomes, that Kansans are shouldering substantial financial costs, economic costs, and human costs because of the lack of assess to dental care. In Kansas, that is especially the case for those in rural areas, the elderly, and those insured through Medicaid, or not at all. A short question and answer session followed. The Committee requested data comparing the number of dentists per county in Kansas to the national numbers, and also as compared to other states. Ms. Hubbell indicated she would provide the information requested.

Chairperson Bethell introduced Tanya Dorf Brunner, Executive Director, Oral Health Kansas, to give her testimony regarding the impact of the removal of dental care from waiver services. Ms. Brunner presented written copy of her testimony (Attachment 7). She stated that in January 2010, the dental services for people on the PD, DD, and Traumatic Brain Injury (TBI) waivers were eliminated, and dental services for people on the FE waiver will be accessed only through a rare crisis exception. Eight people have received services through the FE waiver crisis exception to date. Oral Health Kansas has been working with at least one of the Area Agencies on Aging and many CDDOs to stress preventive oral health care. Research shows that people who receive routine dental services tend to be able to manage oral health problems that could lead to more serious and costly health problems, including pneumonia, strokes, and heart conditions. In closing, she stated that when waiver dental services were in effect, the cost to provide them was extremely low. Nearly five thousand Kansans per year benefitted from an investment of approximately $600,000 in State General Funds (SGF). She stated that even without a

comprehensive study, the return on investment of this $600,000 was high. Dental services help people keep their mouths healthy, avoid or manage some chronic health conditions, and gain confidence. Ms. Brunner was asked to provide copies of the 2009 California HealthCare Foundation study and the state of Michigan study referred to in her testimony.

Chairperson Bethell introduced Cindy Luxem, President/CEO of the Kansas Health Care Association/Kansas Center for Assisted Living, to give her testimony. Ms. Luxem stated dental services are vital and necessary, not only for good oral health, but also for good medical condition. She also mentioned that the Kansas Healthcare Association had received a $50,000 grant. She then introduced Loretta Seidl, Director of Oral Health, Kansas Health Care Association, to provide her testimony. Ms. Seidl presented written copy of her testimony (Attachment 8). She cited three different cases in which oral issues had caused bad health problems. A short question and answer session followed. Questions were posed as to the extended care permit for dental hygienists with regard to whether the permit expanded the scope of practice for hygienists or expanded the sites of practice.

Chairperson Bethell stated the Committee would adjourn for lunch and reconvene the meeting at 1:30 p.m.

Afternoon Session

Chairperson Bethell called the afternoon session to order at 1:30 p.m. and called on Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services (SRS), to present an update on Pay-As-You-Go and Sliding Scale Programs for HCBS. Deputy Secretary Dalton referred the Committee to Attachment 1-Pages 3, 4 and 5. He gave a brief history of the sliding scale program. In 2002, the Kansas Legislature passed a proviso authorizing the SRS Secretary to collect fees from parents to pay for a portion of services provided to their children. Affected by this proviso are parents of children whose eligibility for the Home and Community Based Service waiver was determined without considering parental resources or income. A sliding fee scale was developed by SRS in conjunction with a working group that included representatives of stakeholder agencies and family members. Parents pay a set fee each month based on their family size and income, although families with incomes below 200 percent of the federal poverty level do not pay. He noted that, during the time a child is receiving HCBS services, if a parent or parents fail to pay, SRS will not deny services to the child.

Chairperson Bethell introduced Bill McDaniel, Program and Policy Commissioner, Kansas Department on Aging, to give an update on the Senior Care Act sliding scale. Mr. McDaniel presented written testimony (Attachment 9). He stated the Senior Care Act (SCA) is a program of in-home services for residents of Kansas, 60 years of age or older, who have functional limitations which restrict their ability to carry out activities of daily living and impede their ability to live independently. The Secretary of Aging is required to develop a sliding fee scale which must be published annually in the *Kansas Register*. Each customer's fee is based on the customer's income and assets. All customer fees and donations reduce the cost of services paid by the Department on Aging under the Kansas Senior Care Act. The income level on the sliding fee scale is based on the federal poverty level. The more income and liquid assets a senior has, the larger the percentage they must pay for the services. A question and answer session followed. A request was made to SRS to provide information on the Autism Waiver with regard to: the number of persons on the waiver who are or should be paying at some level; the number of persons not paying; and the effectiveness of collections and enforcement.

Chairperson Bethell called the Committee's attention to the written testimony of Michael Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, Inc. (Attachment 10).

Chairperson Bethell called on Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services (SRS), to present his testimony regarding an update on voluntary admissions to state mental health hospitals, along with data on mental health facilities in the state. Secretary Jordan referred the Committee to the chart in Attachment 1-Page 8, stating the number of patients in state mental hospitals has been increasing for the past several years. In May of this year, the decision was made to delay admissions to the state hospitals in order to address the problem of overcrowding. Secretary Jordan submitted a written copy of *PSH/KNI Executive Order Advisory Group-Report to SRS Secretary, Don Jordan, June 2010* (Attachment 11). Secretary Jordan gave a brief review of this report. A question and answer session followed. A request was made for the average daily census, highs and lows, and number of days over for beds in mental health facilities. Secretary Jordan stated he would provide the information.

Chairperson Bethell introduced Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities, to give her testimony regarding the outcomes of the Winfield State Hospital closure. Ms. Rhys presented written copy of her testimony (Attachment 12) and also a booklet entitled *The Right Thing To Do.* (A copy can be found in the Kansas Legislative Research Department.) She opened by stating that a developmental disability is one or more impairments that begin before the age of 22, and alter or substantially hinder a person's ability to do at least three major life functions which would include: learning; taking care of one's self; walking; talking. She stated the Council on Developmental Disabilities visited with each person living at Winfield to measure dozens of aspects of quality of life and characteristics of service provision for each person.

The Kansas experience of the closure of Winfield has been far more successful than the consulting team predicted. Based on their data, it has been determined that the persons moved from Winfield into the community are better off, and their quality of life has vastly improved. In closing, she stated that persons with development disabilities are healthier, and their quality of life is better when they live in the community. Closing both state hospitals and using all savings for community developmental disabilities services would permit service to many individuals who are desperately waiting for services, some as many as 3 to 5 years. A question and answer session followed. Senator Kelly requested data on the cost of acute medical care services for those on HCBS waivers. Ms. Rhys stated she would attempt to obtain that information for the Committee.

Chairperson Bethell introduced Sharon Bird, a private citizen, whose son has developmental disabilities and was a former patient at the Winfield State Hospital. Ms. Bird presented written copy of her testimony (Attachment 13). She stated she was instrumental in helping to set up Creative Community Living in Cowley and Butler Counties due to the closing of Winfield. Ms. Bird stated that closing Winfield was very good for her son. He has a much better quality of life now and is happier than he has ever been, residing in Creative Community Living.

Chairperson Bethell called on Martin Kennedy, Secretary, Department on Aging, to provide his testimony regarding the Quality Care Improvement Panel Implementations (Attachment 14), Nursing Facility Incentive Factor for FY 2011 (Attachment 15), and Data on Non-Medical Nursing Facilities in Kansas (Attachment 16). Secretary Kennedy opened by stating **Senate Sub. For Senate Sub. For Sub. For HB 2320** passed by the 2010 Kansas Legislature, directs the KDOA to establish a Quality Care Improvement Panel. Among its charge, the panel is to administer and direct the expenditure of funds collected from nursing facilities through the quality care assessment. At this time the panel is being appointed, and he hoped to have the first meeting with the panel in October. The panel will not be compensated or receive expenses, and is directed to report to the

Kansas Legislature and the Health Policy Oversight Committee annually, on or before January 10. Secretary Kennedy addressed questions during his testimony. The Committee requested he send them a copy of the report that would be presented to the Kansas Legislature and the Health Policy Oversight Committee in January. Secretary Kennedy stated he would comply with that request.

Secretary Kennedy spoke on the Nursing Facility Incentive Factor for FY 2011. He stated the Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn $2.50 per diem add-on. Providers that fall below the 75th percentile staffing ratio, but improve the staffing ratio by 10 percent or more will earn a $0.25 per diem add-on. Providers that achieve a turnover rate at or at or below the 75th percentile will earn a $2.50 add-on. Providers that have a turnover rate greater than the 75th percentile, but that reduce their turnover rate by 10 percent or more will receive a per diem add-on of $0.25. Providers that have completed the full Kansas Culture Change Instrument Survey will receive a $0.38 per diem add-on. Providers that have a Medicaid occupancy percentage of 60 percent or more will receive a $1.13 per diem add-on. Secretary Kennedy addressed the questions of the Committee.

Vice-chairperson McGinn introduced Tom Laing, Executive Director, InterHab, to give his testimony on the potential for provider assessment for HCBS waivers. Mr. Laing presented written copy of his testimony on the impact of removal of dental care from HCBS (Attachment 17) and provider assessments for HCBS services (Attachment 18). Mr. Laing stated nearly all persons with developmental disabilities receive comprehensive developmental disabilities services via the Home and Community Based Services waiver provided by Medicaid. Nearly every dollar assessed against providers will produce a benefit to persons served by those same providers. Talks have continued over the past year between CMS and representatives of the national developmental disabilities services advocacy groups working to advocate for CMS to move forward on plans to allow a HCBS DD provider assessment. When provider assessments were authorized, states were attempting to make Medicaid a more affordable and flexible funding source. InterHab has been contacting providers that belong to other associations, as well as those not aligned with a professional association. To date there has been broad receptivity to this initiative. The details will be shaped by such collaboration, and by any additional information from CMS developments. InterHab expects it will be providing the Legislature with drafts of consensus supported legislation for its consideration in the coming months. A question and answer session followed.

Chairperson Bethell called the Committee's attention to the minutes of the previous meeting. *Representative Mast made a motion to approve the minutes for September 8, 2010. Representative Henry seconded. Motion carried.*

Chairperson Bethell adjourned the meeting at 3:35 p.m. with the next meeting scheduled for November 8, 2010 at 10:00 a.m. in room 548-S.

Prepared by Jackie Lunn
Edited by Iraida Orr

Approved by Committee on:

November 8, 2010
(Date)

Information for the Joint Committee on HCBS Oversight September 8, 2010 Meeting

1. **Our plan for dealing with the FMAP shortfall**

SRS Response

The federal jobs bill includes less Medicaid funding than anticipated in the approved FY 2011 state budget. However, the total new federal funding received from the passage of the federal jobs bill (including enhanced federal match for Medicaid and aid to local public school districts) exceeds the amounts assumed in the approved FY 2011 budget by $40 to $50 million. The Governor has recommended that the Legislature pass a revised FY 2011 budget to replace State General Fund allocations to education with funds given through the federal Education jobs fund. This would in turn free up State General Fund dollars to fully fund the Medicaid program as originally approved by the Legislature, keeping the state budget in balance. As recommended by Governor Parkinson, SRS will factor the FMAP extension along with up to date program enrollments into our fall caseload estimates for inclusion in a revised FY 2011 budget.

2. **Whether there are more incidents of ANE because of reduced services**
   a. **Requested: The definition of/criteria for a crisis admission to a waiver**

PD Waiver

The crisis criteria that were implemented December 1, 2008 are:

1. SRS APS confirmed abuse, neglect, or exploitation case; or
2. Risk of family unit dissolution (break-up)involving minor dependent child or dependent spouse; or
3. End stages of a terminal illness, and life expectancy is documented by a physician to be less than six (6) months ; or
4. Individual is the victim of domestic violence.

From February 27, 2009 until January 1, 2010 the following criteria for the exception process was used:

5. Significant, imminent risk of serious harm because the primary caregiver(s) is/are no longer able to provide the level of support necessary to meet the consumer's basic needs due to the *primary caregiver(s):*

   a. own disabilities;
   b. return to full time employment;
   c. hospitalization or placement in an institution;
   d. moving out of the area in which the consumer lives; or
   e. death.

Number of individuals entering PD waiver services due to ANE:
December 2008 through December 2009 – 53
January 2010 through July 2010 – 62

Home and Community Based Services Oversight
Date: 9-8-10
Attachment: 1

Persons who may access DD waiver services due to a crisis situation are those persons who:

a. Require protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same; or
b. Are at significant, imminent risk of serious harm to self or others in their current situation.

Number of individuals entering DD waiver services due to ANE:
July 2009 through December 2009 – 4
January 2010 through June 2010 – 6

3. **Hospitalization resulting from lack of dental services**
   a. **Wants expenditure information from providers about how much they spend on hospitalization**

SRS Response

Information from community service providers regarding the loss of HCBS Oral Health Services: SRS worked with seven CDDOs to gather responses from providers as to how they have been handling dental services since waiver coverage was discontinued. The majority responded that either individuals were going without oral health services, working with one of the clinics in their areas that offered an income-based fee system, or the case managers were asking the CDDOs to assist through any funding they may have access to. Some stated that private pay was the only option. Some did say they were accessing services through KNI or the Marian Clinic here in Topeka, and there were also other free clinics that were brought up that were assisting as much as possible.

Some responded that there was little impact because they could not find dentist in their area that would accept Medicaid. We knew this was an issue and were working with Oral Health Kansas to provide training and education to provider.

KHPA Response

Data were pulled utilizing an aggregate data source to determine expenditures for hospitalizations coded as dental related procedures. That data are below. Aggregate data does not provide detail on why individuals may have needed or how they arrived at receipt of these services and it does not capture hospitalizations associated with untreated dental disease. That would only be possible through a labor intense review of actual individual records.

The average annual expenditure for hospitalization claims related to dental problems, for all beneficiaries, was $830,000 for fiscal years 2007 through 2010. The largest expenditure by age group is the 22 and under category. This population's average annual expenditure was $589,000 from 2007 to 2009, representing 70.8% of total expenditure for all ages.

Average annual expenditure for HCBS beneficiaries for fiscal years 2007 through 2010 was $181,000. The largest expenditure by age group is again the 22 and under age group. The average annual expenditure for these beneficiaries was $91,000 from 2007 to 2010. The 22 to 64 age group annual average expenditure was $87,000 during that time. Chart 1 below shows the expenditure broken out by age group from 2007 to 2010.

Chart 1:

Inpatient & Outpatient Expenditures for Services Related to Dental or Tooth Problems: All Beneficiaries FY 2007-2010				
Age Group	FY 2007	FY 2008	FY 2009	FY 2010
Youth under 22 years of Age	$ 881,179.31	$ 403,428.89	$ 565,405.50	$ 504,689.42
Adults 22 to 64 Years of Age	$ 247,569.44	$ 175,926.06	$ 167,460.41	$ 294,934.42
65 and Older	$ 42,944.65	$ 11,546.28	$ 3,223.44	$ 24,205.01
Total Expenditure	$ 1,171,693.40	$ 590,901.23	$ 736,089.35	$ 823,828.85

Inpatient & Outpatient Expenditures for Services Related to Dental or Tooth Problems: HCBS Beneficiaries FY 2007-2010				
Age Group	FY 2007	FY 2008	FY 2009	FY 2010
Youth under 22 years of Age	$ 100,312.22	$ 76,435.64	$ 92,863.79	$ 94,546.61
Adults 22 to 64 Years of Age	$ 99,510.57	$ 63,510.09	$ 59,931.48	$ 125,753.37
65 and Older	$ 4,724.03	$ 1,283.88	$ -	$ 4,380.13
Total Expenditure	$ 204,546.82	$ 141,229.61	$ 152,795.27	$ 224,680.11

The most common diagnosis codes on all claims that involved dental problems were 52100 – Dental Caries NOS (Not Otherwise Specified) and 52109 – Dental Caries NEC (Not Elsewhere Classified). This aggregate data reflects expenditures for the time period for hospitalizations related to dental services, but not necessarily as a result of a lack of adequate dental care. It is noted that a 10% reduction in reimbursement is present in the data for part of fiscal year 2010. This data does *not* provide information which would lend itself to drawing conclusions regarding why the services were needed. Other information, which might be of use, regarding dental services is available in the 2009 KHPA program review on dental services located at

http://www.khpa.ks.gov/medicaid_transformation/download/2008/Chapter%203%20-%20Dental%20Services.pdf.

4. **Update on sliding scale payments for waiver services and "pay as you go" – Aging and KHPA have been asked to be present for this topic**

SRS Response

a.) Background of the parent fee program

In June 2002, the Kansas Legislature passed a Proviso that authorized the SRS Secretary to collect fees from parents to pay for a portion of the services provided to their children. Affected by this Proviso are parents of children whose eligibility for the Home and Community Based Services Waiver (HCBS) was determined without considering parental resources or income.

In the Parent Fee Program, parents share in the financial responsibility of providing HCBS services for their child by paying a portion of the cost. A Sliding Fee Scale was developed by SRS in conjunction with a working group that included representatives of stakeholder agencies and family members. Parents pay a set fee each month based on their family size and income, although families with incomes below

200% of the Federal Poverty Level pay nothing. While SRS will take steps to collect delinquent fees, SRS will not deny services to a child whose parents fail to pay their fee.

b.) What programs are included in the parent fee program?

- Autism Wavier program
- Developmental Disabilities (DD) Waiver program
- Physical Disability (PD) Waiver program
- Traumatic Brain Injury (TBI) Waiver program
- Technologically-Assisted (TA) Waiver program
- Serious Emotional Disturbance (SED) Waiver program

c.) How much revenue is generated, by program?

Waiver Program	SFY 2009	SFY 2010
Autism Waiver Program	N/A	$1,330
DD Waiver program	$138,629	$113,688
TA Waiver program	$7,605	$23,293
SED Waiver program	$101,249	$108,080

SRS added the Autism Waiver, the TBI Waiver, and the PD Waiver to the Parent Fee program in February 2010. There are no collections shown for the TBI and PD waiver as there were no families who qualified to be assessed a fee. There is only one child on the TBI waiver and only six children on the PD waiver.

- *What is the fee scale?*
- The current fee scale is attached.

d.) What is the Parent Fee collections policy, including policy with respect to non-paying families?

- During the time a child is receiving HCBS services and parent(s) fail to pay, SRS will not deny services to the child.
- An additional detail as to the collection process is attached.

5. Delay in voluntary admissions

a. A list of MH facilities that have closed in the last 10 years
b. "Census numbers" for the last 10 years
c. Number of providers over the last 10 years
d. MH expenditures over the last 10 years

SRS Response

Attached are charts with:
The History of Medicaid Funding for Community Inpatient Hospital Psychiatric Program
State Mental Health Hospital Admissions For The Last Ten Years
Community Hospital Inpatient Psychiatric Programs 2006 through 2010
History of Mental Health Expenditures since 2010

6. **Additional request: A copy of the KNI/PSH Advisory Committee Report – copy for each member of the committee.**

   Copies of the Report are provided along with this information.

Parent Fee Schedule

(Sometimes referred to as "Sliding Fee Scale")

Effective February 1, 2010

Federal Poverty Level (FPL)	Monthly Fee	A Family of Two * Adjusted Gross Income Annual	A Family of Two * Adjusted Gross Income Monthly	B Family of Three * Adjusted Gross Income Annual	B Family of Three * Adjusted Gross Income Monthly	C Family of Four * Adjusted Gross Income Annual	C Family of Four * Adjusted Gross Income Monthly	D Family of Five or More * Adjusted Gross Income Annual	D Family of Five or More * Adjusted Gross Income Monthly
100%	$0	$14,570	$1,214	$18,310	$1,526	$22,050	$1,838	$25,790	$2,149
151%	$0	$22,001	$1,833	$27,648	$2,304	$33,296	$2,775	$38,943	$3,245
176%	$0	$25,643	$2,137	$32,226	$2,686	$38,808	$3,234	$45,390	$3,783
201%	$10	$29,286	$2,441	$36,803	$3,067	$44,321	$3,693	$51,838	$4,320
226%	$15	$32,928	$2,744	$41,381	$3,448	$49,833	$4,153	$58,285	$4,857
251%	$20	$36,571	$3,048	$45,958	$3,830	$55,346	$4,612	$64,733	$5,394
276%	$26	$40,213	$3,351	$50,536	$4,211	$60,858	$5,072	$71,180	$5,932
301%	$33	$43,856	$3,655	$55,113	$4,593	$66,371	$5,531	$77,628	$6,469
326%	$41	$47,498	$3,958	$59,691	$4,974	$71,883	$5,990	$84,075	$7,006
351%	$49	$51,141	$4,262	$64,268	$5,356	$77,396	$6,450	$90,523	$7,544
376%	$58	$54,783	$4,565	$68,846	$5,737	$82,908	$6,909	$96,970	$8,081
401%	$68	$58,426	$4,869	$73,423	$6,119	$88,421	$7,368	$103,418	$8,618
426%	$79	$62,068	$5,172	$78,001	$6,500	$93,933	$7,828	$109,865	$9,155
451%	$90	$65,711	$5,476	$82,578	$6,882	$99,446	$8,287	$116,313	$9,693
476%	$102	$69,353	$5,779	$87,156	$7,263	$104,958	$8,747	$122,760	$10,230
501%	$115	$72,996	$6,083	$91,733	$7,644	$110,471	$9,206	$129,208	$10,767
526%	$129	$76,638	$6,387	$96,311	$8,026	$115,983	$9,665	$135,655	$11,305
551%	$143	$80,281	$6,690	$100,888	$8,407	$121,496	$10,125	$142,103	$11,842
576%	$159	$83,923	$6,994	$105,466	$8,789	$127,008	$10,584	$148,550	$12,379
601%	$174	$87,566	$7,297	$110,043	$9,170	$132,521	$11,043	$154,998	$12,917

* Number of exemptions claimed on your Federal Income Tax Return

AGI - Adjusted Gross Income per your Federal Income Tax Return

For Incomes Below 601% of the Federal Poverty Level

1 Find the column for your family size
2 Find the lines that your AGI fall between
3 Find the corresponding estimated "Monthly Parent Fee" for the smaller of the 2 AGIs in Step 2.

EXAMPLE

1 For a family of two (Col A), with an AGI of $36,000
2 The AGI falls between $32,928 and $36,571.
3 The Monthly Parent Fee of $15 that corresponds to the smaller AGI of $32,928 is the estimated fee.

For Incomes Above 601% of the Federal Povery Level

1 Fee is 3% of the income of a family size of 2 at the corresponding FPL

EXAMPLE

1 For a family of four (Col C) with an AGI of $225,000
2 Divide $225,000 by $22,050 = 1021% of FPL
3 Multiply 1021% by $14,570 (AGI for Family of 2-Col A) = $148,760
4 Multiply $148,760 by 3% = $4,462
5 Divide $4,462 by 12 Months = $371.84 (Monthly Fee)

Updated January 2010 - based on Federal Register 2009 Poverty Guidelines for 48 Contiguous States

PART VII - COLLECTION PROCESS

1. Parents unable to pay their fees by the due date are encouraged to contact DBHS at (785) 296-3536 to discuss entering into a Payment Agreement and to see if their fees may be paid in whole or part by the State Debt Set Off process described in #3 below.

2. Parents who either do not pay their fees or otherwise do not cooperate with the rules of the Parent Fee Program are subject to SRS's collection process.

   (**NOTE**: During the time a child is receiving HCBS services, if parents fail to pay the fees, SRS will not deny HCBS services to the child, but SRS is authorized to pursue collection of the delinquent balance due, including pursuing payment through legal action, if necessary. SRS is also authorized to pursue any balance due after a child is no longer receiving services.)

3. When a parent has received at least three monthly billing invoices and is twenty-five dollars ($25.00) or more overdue, SRS may submit a notice to the State Debt Set-off (SDSO) Section, which is not a part of SRS. SDSO will intercept any State payment due the parent. This may include the following types of payments: tax refunds; lottery winnings; contract payments; salary; wages; KPERS lump-sum withdrawals; and travel reimbursements. Money collected by the SDSO Section will be applied to the parent's debt.

4. SRS may negotiate a Payment Agreement in lieu of or in addition to the SDSO process.

5. Parents with overdue balances not brought current by SDSO are to be mailed a Collection Letter stating the amount due and the need for them to contact DBHS within 10 days to set up a Payment Agreement that will pay the debt in a reasonable amount of time, usually within 12 - 24 months, depending on the size of the debt.

6. If the parent contacts DBHS within the 10 days, DBHS will make every reasonable effort to negotiate a mutually agreeable method for the debt to be paid.

   a. DBHS will send the parent a written Payment Agreement to sign and return. The case will be monitored until the debt is paid in full.

   b. DBHS will refer the matter to SRS Legal Section (see #7) if the payment agreement is not followed.

7. If the parent does not contact DBHS within 10 days, then the matter will be referred to the SRS Legal Section for additional action, which may include Judgment, Wage Garnishment, and Notification to Credit Bureaus. The SRS Legal Section will notify the parent of the referral, as appropriate, during the legal process. DBHS may be the contact if the parent wants to discuss payments prior to the SRS Legal Section obtaining Judgment. DBHS will monitor all cases involved in the above Collection Process until the balance is paid and the matter is resolved to the satisfaction of SRS.

HISTORY OF MEDICAID FUNDING FOR COMMUNITY INPATIENT HOSPITAL PSYCHIATRIC PROGRAM: AMOUNT PAID AND NUMBER OF ADMISSIONS

September 3, 2010

	2000		2001		2002		2003		2004	
Type of Admission	Amount Paid	Admits	Amount Paid	Admits	Amount Paid	Admits	Amount Paid	Admits	Amount Paid	Admits
880 - Acute adjustment reaction & psychosocial dysfunction	202,210	83	247,132	101	215,937	90	174,169	74	156,053	68
881 - Depressive neuroses	384,096	132	503,237	165	527,466	159	637,273	208	699,268	277
882 - Neuroses except depressive	284,117	97	242,910	83	505,977	138	441,370	154	336,185	120
883 - Disorders of personality & impulse control	212,477	64	231,523	52	186,586	53	166,750	52	149,342	53
885 - Psychoses	7,511,354	2,355	8,685,034	2,600	12,024,314	3,326	11,684,540	3,639	12,196,721	4,043
887 - Other mental disorder diagnoses	19,967	8	3,824	1	17,358	6	9,170	2	4,425	3
Grand Total	8,614,221	2,739	9,913,660	3,002	13,477,637	3,772	13,113,271	4,129	13,541,994	4,564

	2005		2006		2007		2008		2009	
Type of Admission	Amount Paid	Admits	Amount Paid	Admits	Amount Paid	Admits	Amount Paid	Admits	Amount Paid	Admits
880 - Acute adjustment reaction & psychosocial dysfunction	319,733	120	389,998	118	239,623	74	244,394	66	236,221	70
881 - Depressive neuroses	620,934	234	601,116	195	578,592	211	502,622	173	386,175	137
882 - Neuroses except depressive	322,728	110	458,133	139	397,477	125	447,358	153	443,375	149
883 - Disorders of personality & impulse control	192,188	54	220,609	45	237,983	51	108,568	35	145,512	41
885 - Psychoses	12,981,884	4,187	14,343,444	4,280	14,273,117	4,118	15,397,555	4,397	13,046,368	3,842
887 - Other mental disorder diagnoses	3,907	2	13,839	6	5,299	7	7,842	5	11,808	5
Grand Total	14,441,374	4,707	16,027,140	4,783	15,732,091	4,586	16,708,339	4,829	14,269,458	4,244

STATE MENTAL HEALTH PSYCHIATRIC SERVICE PROGRAM HOSPITAL
ADMISSIONS AND AVERAGE DAILY CENSUS FOR TEN YEARS

September 3, 2010

State Fiscal Year	OSH Budgeted Beds	OSH Average Daily Census	OSH Admissions	RMHF Budgeted Beds	RMHF Average Daily Census	RMHF Admissions	LSH Budgeted Beds	LSH Average Daily Census	LSH Admissions	TOTAL Budgeted Beds	TOTAL Average Daily Census	TOTAL Admissions
2001	190	177	886	60	35	435	126	117	684	376	329	2,005
2002	190	178	1,023	60	41	513	104	102	663	354	321	2,199
2003	176	168	1,189	50	37	588	104	91	738	324	296	2,515
2004	176	176	1,404	50	41	715	99	92	846	304	309	2,965
2005	176	167	1,767	50	39	671	99	72	990	304	263	3,428
2006	176	166	2,016	50	41	664	99	81	1,064	304	273	3,744
2007	176	170	1,969	50	41	671	99	82	1,097	304	282	3,737
2008	176	169	2,181	50	44	810 *	99	94	1,177	325	307	4,168
2009	176	169	2,042	50	42	875	99	86	1,071	325	297	3,988
2010	176	172	2,193	50	49	840	79	93	1,223 **	305	314	4,256
2011	176			50			90		***	316		

* Stopped admitting children and adolescents. All children and adolescents are now served at KVC STAR.
** Stopped admitting children and adolescents in May 2010. All children and adolescents are served by Wheatland Hospital in Hays.
*** LSH increased their capacity to 90 beds using funding from savings of children's bed closure

Community Hospital Inpatient Psychiatric Programs 2006 through 2010

September 3, 2010

KDHE Report Plus "Distinct Part Beds" (i.e., Stormont West and Via Christi)

Names	Locations	2006 Beds	2007 Beds	2008 Beds	2009 Beds	2010 Beds
Memorial Hospital	Abilene	10	10	10	10	10
Atchison Hospital	Atchison					
Mitchell County Hospital	Beloit	10	10	10	10	10
Coffeyville Regional Medical Center	Coffeyville	17	19	19		
Susan B. Allen Memorial Hospital	El Dorado	11	10	10	10	10
Morton County Hospital	Elkhart	11	11	11	11	11
Fredonia Regional Hospital	Fredonia	9	9	9	9	9
St. Catherine Hospital	Garden City	14	14	14	14	14
Girard Medical Center	Girard			10	10	10
Kiowa County Memorial Hospital	Greensburg	10	10			
Hertzler Regional Medical Center	Halstead					
Hillsboro Community Medical Center	Hillsboro					
Promise Regional Medical Center	Hutchinson	16	13	13	13	15
Geary Community Hospital	Junction City	11	9	9	9	9
Providence Medical Center	Kansas City					
University of Kansas Hospital	Kansas City	48	48	48	48	42
Edwards County Hospital	Kinsley		10	10	10	10
Lawrence Memorial Hospital	Lawrence					
Cushing Memorial Hospital	Leavenworth	20	20			
St. John Hospital	Leavenworth	16	16	16	16	18
Southwest Medical Center (1)	Liberal	12	12	12	12	12
Mercy Regional Health Center	Manhattan	11	11			
Minneola District Hospital	Minneola					
Wilson County Hospital	Neodesha					
Newton Medical Center	Newton	12	12	12	12	12
Overland Park Regional Medical Center	Overland Park					
Mt. Carmel Medical Center	Pittsburg	14	14			
Salina Regional Health Center	Salina	16	16	16	16	15
Shawnee Mission Medical Center	Shawnee Mission	32	32	32	32	32
Stormont-Vail Regional Health Center	Topeka	76	76	76	76	76
Sumner Regional Medical Center	Wellington	10	10	10	10	10
Via Christi Regional Medical Center	Wichita	108	108	108	108	108
Wesley Medical Center	Wichita	18				
Total		512	500	455	436	433

(1) Announced closure Fall 2010

SRS Licensed Free Standing Hospitals

Prairie View	Newton	60	60	60	60	60
Marillac	Overland Park	32	32	32	32	32
KVC Behavioral Healthcare	Kansas City	23	23	23	23	23
KVC Wheatland	Hays					24

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
DISABILITY AND BEHAVIORAL HEALTH SERVICES
HISTORY OF MENTAL HEALTH EXPENDITURES

	SFY 2000	*SFY 2001*	*SFY 2002*	*SFY 2003*	*SFY 2004*	*SFY 2005*	*SFY 2006*	*SFY 2007*	*SFY 2008*	*SFY2009*	*SFY 2010*
Community Mental Health Center Grants											
State Aid	10,233,297	10,233,297	10,233,297	7,733,297	10,233,297	10,233,297	10,233,297	10,233,297	10,233,297	10,233,297	10,233,297
Grants	37,119,330	36,137,269	36,140,014	37,081,367	37,081,366	37,336,366	37,019,431	36,788,244	26,874,340	25,074,340	15,890,993
Mental Health Block Grant	2,258,210	2,528,707	2,728,707	2,728,707	2,851,707	2,748,707	2,649,857	2,465,801	2,465,801	2,465,801	2,465,801
TOTAL CMHC GRANTS	**49,610,837**	**48,899,273**	**49,102,018**	**47,543,371**	**50,166,370**	**50,318,370**	**49,902,585**	**49,487,342**	**39,573,438**	**37,773,438**	**28,590,091**
Medicaid Payments										Note A	Note B
CMHC Medicaid Payments	38,039,387	55,505,526	81,819,371	99,911,201	113,121,495	134,640,619	116,062,367	123,740,780	159,143,233	168,988,567	166,360,374
Private Medicaid Providers	NA	NA	NA	NA	NA	4,275,099	3,268,164	3,680,510	8,375,819	8,974,573	11,322,641
TOTAL COMMUNITY MEDICAID	**38,039,387**	**55,505,526**	**81,819,371**	**99,911,201**	**113,121,495**	**138,915,718**	**119,330,531**	**127,421,290**	**167,519,052**	**177,963,140**	**177,683,015**
Residential Treatment											
PRTFs	NA	NA	NA	NA	NA	NA	NA	NA	29,434,293	36,276,452	42,150,467
NF/MHs	13,017,723	13,529,803	14,242,525	13,625,423	13,425,068	13,117,334	11,750,315	13,574,494	14,484,069	15,578,223	15,836,973
TOTAL RESIDENTIAL TREATMENT	**13,017,723**	**13,529,803**	**13,017,723**	**13,625,423**	**13,425,068**	**13,117,334**	**11,750,315**	**13,574,494**	**43,918,362**	**51,854,675**	**57,987,440**
State Mental Health Hospitals	56,100,171	57,424,524	58,137,114	58,364,134	62,883,107	68,710,700	76,839,020	83,338,330	88,654,338	87,248,055	93,419,381
TOTAL MENTAL HEALTH	**156,768,118**	**175,359,126**	**202,076,226**	**219,444,129**	**239,596,040**	**271,062,122**	**257,822,451**	**273,821,456**	**339,662,509**	**353,951,811**	**357,679,927**

Note A: Matches IBARs plus $8,760,632 paid in FY 2010 for services provided in FY 2009 and $876,275 expended for the PRTF CBA

Note B: Matches IBARs minus $8,760,632 paid in FY 2010 for services provided in FY 2009

KANSAS
DEPARTMENT ON AGING

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

Joint Committee on
Home and Community Based Services Oversight
Sept. 8, 2010

Addressing the Decrease in FMAP Funds from FY 2011 Projections

Martin Kennedy, Secretary

Appropriated State General Fund (SGF) Percentage	30.32%
Increased FMAP SGF Percentage	32.23%
Percentage SGF Request	1.91%

	Current Appropriation	Supplemental FMAP
HCBS-FE		
Total Request	$71,365,389	$71,365,389
State General Fund	$21,637,986	$23,001,065
Additional SGF		$1,363,079
Nursing Facility		
Total Request	$373,650,699	$373,650,699
State General Fund	$113,290,892	$120,427,620
Additional SGF		$7,136,728
PACE		
Total Request	$5,082,711	$5,082,711
State General Fund	$1,541,078	$1,638,158
Additional SGF		$97,080
TCM		
Total Request	$5,072,873	$5,072,873
State General Fund	$1,538,095	$1,634,987
Additional SGF		$96,892

New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404

Voice: (785) 296-4986 • Toll-Free: (800) 432-3535 • Fax: (785) 296-0256

TTY (Hearing Impaired): (785) 291-3167 • E-Mail: wwwmail@agir

Home and Community Based Services Oversight
Date: 9-8-10
Attachment: 2

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

Joint Committee on Home and Community Based Services Oversight: FY 2011 Caseload

September 8, 2010

Scott Brunner
Chief Financial Officer
Kansas Health Policy Authority

Home and Community Based Services Oversight
Date: 9-8-10
Attachment: 3

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

Mr. Chairman and members of the committee, my name is Scott Brunner and I serve as the Chief Financial Officer for the Kansas Health Policy Authority (KHPA). I've been asked to describe the impact of the extension of enhanced federal Medicaid matching funds on the KHPA FY 2011 approved budget.

The approved FY 2011 budget is based on the state receiving $131.0 million in additional federal dollars for all Medicaid programs. This amount assumed that the enhanced federal Medicaid matching percentage (FMAP) would be maintained after the current stimulus period ends in December 2010. The stimulus FMAP includes a base rate increase of 6.2% and an additional bonus due to Kansas' unemployment rate for a total matching percentage of 69.68%. KHPA's share of the additional federal share in the approved budget was $67,003,927.

Public Law 111-226, signed on August 10, 2010, provided a six month extension of increased FMAP payments. The increase in the FMAP, however, was reduced from 6.2% to 3.2% between January 1 and March 31, 2011 and further reduced to 1.2% between April 1 and June 30, 2011. The unemployment bonus continues under the new law, however the way the bonus is calculated changes. KHPA's reading of the legislation and available data indicates that the unemployment bonus should continue to add 3.4% to the FMAP rate through June 30, 2011.

In all, the new law reduces the amount of additional federal share Kansas will receive to match Medicaid payments compared to the approved budget. For FY 2011, KHPA's Medicaid assistance budget is $1,226,228,635, including $351,204,882 from the State General Fund. This amount is the Spring 2010 consensus caseload amount adjusted for Legislative action. Applying the revised FMAP rate provided by the Division of the Budget for FY 2011, the federal share of the approved budget for KHPA Medicaid assistance would be decreased by $32.0 million. That amount would have to be replaced by State General Fund dollars or expenditure reductions.

KANSAS
DEPARTMENT ON AGING

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

Joint Committee on
Home and Community Based Services Oversight
Sept. 8, 2010

KDOA Responsibilities for Adult, Abuse and Exploitation

Martin Kennedy, Secretary

The Kansas Dept on Aging Licensure and Certification Commission is responsible for the licensing and certification surveys of all adult care homes. In addition to annual surveys, Health Facility Surveyors conduct abbreviated or complaint surveys in response to complaints received through the Complaint Program's hotline. Surveyors investigate allegations of abuse, neglect, exploitation and/or inadequate care and services. Investigations are conducted to assure compliance with federal nursing home and/or state adult care home regulations as appropriate in addition to KSA 39-1401(a)(1)(3)(b) for residents in KDOA licensed adult care homes.

Complaint intake specialists are responsible for recording accurately the complainant's allegation(s) into the Aspen Complaint/Incidents Tracking system. The complaint is then triaged in accordance with federal guidelines and the seriousness of the allegation:

1. Immediate Jeopardy (IJ)- a complaint triaged at this level must be investigated same day or next business day depending on the nature of the allegation.
2. Non-IJ, Actual harm-an allegation of actual harm (as defined by the State Operations Manual) to a resident requires onsite investigation to start within 10 working days.
3. Non-IJ Medium-these complaints are assigned for investigation within 30, 60 or 90 days
4. Non-IJ Low-these complaints are assigned for investigation at the time of the next annual resurvey or within 180 days whichever occurs first.
5. Administrative Review-these complaints are handled off-site through review of a facility's self investigation

Investigations include conducting the appropriate survey task to evaluate the allegation and standard investigation techniques of observation, interview and record review.

New England Building, 503 S. Kansas Avenue, Topeka, KS 6660
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Home and Community Based Services Oversight
Date: 9-8-10
Attachment: 4

Joint Committee on
Home and Community Based Services Oversight
Sept. 8, 2010

Defining Crisis Exceptions for HCBS-FE Services
Martin Kennedy, Secretary

Crisis Exception Criteria:

Oral Health
(1) Did the customer have a treatment plan in place prior to 1/1/2010? What point is the dentist in working with the customer on the total oral procedure/plan?

(2) Does the customer require emergency treatment to resolve an oral health issue that is life threatening?

(3) How will non-treatment of the oral health issue impact the customer?

The staff who review the oral health requests take into consideration the responses to the three questions above. In addition, the narrative is reviewed for critical oral health symptoms such as infections, abscesses, sores, or degree of decay in combination with diseases such as diabetes, heart conditions, etc.

Preliminary Questions for Assistive Technology, Comprehensive Support and Sleep Cycle Support:
(1) Does customer have family or friends within a close proximity to provide daily informal supports?

(2) Has there been an APS confirmation of self-neglect or abuse?

(3) Is the customer isolated or lives alone?

(4) Does the customer have a cognitive impairment? What is the severity of the cognitive impairment?

(5) Is the customer in the end stages of an illness and receiving hospice care?

(6) Did the customer score a "4" in toileting, transferring, medication management/treatment, and walking/mobility?

The staff reviewing these preliminary questions looks for critical responses to determine the severity of the circumstances that leads to lack of support for the senior requesting the crisis

exception. The six questions are considered for the complete picture and do not stand alone as an individual question. Additional questions to the service or services requested are as follows:

Assistive Technology

(1) Does the customer meet the criteria in Preliminary Question #1?

(2) Does the customer meet the criteria in Preliminary Question #3?

(3) Has the customer had surgery in the last 30 days that resulted in a loss of functional ability or mobility? Surgery must have been due to stroke, broken hip, or other medical incident/justification and they must list the reason for the surgery.

(4) Is the customer being discharged from NF/Hospital/Rehab?

(5) Is the Assistive Technology necessary to be received in the first 30 days of discharge to the community?

The item requested is included on the Crisis Exception Request Form.

Comprehensive Support

(1) Is the customer a MFP Grant Program transfer? (If yes, automatically approved.)

(2) Is the customer in the end stages of Alzheimer's?

(3) Does the customer suffer from a brain injury with memory loss?

(4) Does the customer require supervision for elopement that is likely to result in danger to self?

Sleep Cycle Support

(1) Is the customer a MFP Grant Program transfer? (If yes, automatically approved.)

(2) Does the customer have a documented health and welfare need? If yes, a doctor's letter can be attached that explains specifically how and in what way there is a health and welfare need. Health and welfare need would include bedridden and requiring turning or toileting; certain medical interventions. Two sub questions include: What is the health and welfare need? What is the medical intervention that is needed?

The KDOA staff reviewing the requests for assistive technology, comprehensive support and/or sleep cycle support review the responses to the specific service need questions. The information combined with the narrative explaining the specific issues such as hospitalizations, medical conditions, and other health and welfare needs are taken into consideration for approval.

Impact on Recipients:

	Services Requested	Services Approved
Oral Health Services	78	8
Sleep Cycle Support	96	4
Comprehensive Support	33	1
Assistive Technology	38	0
Total	**245**	**13 (5%)**

Estimated Cost of Restoring Services:
The four services prior to the implementation of the Crisis Exception process served an are estimated to serve 600 seniors at a monthly cost of $903 per month for a total cost of $6.5 million. All four services are part of a comprehensive service package that, based on need, assists helseniors in maintaining their independence and remain healthy andin their home.

KANSAS
DEPARTMENT ON AGING

Home & Community Based Services Oversight 9-8-2010 5

Joint Committee on Home and Community Based Services Oversight

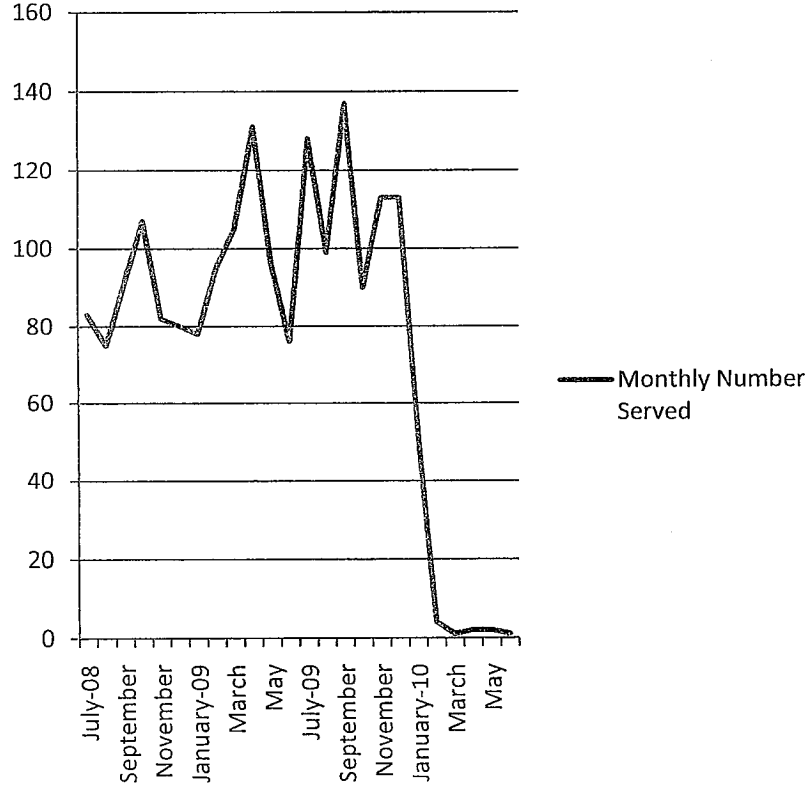
Sept 8, 2010

Impact of Removal of Oral Health Care from HCBS Waiver Services

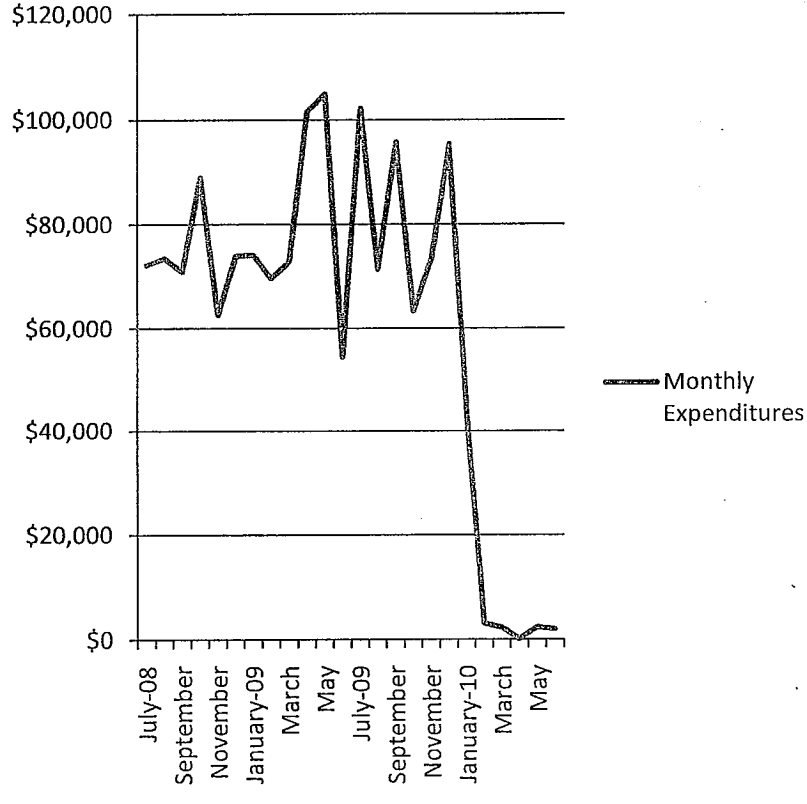
Kansas Department on Aging
Bill McDaniel, Commissioner
Program & Policy Division

Impact of elimination of oral health services for HCBS-FE by month

Recipients



Expenditures



Home and Community Based Services-Frail Elderly
Impact of Reducing Oral Health Services

	Number Served	Monthly Cost-Per Person	Total Expenditure
July-08	83	$869	$72,160
August	75	980	73,499
September	91	779	70,871
October	107	832	89,002
November	82	763	62,553
December	80	924	73,928
January-09	78	950	74,126
February	95	732	69,566
March	105	694	72,843
April	131	775	101,588
May	96	1,093	104,958
June	76	716	54,400
Total Expenditures			$919,494
Fiscal Year Averages	92	$842	
July-09	128	$799	$102,266
August	99	721	71,376
September	137	699	95,794
October	90	703	63,248
November	113	648	73,183
December	113	845	95,457
Total Expenditures			$501,324
Year to Date Average	113	$736	
January-10	52	839	$43,643
February	4	766	3,064
March	1	2,244	2,244
April	2	47	94
May	2	1,160	2,320
June	1	1,993	1,993
Total Expenditures			$53,358

KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS

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Testimony on:

Medical and Hospital Costs Related to the Lack of Access to Dental Care

Presented to:

Home and Community Based Services Oversight Committee

By:

Connie Hubbell, Director of Governmental Affairs
Kansas Association for the Medically Underserved

September 8, 2010

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Home and Community Based Services Oversight
Date: 9-8-10
Attachment: 6

Good morning Mr. Chair and members of the Home and Community Based Services Oversight committee. I am Connie Hubbell, Director of Governmental Affairs for the Kansas Association for the Medically Underserved, (KAMU). KAMU represents 39 safety net clinics in the state, including 17 that provide dental care. In 2009, there were 382,287 total medical visits and 99,945 total dental visits to safety net clinics in Kansas.

I have been asked to speak on the medical and the hospital costs related to the lack of access to dental care in Kansas.

Prior to discussing this, I would like to provide you some general information on oral health as well as an update on the workforce concerns and access issues as they relate to dental care in our state.

Kansas is clearly experiencing a shortage of dentists. The severity of the shortage was outlined in a workforce report published last year by KDHE's Bureau of Oral Health. But, more importantly, we see the shortage firsthand as everyday Kansans struggle with the pain of dental health problems....as our community hospitals treat what should be preventive care issues in a costly ER setting...as thousands of Kansans flock to the annual Mission of Mercy event as a last hope of getting the dental care they need.

More specifically, here's what we know:

- Population shifts in Kansas over the past few decades have created a workforce shortage for many of our communities. The shortage of dentists in these communities is of particular concern.

- In fact, out of the 105 counties in Kansas, 91 do not have enough dentists to serve their populations and 14 Kansas counties have no dentist at all.

- 63% of Kansas dentists are practicing only in urban areas.

- The average dentist is approaching retirement age. As these dentists begin to retire, we can't recruit and retain new dentists at a fast enough rate to replace them. This is especially true for our rural communities.

These workforce shortages are –and will continue to – result in serious health problems for Kansans.

- Without dental access, many Kansans are forced to go without the check-ups and preventative care needed to stay healthy.

- Dental health isn't just about teeth – We know poor dental health leads to health problems throughout the body, including heart disease, diabetes, and stroke. Gum disease during pregnancy can lead to premature births and low-birthrate babies, both of which are contributing to our state's high infant mortality rate.

- For children, in particular, poor dental health can lead to lifelong medical problems and greatly impact their ability to learn in school.

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- The lack of access in Kansas is compounded by the fact that only 25% of dentists in our state accept patients insured through Medicaid. Comparatively, 80% of Kansas physicians see Medicaid patients as part of their practice.

The costs associated with lack of dental access in Kansas are many and varied. Not only is there a financial cost, but there is also a human cost when people need dental care but cannot find a dentist that can provide services.

- Nationally children miss 51 million hours of school due to dental problems. And, employers lose 164 million work hours – not to mention reduced productivity – because of dental problems within our workforce. (CDC)

- According to the Journal of Dental Education, oral-related illnesses account nationally for 3.6 million days of bed disability, 11.8 million days of restricted activity and 1 million lost school days.

- Preventative care and early detection and treatment save $4 billion annually in the United States. (Delta Dental)

- Dental-related problems continue to burden our community hospitals and safety net clinics through costly emergency room visits and uncompensated care. In fact there were at least 6,078 emergency room (ER) visits to Kansas hospitals last year related to dental needs.

- Vulnerable Kansans – especially senior citizens, the disabled and children- are particularly affected by the lack of access to dental care.

- $106 billion is expected to be spent by Americans on dental care in 2010. That includes expensive treatments – everything from fillings to root canals – which could be mitigated or avoided if Kansans had access to adequate dental care.

- When we consider the cost of treating dental health problems in an ER setting rather than through preventive care methods, there are numerous stories that illustrate the problem.

    - Some of you may be familiar with the cost of Deamonte Driver's hospitalization. Deamonte's treatment cost an estimated $250,000 in an emergency room setting rather than the estimated $80 it would have cost to treat the problem early on in a dental office. And this child probably would have lived to see his 13th birthday.

    - Unfortunately, these stories – and the health care costs associated with them – are happening right here in Kansas too. Nine year old Michael was carried into the Community Health Center of Southeast Kansas dental clinic in Pittsburg with a high temperature and an abscessed tooth. He was within hours of being admitted to the hospital. The dental staff gave him a large dosage of antibiotics, and his tooth was extracted. His relief was instantaneous and while still uncomfortable due to the infection, the look in his eyes said it all.

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- A patient presented at a mini Mission of Mercy Urgent Dental program with the need for a full upper denture and a lower partial and she said she was told by her employer that she could not come back to work until she had her teeth fixed. She worked as a waitress making less than $2.50 per hour plus tips.

- The cost of providing preventive dental treatment is estimated to be 10 times less costly than managing symptoms of dental disease in a hospital emergency room. So, if we put those savings into context in Kansas: ER visits related to dental problems are costing our community hospitals – and all of us through health insurance premiums. By increasing access to dental care on the local level, Kansans stand to reduce those costs each year and - more importantly – to hold the line on these increasing costs as the dental workforce shortage worsens in our state.

Mr. Chairman and members of the committee: It is difficult to identify the exact costs for medical care and hospitalizations in Kansas due to lack of access to dental care as the health care industry does not have specific codes that allow us to collect that information. We are aware through experiences and outcomes that Kansans are shouldering substantial financial costs, economic costs and human costs because of the lack of access to dental care in Kansas – especially for those in rural areas, our elders, and those insured through Medicaid or not at all.

Thank you and I would be glad to stand for questions.

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Reflections on Success: Health Center Voices

Kansas

Community Health Center of Southeast Kansas
Pittsburg

Little nine-year-old Michael was carried into the Community Health Center of Southeast Kansas (CHCSEK) dental clinic in Pittsburg, Kansas with a high temperature and an abscessed tooth. He hadn't eaten solid foods in weeks—the lunch ladies at his elementary school in Coffeyville had fixed him oatmeal to make sure he had nourishment. The school nurse also visited with his disabled grandmother with whom he lived. She had no transportation and there was no dentist in the community that accepted Medicaid. Although the CHCSEK clinic was 77 miles and 90 minutes away, the school nurse called and the staff told her to proceed immediately to the health center. Crying and so very afraid when he arrived, he was bundled into blankets and taken into a quiet corner where the dental assistant held him while the dentist examined him. The problem was obvious and, as staff said later, the amount of pain he must have endured for weeks greatly moved the staff. He was within hours of being admitted to a hospital. After being given a large dose of antibiotics, the tooth was extracted. His relief was instantaneous and while still uncomfortable due to the infection, the look in his eyes said it all.

We continue to provide care for Michael—he had extensive decay throughout his mouth. When staff went to his school a few months later to screen 700 other children, he took the hands of CHCSEK staff, led them into his classroom and announced "These are my friends and they will help you."

ORAL HEALTH KANSAS

Joint Committee on Home and Community Based Services Oversight
September 8, 2010

Chairman Bethell and members of the Committee, thank you for the opportunity to talk with you today about the impact of the HCBS dental benefit cuts. My name is Tanya Dorf Brunner, and I am the Executive Director of Oral Health Kansas. We are a statewide advocacy organization that promotes the importance of lifelong dental health by shaping policy and educating the public so Kansans know that all mouths matter.

In 2007 the Legislature established dental services for people who are on the developmental disabilities (DD), physical disabilities (PD), traumatic brain injury (TBI) and frail elderly (FE) Medicaid Home and Community-Based Services (HCBS) waivers. Since then thousands of Kansans have had access to basic dental services, including cleanings, root canals, and basic fillings.

In January 2010 the dental services for people on the PD, DD, and TBI waivers were eliminated, and dental services for people on the FE waiver will be accessed only through a rare crisis exception. Eight people have received services through the FE waiver crisis exception so far.

Prevention

Oral Health Kansas has been working with at least one of the Area Agencies on Aging and many Community Developmental Disabilities Organizations to stress preventive oral health care. While it is important to ensure people on the waivers (and all people) brush and floss well, the most effective preventive care only can be provided through routine visits to a dentist. Research shows that people who receive routine dental services tend to be able to manage oral health problems that could lead to more serious and costly health problems, including pneumonia, strokes, and heart conditions.

The New York University College of Dentistry released a study just last month noting the connection between gum inflammation and Alzheimer's Disease. (http://www.nyu.edu/about/news-publications/news/2010/08/03/new-evidence-supports-link-between-gum-inflammation-and-alzheimers.html)

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Dr. Angela Kamer, Assistant Professor of Periodontology & Implant Dentistry, examined 20 years of data regarding a possible link between periodontal disease and Alzheimer's disease. "The research suggests that cognitively normal subjects with periodontal inflammation are at an increased risk of lower cognitive function compared to cognitively normal subjects with little or no periodontal inflammation," Dr. Kamer said.

Emergency dental visits

We know emergency rooms frequently become the provider of last resort for people who are uninsured, including for people who have no means to pay for dental care. A 2009 study by the California HealthCare Foundation showed the cost of dental neglect:

Periodic oral exam	$41
Comprehensive oral exam	$60
Emergency room visit without hospitalization	$172
Emergency room visit with hospitalization	$5044

The study also noted that emergency room dental visits were frequently due to preventable dental conditions, such as tooth decay, abscesses, and periodontal diseases. One of the findings was that the ED visit rate for preventable dental conditions, without hospitalization, was higher than that for diabetes. (http://www.chcf.org/~/media/Files/PDF/E/EDUseDentalConditions.pdf) The state of Michigan also has examined the cost of emergency room dental visits and found that when Medicaid stopped covering dental services, the number of dental visits increased dramatically.

Real impact on people

Absent a comprehensive cost study of emergency room dental visits in Kansas, we have anecdotal stories of people affected by the cuts.

Douglas County:

In October 2009 Mary visited the clinic for a lengthy appointment to restore 13 teeth, extract one, and undergo a deep cleaning. It would not have been possible to do any of this without sedation. In addition to the Medicaid waiver covering all the necessary dental treatment, it also covered the sedation. When Mary left the clinic last year, she had been restored to good oral health. Unfortunately, we have not been able to accomplish anything more since the discontinuation of funding to the waiver because sedation is very costly and Mary's family does not have the means to pay for this expense out of pocket so we are unable to even provide routine preventative care to her.

Douglas County:

Ashley has been a patient since 2006. She has periodontal disease and is on a three month recall for cleanings. Preventative appointments were covered under the Medicaid waiver twice per year so we would see Ashley here in the clinic twice a year and were able to submit claims to Medicaid for these services, and then another two times at the Cottonwood clinic for which we could not bill Medicaid. Ashley was able to cooperate for preventative appointments but not for restorative. In March of 2009, it was identified at one of her preventative appointments here in the clinic that she had six cavities. We attempted restorations without sedation and were unsuccessful. In June of 2009 we were able to treat Ashley under sedation in our office. Since this time we have seen Ashley four times for preventative appointments and at her last appointment in July 2010 she had additional diagnosed decay that needed treatment. We are unable to provide this treatment to Ashley without the waiver because we cannot sedate her and she is unable to be treated without it.

Franklin County:

Max has to have dentures because of lack of care for his teeth. The dentist requires $2700 up front before he will make the dentures. Because he has received a back payment from Social Security, he has the money to get his teeth. Without this happenstance, he would continue with his current bad teeth because he could not afford dentures or dental visits.

Financial impact

When waiver dental services were in effect, the cost to provide them was extremely low. Nearly five thousand Kansans per year benefitted from an investment of approximately $600,000 SGF. Even without a comprehensive study, we know the return on investment of this $600,000 is high. Dental services help people keep their mouths healthy, avoid or manage some chronic health conditions, and gain confidence. All people are able to accomplish more and enjoy life more when they can smile confidently.

HCBS waiver	FY 2010 SGF savings (projected)	Estimated Annual SGF cost	Estimated Number of People affected
Frail Elderly	$ 113,310	$ 226,620	1038
Physical Disabilities	$ 78,121	$ 156,242	1345
Developmental Disabilities	$ 101,294	$ 202,588	2391
Traumatic Brain Injury	$ 7,045	$ 14,090	111
Total	**$ 299,770**	**$ 599,540**	**4885**

I am happy to stand for any questions.

Tes ıy # 1

2007: for the winter months (October-March):at least 10 residents at a time were in the hospital for respiratory issues over a 3 month period concurrently, mind you the residents would change however, not the numbers by much you could give a variance of 1-2 residents at a time. There were big census variances as well.

2008: for the winter months (October-March): only 5 residents maximum at one time have been in the hospital for any type of respiratory issues, however only 1-2 of these residents went for actual respiratory problems keep in mind that one of these residents has Barretts Espophagitis as well as aspiration pneumonia and he is a revolving door to the hospital for respiratory problems not related to oral care. Our residents now go to the hospital for critical reasons: ie, GI bleed for blood transfusions, cardiac related symptoms, electrolyte imbalances or even skin issues if needed. The numbers have dropped dramatically since implementing the Oral Health Training Program. Census has not changed very much. (With this case the Director of Nursing noticed a decrease in the number of hospital cases from one year to the next and attributed the decrease to having the Oral Health Training Program in place)

#1 a *We have also sent residents to the dentist for tooth extractions that would have otherwise caused tooth pain to then decrease appetite then decrease food intake then could result in a weight loss. However, by doing quarterly exams on all the residents I feel we are on top of these issues and get the problems resolved sooner.*

Testimony # 2

One resident was repeatedly having tearful episodes at meal time and would leave the dining room crying. The resident was prescribed Seroquel (psychotropic medication) and placed on the Special Care Unit and was monitored for behavior issues. She was evaluated her and we all thought that it was a behavior. Well, a few weeks passed and the behavior continued. One day while sitting with the resident in the dining room she made the comment on how her teeth hurt when she ate. The program allowed us to examine her teeth at which time we discovered all six lower teeth remaining were broken and had dark spots on them. The resident was referred to a dentist. We scheduled an appointment for her to see the dentist. In the meantime though her family was somewhat reluctant to send her to the dentist as she had not seen in one 30 yrs.. I reminded them that she was having difficulties with meals, and having pain. They agreed and within a month of seeing the dentist she had all of the lower teeth pulled and had dentures placed. Since having her teeth removed, we have also discontinued the Seroquel she was on for her tearfulness and behavior problems as this stopped after having her teeth removed and dentures placed. Nice to know that it was not a behavior but pain induced that could be fixed and that we could discontinue an unnecessary medication.

Testimony # 3

Resident was non verbal and stayed in her room even for her meals. Resident having some signs/symptoms of hot and cold intolerance and had multiple broken teeth. Referred to dentist and sent to oral surgeon for extraction of all teeth remaining. For several weeks after extractions, Resident resisted food and drink but has since began eating better and seem more content. Smiles more often. No signs/symptoms of oral issues now and she is coming out to the dining room for her meals.

Loretta J. Seidl RDH, MHS
Director of Oral Health
Kansas Health Care Association

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KANSAS
DEPARTMENT ON AGING

Joint Committee on Home and Community Based Services Oversight

Sept 8, 2010

Update on Senior Care Act Sliding Scale

Kansas Department on Aging
Bill McDaniel, Commissioner
Program & Policy Division

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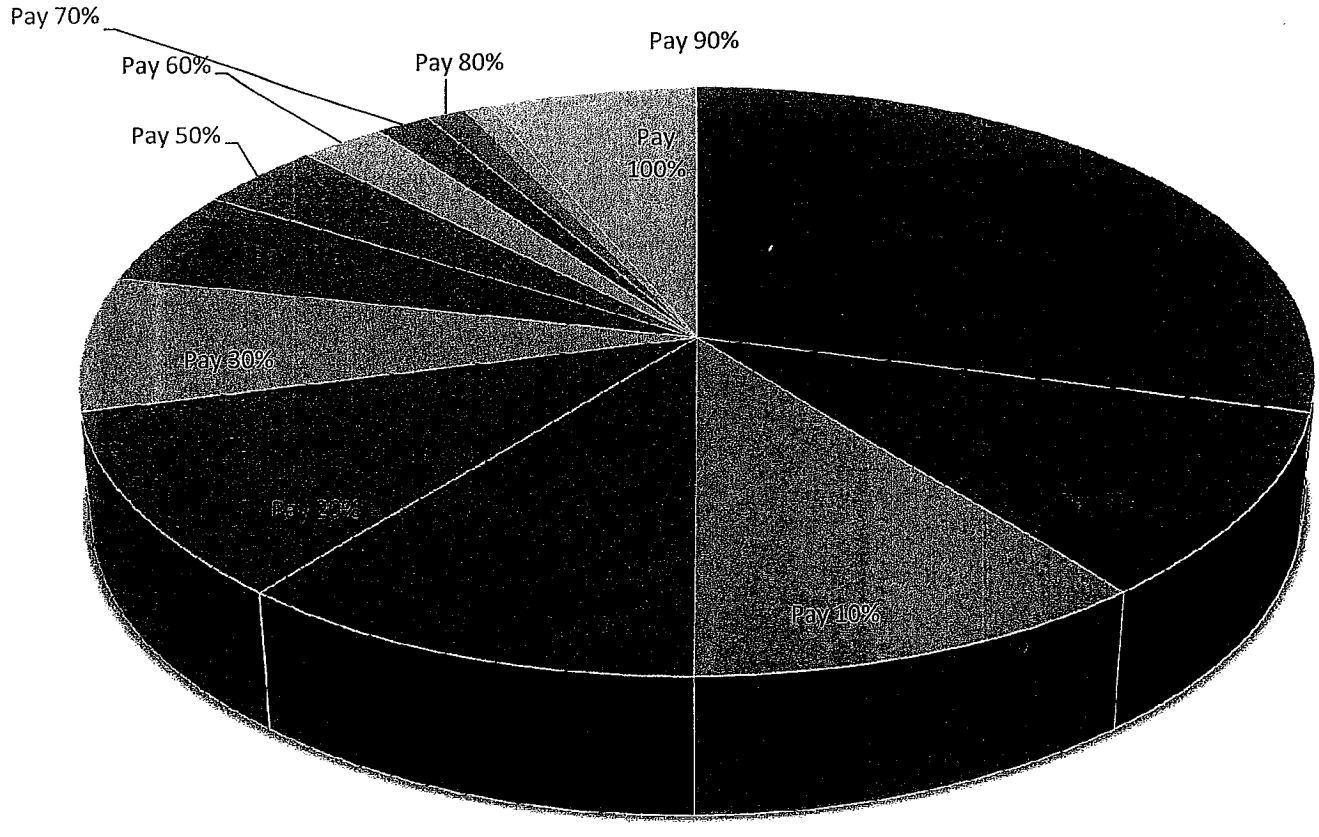
Senior Care Act Sliding Scale

- The KSA 75-5928 established the Senior Care Act (SCA), "...a program of in-home services for residents of Kansas 60 years of age or older who have functional limitations which restrict their ability to carry out activities of daily living and impede their ability to live independently." The SCA has a provision for charging customers a fee as follows:

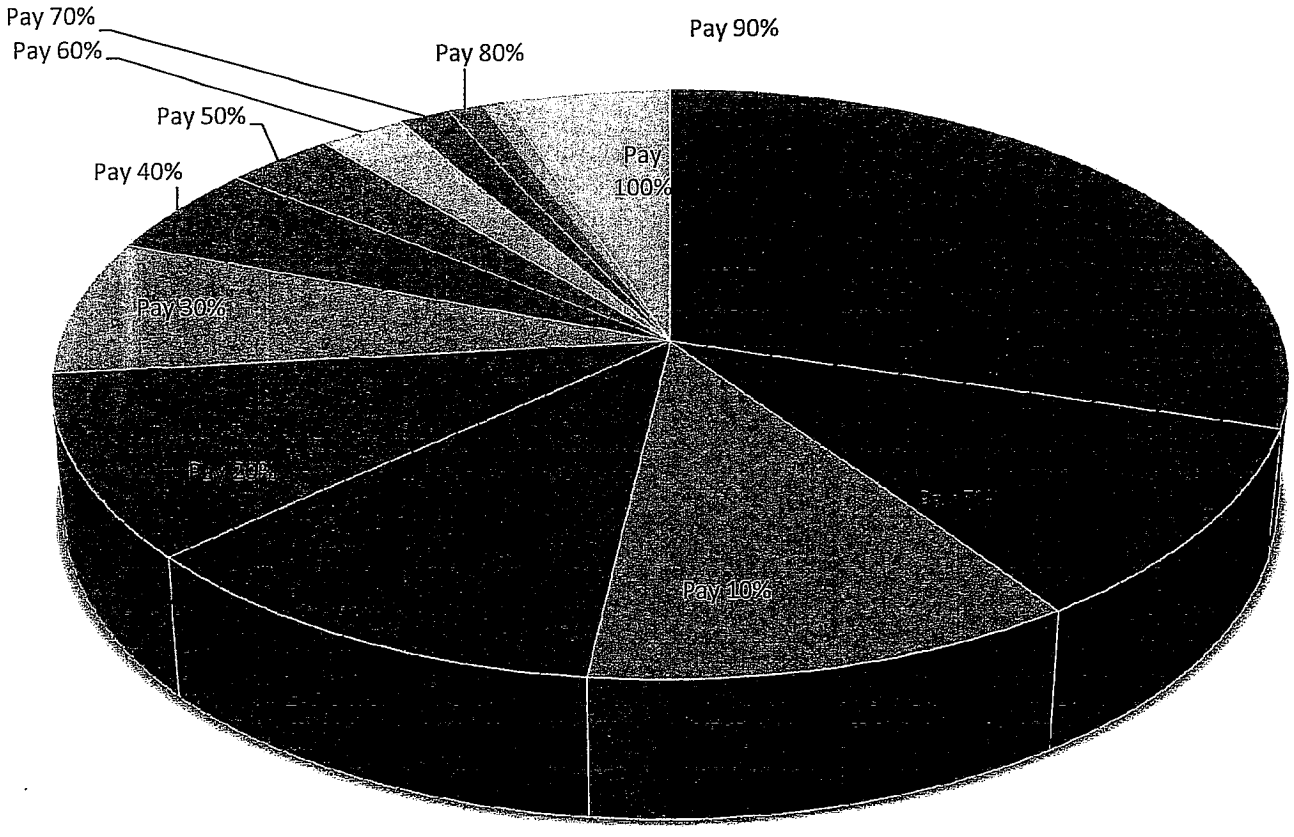
  75-5933 Same, fees, guidelines. The Secretary shall develop a sliding fee scale which shall be published annually in the Kansas Register. Each customer's fee shall be based on the customer's income and assets. All customer fees and donations shall reduce the cost of services paid by the department on aging under the Kansas senior care act.

- The sliding fee scales include a family of one and a family of two. The starting income level is based on the federal poverty level. The more income and liquid assets a senior has, the larger percentage they must pay for the services.

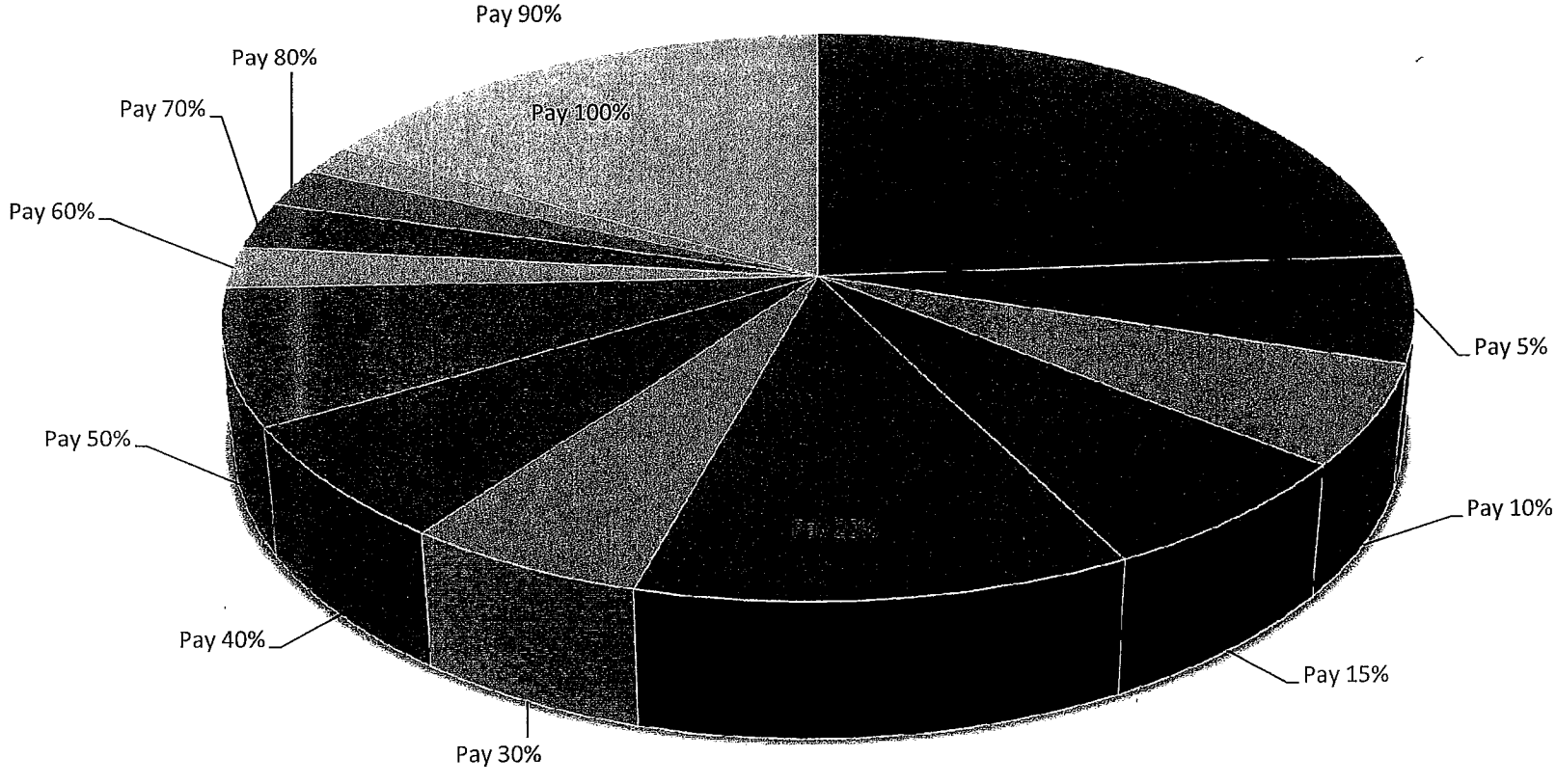
Senior Care Act Customers for All Family Sizes by Customer Responsibility Percentages



Senior Care Act Customers with One-Person Families by Customer Responsibility Percentages



Senior Care Act Customers with Two-Person Families by Customer Responsibility Percentages



Number of SCA Customers Statewide for SFY 2010 by Family Size and Customer Responsibility Percentage*

**Note: The table does not include any SFY 2010 customers who had only ASMT, CMGTJ or CMGTS services. Also, the table reflects SFY 2010 KDOA payments in AdHoc as of Sept. 1, 2010.*

Customer Responsibility Percentage	Family Size 1		2		3		4		5			
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Total Count	Total Percent
0%	1,007	29.87%	100	24.04%	1	100.00%		0.00%		0.00%	1,108	29.22%
5%	361	10.71%	25	6.01%		0.00%		0.00%	1	100.00%	387	10.21%
10%	380	11.27%	24	5.77%		0.00%		0.00%		0.00%	404	10.65%
15%	384	11.39%	28	6.73%		0.00%		0.00%		0.00%	412	10.86%
20%	342	10.15%	49	11.78%		0.00%		0.00%		0.00%	391	10.31%
30%	252	7.48%	24	5.77%		0.00%		0.00%		0.00%	276	7.28%
40%	170	5.04%	28	6.73%		0.00%	2	100.00%		0.00%	200	5.27%
50%	109	3.23%	32	7.69%		0.00%		0.00%		0.00%	141	3.72%
60%	87	2.58%	10	2.40%		0.00%		0.00%		0.00%	97	2.56%
70%	52	1.54%	11	2.64%		0.00%		0.00%		0.00%	63	1.66%
80%	35	1.04%	9	2.16%		0.00%		0.00%		0.00%	44	1.16%
90%	23	0.68%	7	1.68%		0.00%		0.00%		0.00%	30	0.79%
100%	169	5.01%	69	16.59%		0.00%		0.00%		0.00%	238	6.28%
Grand Total	3,371	100.00%	416	100.00%	1	100.00%	2	100.00%	1	100.00%	3,792	100.00%

Association of Community Mental Health Centers of Kansas, Inc.

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Telephone (785) 234-4773 Fax (785) 234-3189
Web Site: www.acmhck.org

Michael J. Hammond
Executive Director

September 7, 2010

The Honorable Bob Bethell, Chairman
HCBS Oversight Committee
Statehouse, Room 55 South
Topeka, KS 66612

RE: Follow up to August 16th Testimony

Dear Mr. Chairman:

During my testimony on August 16th, I offered to provide the Committee with a copy of the relevant section of the Participating Community Mental Health Center (CMHC) contract with the Kansas Department of Social and Rehabilitation Services (SRS) which allows the CMHCs to triage clients for services. I have enclosed that for the Committee's information.

If you have any questions about this information or on any other issue, please feel free to contact me at (785) 230-3577.

Thank you.

Sincerely,

Michael J. Hammond
Executive Director

Enclosure

Home and Community Based Services Oversight
Date: 9-8-10
Attachment: 10

AGREEMENT FOR PARTICIPATING COMMUNITY MENTAL HEALTH CENTER
CONSOLIDATED CONTRACT
MHCC 11-028
48-0576044

This Agreement is made and entered into this 1st day of July, 2010 by and between Wyandot Center for Community Behavioral Healthcare, Inc., whose address is P.O. Box 171578, Kansas City, KS 66117, hereinafter referred to as "CMHC" or "Center", and the Secretary of the Kansas Department of Social and Rehabilitation Services, whose address is 915 SW Harrison, Docking State Office Building, Topeka, Kansas 66612, hereinafter referred to as "SRS" or "Secretary".

Whereas, the Secretary, authorized by K.S.A. 39-708c to enter into contracts, desires to fund medically necessary mental health services for individuals needing services within the CMHC's designated county(ies) of Wyandotte;

Whereas, the CMHC is a recognized provider of said goods or services and desires to provide the same to the citizens of Kansas.

Whereas, K.S.A. 19-4001 et seq. authorizes the board of county commissioners to establish community mental health centers and states that no persons shall be denied community mental health services because of their inability to pay;

Whereas, K.S.A. 39-1602 states that "'Target Population' means the population group designated by rules and regulations of the secretary as most in need of mental health services which are funded, in whole or in part, by state and other public funding sources, which groups shall include adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care (because of their mental illness)."

Whereas, funding included in this agreement is intended to, in part, fund the cost of community mental health services to persons with mental illness without the ability to pay;

Whereas, the state funding for this agreement has been reduced from that provided in state fiscal year 2009 and both parties acknowledge that fulfilling certain provisions of this agreement are subject to available resources;

Whereas, the CMHC must meet the licensing requirements contained in K.A.R. 30-60-1 et seq. (CMHC licensing regulations) especially emergency treatment and first response services and K.A.R. 30-61-1 et seq. especially liaison services;

Now, therefore, for and in consideration of the mutual covenants and agreements contained herein, SRS and the CMHC do hereby mutually covenant and agree as follows:

1) DEFINITIONS
   a. "Consumer" means a person with mental illness who is a direct recipient of mental health services and supports.

   b. "Youth" means a person less than 18 years of age.

   c. Persons in the priority target populations include:

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i. Youth who have a serious emotional disturbance (SED) as defined in the glossary;
ii. Adults who have a severe and persistent mental illness (SPMI) as defined in the glossary; and
iii. Other persons who, are:
    1. At risk of requiring inpatient mental health care and treatment due to their mental illness;
    2. Causing or at serious risk of causing serious harm to themselves or others due to their mental illness;
    3. Likely to experience serious deterioration in their mental health if they do not receive community mental health treatment;
    4. Homeless or at risk of homelessness due to their mental illness; or
    5. At risk of being jailed due to their mental illness.

2) SCOPE OF WORK: The CMHC shall use funds from this agreement to provide medically necessary mental health services to persons with mental illness, especially persons in the target populations. The CMHC will fulfill this scope of work to the extent possible within its available resources. If the CMHC's resources are insufficient to fulfill the entire scope of work the CMHC will, in addition to providing emergency treatment and first response services described in K.A.R 30-60-64 (a) (3), serve persons and provide services in the following priority order:

First, Inpatient screenings: Funds may be used for the cost of necessary screenings not otherwise funded through Kansas Health Solutions or the Medicaid Management Information System (MMIS);

Second, Persons in the priority target population described above who do not have the ability to pay;

Third, Liaison Services: The CMHC will actively and effectively participate in admission and discharge decisions and in treatment planning for all consumers from the CMHC's catchment area who are served in a state mental health hospital, nursing facility for mental health (NF/MH), or psychiatric residential treatment facility (PRTF);

Fourth, Persons not in the target population who do not have the ability to pay.

Determination of which individual consumer will receive priority services is based on the priority order above, the CMHC's clinical judgment, and available resources. Limitations on the scope of work will be revisited by the parties when reduced funding is restored.

3) SRS will interpret K.A.R. 30-60-1 et seq. and K.A.R. 30-61-1 et seq. consistent with the terms of this agreement and will work cooperatively with the CMHC to examine all CMHC regulations and AIMS data elements to make expeditious changes to reduce the administrative cost of providing services while maintaining consumer treatment standards. The expeditious changes of K.A.R. 30-60-1 et seq. will include needed changes to regulations that limit what the CMHC may do if a consumer refuses to pay reasonable fees for services.

4) Within the parameters described in this agreement the CMHC will:

PSH/KNI Executive Order Advisory Group

Report to SRS Secretary Don Jordan
June 2010

Background

On January 26, 2010, after considerable review and thought, Governor Parkinson responded to the report of the Kansas Facilities Realignment and Closure Commission by issuing Executive Order (EO) 10-01. That order sets the stage for some 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). One of the important parts of the Governor's order is for the Kansas Department of Social and Rehabilitation Services (SRS) to work in cooperation with Community Developmental Disability Organizations (CDDOs) to establish standards related to state hospital services and also to increase the capacity of community service providers to successfully receive into services and meet the needs of people currently being served in the state hospitals.

SRS accomplished a significant part of that collaboration by seeking recommendations about some of the key issues from an advisory group. This report summarizes the work of that advisory group and its key recommendations. In addition, SRS sponsored two focus group/listening sessions to get input from the parent/guardian groups at both KNI and PSH. Those sessions were facilitated by staff from Wichita State University's Center for Community Support & Research, and a resulting report was provided to the advisory group; in addition, each parent/guardian group selected representatives to serve on the advisory group.

Advisory Group Members

Karen Flattery, representing the KNI parent/guardian group
Mark Athon, representing the KNI parent/guardian group
Sandra Havelka, representing the PSH parent/guardian group
Scott Shepherd, representing the PSH parent/guardian group
Greg Jones, representing the PSH parent/guardian group
Ray Dalton, Deputy Secretary, Disability & Behavioral Health Services
Barney Hubert, Superintendent, Kansas Neurological Institute
Jerry Rea, Superintendent, Parsons State Hospital
Margaret Zillinger, Director, Community Supports & Services
Elizabeth Phelps, Special Assistant, Disability & Behavioral Health Services
Chad VonAhnen, Director, Sedgwick County Developmental Disability Organization
Mary Ann Keating, Director, TARC
Gordon Criswell, Director, Wyandotte County Developmental Disability Organization
Jan Bolin, Director, CDDO of Southeast Kansas
Linda Misasi, Director, Creative Community Living of Southcentral Kansas
Kathy Stiffler, Director, Individual Support Systems
Lisa Jackson, Director, Sheltered Living, Inc.
Penny Massa, State Coordinator, MOSAIC
Tim Cunningham, Director, Tri-Valley Developmental Services, Inc.

Advisory Group Charge

The PSH/KNI Executive Order Advisory Group was charged with developing recommendations to present to Secretary Don Jordan by 6.15.10, in these areas:

- Standards for KNI/PSH level of care – regarding service continuation [EO #1]
- Standards for KNI/PSH admissions [EO #2]
- Strategies to increase community capacity [EO #3]
- Strategies to introduce guardians to benefits and opportunities available in the community [EO #4]
- Strategies to successfully move from state hospital to community services [EO #5]
- Strategies to establish goals and monitor progress of KNI/PSH consolidation [EO #6], with related timeline recommendations
- Strategies to track that needs are met and quality of lives improved in community [EO #7]

Secretary Jordan will consider this group's recommendations when developing final implementation plans to meet the terms of Executive Order 10-01.

Advisory Group Process

The advisory group decided to put the issues about which they were charged to develop recommendations into the following subject matter clusters, and worked through them together as a full group:

Subject Cluster #1:

- ❖ Standards for KNI/PSH level of care – regarding service continuation [EO #1]
- ❖ Standards for KNI/PSH admissions [EO #2]

Subject Cluster #2:

- ❖ Strategies to increase community capacity [EO #3]
- ❖ Strategies to introduce guardians to benefits and opportunities available in the in community [EO #4]
- ❖ Strategies to successfully move from state hospital to community services [EO #5]

Subject Cluster #3:

- ❖ Strategies to establish goals and monitor progress of KNI/PSH consolidation [EO #6], with related timeline recommendations
- ❖ Strategies to track that needs are met and quality of lives improved in community [EO #7]

Each cluster of issues had designated point person/s to guide the related exploration/discussion, and summaries of the work sessions were developed and posted at www.DBHSUpdates.org for broader review and distribution. In addition to the members' experience and practice input, the following informing materials were utilized:

> Executive Order 10-01
> Advisory Group Charter
> Kansas Facilities Closure and Realignment Commission Report
> Charts from KNI/PSH, identifying by CDDO area the number of people currently being served there
> Current admission policies/procedures for KNI and PSH
> Current service outcome monitoring tools for community based services
> Process for community service monitoring utilized when Winfield State Hospital was closed

Advisory Group Summaries & Recommendations

Subject Cluster #1 – Admission and Service Continuation Standards for State DD Hospital Services

- ❖ Standards for KNI/PSH level of care – service continuation [EO #1]
- ❖ Standards for KNI/PSH admissions [EO #2]

2.1.05-ReviewofRequestsforAdmissiontoK

The advisory group reviewed the current policies/procedures for admission consideration at KNI:

Admission policy.docx

And at PSH:

The group also explored an array of issues related to service continuation standards, including what those standards should be, how they should be measured, effective strategies for evaluating both basic and more comprehensive pictures of each person's support needs – both in their current environment and how that may change when moving to a new environment; how parents/guardians and other members of the person's support network can be most effectively engaged in the evaluation process; what role the length of time in service at a state hospital should play; and potential due process considerations for a person moving from state hospital to community service settings. Additional details about that exploratory discussion are included in the meeting summary and not repeated here.

The advisory group's concluding recommendations are these:

1. The current admission policies and practices at both KNI and PSH are appropriate and should continue as they are. Current policies reflect the safety net functions of these facilities in the overall service system for people with developmental disabilities.

2. At this time, there should not be any "forced" selection of community services; people who currently choose to remain with state hospital services should have that option. However, one condition of that continued service choice is that the person and his/her supporters (parents/guardians and otherwise) will need to become increasingly aware of community service provider options and the community service system, including the safeguards, quality assurance, oversight, monitoring and grievance procedures available to people using that system.

3. SRS should support and facilitate a robust parent/guardian information and education process, engaging both state hospital and CDDO/community service provider staff, starting immediately and completed by March 1, 2011 (as an initial phase, with some ongoing information/education available). Additional details are included in recommendation #4 under "Subject Cluster #2" below.

4. After an information/education process, each person and his/her supporters should be required to again make a decision as to exploring community services as an option. That decision should be revisited at least annually, with barriers to accessing community services identified and strategies to address those concerns included in the person's support plan. If, by July 1, 2011, at least 53 people (out of 185) receiving services at PSH, and at least 47 people (out of 157) receiving services at KNI have not elected to transition to community services, the State should consider whether it is necessary to formally limit service continuation at PSH and KNI. Electing to transition to community services is demonstrated by the person having identified a CDDO area in which to access services and expressed a commitment to pursue the transition.

5. SRS, the state hospitals, and CDDOs/community service providers should continue to use a combination of the BASIS assessment process and individualized person-centered support planning to evaluate each person's support needs and strategies to meet those needs. When appropriate and necessary to meet the needs of any specific person, specialized funding options should be pursued and should be available within the existing structure for extraordinary funding and/or other specialized funding structures that may be or become available.

6. The length of time someone has received state hospital services should not be a determinative factor when evaluating whether or not that person can and should transition to community based services. Certainly the emotional components of the situation should be taken into account when developing the person's services.

7. The interests of a person transitioning from state hospital to community services will be considered and protected in a variety of ways. This should include some or all of the following considerations: a transition plan that allows for periods of pre-move visits; the option to return to state hospital services if the support team concludes that community services are not meeting the person's needs, at least until adjustments to the support plan can be made; factoring in an assessment as to whether the experience in the community setting is better or worse than in the state hospital setting; and the person's case manager should serve as an advocate for the person during the transition process and in any situation involving potential disruption of services, with access to SRS quality management staff if concerns are not resolved with the case manager's help.

Subject Cluster #2 – Increasing Community Service Capacity and Parent/Guardian Awareness

- Strategies to increase community capacity [EO #3]
- Strategies to introduce guardians to benefits and opportunities in community [EO #4]
- Strategies to successfully move to community [EO #5]

The advisory group explored each of the following community capacity related issues:

Assistive Technology
- Medical
- Activities of Daily Living
  - Communication, eating, dressing, recreation,
  - Hoyer lifts
- Seating
- Wheelchair repair

Behavioral
- Community mental health resources
- Hospital resources

Crises

Employment

Environmental Factors
- Noise level
- Number of individuals in the home

Funding

Housing
- Accessibility
- Environmental Factors: noise level, small or large home

Medical Specialists
- Physicians
- Dentists
- Nursing
- Numbers willing to serve persons with Medicaid funding

Oversight
- Role of CDDO as gatekeeper
- Role of SRS Quality Management Specialists

Resources
- Access to existing hospital resources

Staffing/Human Resource Infrastructure/Workforce Capacity
- Staff shortages
- Attract, train and retain a qualified, professional work force to meet the expanding need

Adequate numbers of trained staff
Availability of 24/7 support when indicated
Significant wage increases to currently low wages for direct service professionals

Transportation
Community transportation
Specialized transportation
Para Transit

Turnover
Strategies to overcome and reduce high turnover and retain quality staff
Impact on consistency
Impact on quality of care

Transition Plans
Accurate identification of needs

Training
Medication administration
Medical procedures
Suctioning
Insulin
Special diets
Identify training gaps for direct service professionals

Significant health needs, Alzheimer's and other forms of dementia, behavioral challenges, autism, or other.

For each area, the advisory group identified potential barriers, recognized that there are varying degrees of resources and provider capacity across the state, and identified some best practices. The details of that exploratory process are included in the advisory group meeting summaries and not repeated here.

The advisory group's concluding recommendations are these:

1. For each person moving from a state hospital to community based services, individualized attention to that person's needs and his/her chosen community's capabilities in each of these areas should be explored; any potential barriers specific to that situation should be identified and addressed in the person's support plan; and strategies to address each need should be articulated in the plan so that all participants are aware of and accountable for the issue, with modifications made as necessary.
    - This should include plans specific to each person for pre-move training and post-move access to state hospital staff and other support in the event there are issues which threaten the success of community placement. This should include plans for short-term return to hospital services as necessary to support long-term success.

2. Additional strategies to build community capacity to meet the needs of people transitioning from PSH and KNI should be identified based upon each person's needs, including:
    - Proactively ensuring that CDDOs have a current picture of resources and supports available in their community.
    - Enhancing the information/education available to CDDOs, community service providers, and other health care provider as to meeting the individual's needs.
    - Facilitating the partnership between CDDOs and community service providers to promptly respond to the identified needs, including by exploring available options or building additional options.
    - Continuing work of statewide work groups to explore challenging service issues and provide technical assistance or guidance.

3. As the resources available in the state hospital settings are reduced, particular attention should be given by SRS and community providers to the following issues:

- Full and adequate transition support for people moving from state hospital to community service settings.
- Clear and accessible funding options for people moving from state hospital to community settings, including for pre-move training and transition supports.

4. The most important tool for parents, guardians and family members to support people moving from state hospital to community settings is factual information about the community service system in Kansas, how to access services, core accountability features, and provider-specific abilities and skills relevant to individual service needs. To support this need, the advisory group suggests:
   - Use of a "things you should know"-type publication for all people seeking community services. The group developed a booklet for this purpose, related to residential services, day services, and targeted case management services, titled "Learning About Community Services." That guidebook is attached here:

Guardian Questions Booklet.pdf

   - SRS should support and facilitate a robust parent/guardian information and education process, engaging both state hospital and CDDO/community service provider staff, starting immediately and completed by March 1, 2011 (as an initial phase, with some ongoing information/education available), which includes these features:
     - Provider presentations at parent/guardian meetings at both KNI and PSH (the frequency of which may need to increase during this information process), or at other areas around the state, open to any interested community service provider, focusing on services available in the area and/or on specific services the provider delivers.
     - Joint SRS and CDDO presentations at parent/guardian meetings at both KNI and PSH, focusing on the role and responsibilities of CDDOs and SRS staff in the community service system, including quality assurance and other accountability functions.
     - State hospital staff providing outreach and information to the people supporting each person receiving state hospital services, to assist in exploring community service options.

     And additional information/educational activities to more fully address individual interests and information needs, to be completed by March 1, 2011, including:
     - Facilitating parent:parent, family:family, and/or one-on-one CDDO/Community Service Provider:customer discussions and supports, pairing those who have made or supported the transition to community services with those who are preparing for that transition.
     - Community service provider fairs or other outreach/education materials made available to parents/guardians.

5. Successfully making the transition from state hospital services to community based services will be supported by well-informed people and their guardians/supporters working through the steps that we have used for many successful transitions in the past. A summary of those steps is captured in the attached flowchart, which will be available to all state hospital parents/guardians as an overall transition success tip sheet.

Steps to Success - Transition Flowchart (

Subject Cluster #3 – Monitoring Progress and Tracking Quality

- ❖ Strategies to establish goals and monitor progress of KNI/PSH consolidation [EO #6], with related timeline recommendations
- ❖ Strategies to track that needs are met and quality of lives improved in community [EO #7]

dvisory group explored a variety of strategies that can be used to effectively connect a specific person and his/her supporters to the CDDO and community service providers in the area(s) of the state they are interested in living. Those strategies vary based upon the person's situation and interests; some of them are captured in the recommendations at subject cluster #3, and others are captured in the meeting summary as a resource and not repeated here. Likewise, some effective practices and system information related to quality monitoring are included in the advisory group meeting summary and not repeated here.

The advisory group's concluding recommendations are these:

1. There already exists a comprehensive service quality monitoring process in the community service system across Kansas, which is tied to each individual's person-centered support plan and includes these elements:
   - SRS's Regional Quality Management Specialist staff (25 staff statewide) – utilizing the Kansas Quality of Living (KLO) instrument utilized to monitor and evaluate services
   - CDDO quality assurance processes
   - Community service provider quality assurance systems
   - Person-centered support planning development and targeted case manager monitoring

2. The overall quality assurance and outcome monitoring process that was used with the closure of Winfield State Hospital was an effective process, the elements of which should be replicated during the consolidation of KNI and PSH services. Those elements include:
   - Receive notification of the date and location for each person moving into the community - 7 days prior to moving – SRS regional staff
   - Assure all sites and services are appropriately licensed – SRS regional staff
   - Visit each person in their new home and day service site 7 days following the date of move – SRS regional staff
   - Provide on-going follow-up through on site review of the implementation of the person centered plan and visits with the person and those who know and care about them including guardians and the State Hospital Placement Team. This follow-up will continue until all members of the person's support network are confident that services are meeting the person's needs. This will occur every 30 days following the move.
   - The State Hospital will be available throughout the transition period to provide consultation and staff assistance to the community provider as requested.
     - The advisory group recommends that a state hospital staff member who is familiar with the person make an on-site visit to the person in his/her new community service setting at least once within the first 30 days after transition, to help ensure all needs are being met.
   - The community service provider will convene a meeting 60 – 90 days after placement with those who know the individual to review the original plan and make any necessary changes.
   - The State Hospital will serve as a backup when there is a need to return an individual to the state hospital if short term hospital services are needed or the placement is not working for whatever reason.

3. SRS should utilize the elements identified in #1 and #2 above, and develop a focused process that will track and monitor services for people moving from KNI or PSH to community services, ensuring that each person is included in the review process both initially, at 6 months after moving date, and at 1 year after moving date. At each of those three touch points, SRS will complete a consistent monitoring tool that assesses the person's key outcome issues over time. All advisory group members have agreed to review and provide feedback on the monitoring tool.

Advisory group members appreciated the opportunity to assist in the exploration of these important issues, and will remain available to assist with the KNI/PSH consolidation process if requested.

SUBJECT

Review of Requests for Admission to KNI

PURPOSE

To provide criteria for considering requests for admission to KNI.

POLICY

Admission to KNI can occur for an individual when a KNI Service Request Review Team confirms:

- Eligibility for and need of an ICF/MR level of care.
- Primary diagnosis of mental retardation.
- Age of 18 or older.
- Referral has been made by the Community Developmental Disability Organization (CDDO) for the area in which the person resides.
- Agreement by the CDDO that appropriate community services are not available to meet the person's health and safety needs.
- Agreement by KNI staff that the person's current support needs may not reasonably be met through the community services system.
- Institutionalization is the least restrictive alternative available (K.S.A. 76-12b03).
- Compliance with the criteria for Emergency Short Term Admissions as adopted by the Secretary of SRS, when appropriate.

PROCEDURES

1. Requests for admission will be made on the State Mental Retardation Hospital (SMRH) Request Form, according to procedures governing use of that form. All requests for admission require the signature of the Director of the CDDO or designee attesting that the person's needs cannot be met adequately within the community service system, that admission is believed to be the least restrictive alternative available to meet the person's needs at this time, and that the Director or designee will actively work to support the person's return to community services within an agreed time period. The request must include the expressed opinion of the Quality Enhancement Coordinator.

2. When a request for admission is received, the Superintendent or Program Director will convene a KNI Service Request Review Team to review information about the person for whom admission is being considered. This team will generally include the Superintendent, the Program Director, the Community Support Coordinator, the Residential Unit Director for the Residential Unit in which the person might live and other pertinent staff to be determined based on the needs of the person. If serious consideration is being given to admitting a person, this team might also include Medical staff, the Health Care Coordinator (HCC), Psychology staff, a Qualified Developmental Disabilities Professional (QDDP), Client Training Supervisor (CTS), representatives of the CDDO and Community Service Provider (CSP), the person's guardian, the person, or others.

3. If additional documentation or records are needed, the KNI Community Support Coordinator will request this information from the CDDO, CSP, guardian, or other entities.

4. In most instances, efforts will be made to meet the person's needs in the community by offering outreach support rather than admitting the person to KNI.

5. If serious consideration is being given to admitting a person to KNI, a group of KNI staff members will be selected to visit the person to meet the person face to face and to gain additional information about the person's needs. The purpose of this visit (or series of visits) will be to confirm that the person appears to be in need of services from KNI, to determine whether the person's needs might be met through providing outreach services, and to assess which home at KNI would be the most suitable home for the person if the person must be admitted to KNI.

6. After all necessary records have been obtained and visits have occurred, an additional meeting of the KNI Service Request Review Team may be scheduled to discuss possible admission. This meeting will generally include the Superintendent, the Program Director, the Community Support Coordinator, the Residential Unit Director, QDDP, CTS, and HCC for the home where the person

may live. Psychology staff, Medical staff, direct support professionals, the person, the person's guardian, representatives of the CDDO and CSP, and other pertinent staff may also be included in this meeting.

7. The needs of people currently living at KNI, as well as the needs of the applicant, will be considered in requests for admission. One factor in approving an admission will be availability of an appropriate home placement for the applicant.

8. If the request for admission is denied, technical assistance and/or consultation may be offered as an alternative to admission to KNI.

9. Prior to admission, post-institutional plans will be developed by the applicant, family/guardian, CDDO, and KNI.

10. When an admission date is established, KNI Community Support will notify the person, case manager, and family/guardian of the agreed-upon terms of services. Letters of Agreement will be developed to specify the responsibilities of all involved parties.

11. Before the person can be admitted to KNI, the guardian must obtain authority to place the person into a more restrictive setting from the district court in which guardianship is assigned.

12. Response to an application that is unacceptable to the applicant and which cannot be resolved by the KNI Service Request Review Team can be appealed to the Office of Administrative Hearings.

Parsons State Hospital and Training Center

Admission, Transfer, and Discharge Policy

A. Residents who are admitted to PSH&TC will be eligible for and in need of ICF/MR level of care (i.e., active treatment services).

B. Referral has been made by the Community Developmental Disability Organization (CDDO) from the area in which the person resides.

C. Agreement by the CDDO that appropriate community services are not available to meet the person's behavioral, social, developmental, health, nutritional, and safety needs.

D. Agreement by the PSH&TC Admissions Committee that the person's current support needs may not reasonably be met through the community service system.

E. PSH&TC is the least restrictive alternative available (K.S.A. 76-12b03) and most likely to be effective.

F. Admission decisions will be based on a preliminary evaluation of the resident that is conducted or updated by the facility or by outside sources. This includes consultation and/or review by the Dual Diagnosis Treatment & Training Services.

G. A preliminary evaluation will contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the resident's needs and if the resident is likely to benefit from placement in the facility.

H. If a resident is to be either transferred or discharged, PSH&TC will have documentation in the resident's record that the resident was transferred or discharged for good cause and provide a reasonable time to prepare the resident and his or her parent(s)or guardian for the transfer or discharge (except in emergencies).

I. At the time of the discharge, PSH&TC will develop a final summary of the resident's developmental, behavioral, social, health and nutritional supports, and with the consent of the resident, parent(s) (if the resident is a minor) or legal guardian, provide a copy to authorized persons and agencies, and provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

Steps to Success: Transitioning from State DD Hospital to Community Based Services

11-12

OVERALL PROCESS THINGS TO CONSIDER – FOR GUARDIANS OR OTHERS SUPPORTING PEOPLE IN THE TRANSITION TO COMMUNITY BASED SERVICES
IN THIS SUMMARY "YOU" AND "YOUR" REFERS BOTH TO THE PERSON RECEIVING SERVICES AND HIS/HER GUARDIAN OR OTHER KEY SUPPORTERS

Are you ready? • Talk to staff • Identify what is most important to your long-term success	Talk with your state hospital staff to help you access information about the community service system and the types of services available. Develop and have at hand a brief summary of the key supports you need to succeed, and think about what is most important to you --- while being open to various ways to meet your needs.
Are you set? • Pick your places to explore • Schedule a visit • Take your guidebook along	Select area/s of the state where you may want to live. Arrange a discussion with the CDDOs and arrange to visit providers in your area/s of interest. Have your "Learning About Community Services" guidebook in hand to help your exploration.
Go! • Talk with potential providers • Talk with other guardians, family members and people being served • Ask your top choices for a demonstration support plan	Spend some time talking with potential providers; utilize your guidebook to explore good matches for your needs. Arrange to talk one-on-one with other people receiving services, family members or guardians who have transitioned from state hospital services or who have loved ones with support needs similar to yours. Ask the providers that you consider your top choices to develop a support plan demonstrating how they will meet your specific needs.
When it's time ... • Make the change • Use transition safety nets • Prepare ahead for hiccups	At a pace you are comfortable with – make the change! Build in transition safety nets for you and your supporters. Schedule some pre-move visit time. Ask state hospital staff to build in visits after the move to check how things are going and make any suggestions. Ask your provider to plan for hiccups during the change and agree up front how you will address them.

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

September 9, 2010

Mr. Chairman and members of the Committee, I am appearing today on behalf of the Kansas Council on Developmental Disabilities regarding the issue of closure of one or both state hospitals on Developmental Disabilities.

What is a developmental disability? A developmental disability is one or more impairments that begin before age 22, and alter or substantially hinder a person's ability to do at least three major life functions (i.e., learn, take care of one's self, walk, talk, etc.). In your folder is a gold sheet that provides the definition found in Kansas's law.

There are two state hospital for persons with a developmental disability, Kansas Neurological Institute in Topeka and Parsons State Hospital and Training Center in Parsons. Attached in grey is some basic information about the Kansas Developmental Disabilities system and a comparison of costs between community-based services and institutional costs.

As you can see, Kansas spends approximately **$157,000 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 **$33,000 per person** in the community. We serve approximately 350 persons in the two institutions and 8,788 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. For many years the number taken off the list and provided services each year 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 and their families who are on the waiting list! If we closed KNI and moved their population of 156 to the community, even estimating an

average cost of $80,000 per person, we would still save **$17,131,033!** KNI's total cost of $29,611,033, minus $12,480,000 (156 persons at $80,000). If we closed both institutions these potential savings would be even greater at $55,000,000 and could be used to dramatically reduce 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.

However, closure should be done not because it is the most economical way to serve persons with developmental disabilities, but because it is the best way to serve them. We successfully closed Winfield State Hospital (WSH) in the mid 1990s and used that savings to bring our DD waiting list to almost nothing. For those who remember there was a huge political outcry, much of it from Winfield who saw the closure as the loss of many jobs in the community. There was also a fear of may parents that their children would be mistreated in the community.

For those reasons the Legislature and Developmental Disabilities Council commissioned and paid for an outside study that showed the overall health and welfare of WSH residents improved after their movement to the community. Also attached in buff are excerpts from that study. Legislative staff have the complete study if you are interested. I wished to point out a few key items. On the page labeled Executive Summary the last paragraph shows them bias of the researchers. They came to Kansas believing that we did not know how to do closure. To quote: "The Kansas experience of the closure of Winfield has been far more successful than this consulting team predicted." If you turn the page, you can see a summary of the Outcomes of Year One – this is what the study found one year after persons from Winfield moved to the community. They reviewed 26 areas and, in all but 4 found the lives of persons with developmental disabilities improved. They improved in behavior, number of services received, integration, qualities of life, reductions in medications needed, physical quality –and many others. Mixed reviews were found in staff pay rate – you have been hearing this for a long time – and unclear results in doctor visits per year. Negative results were found in hours of developmental programming in the home and dental visits per year.

From this study we can predict that the 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. Missouri is also examining closure. The parent of a person who was formerly at Winfield State Hospital in Kansas has assisted them with their planning. We have the expertise and the results of an independent study showing the benefits to persons who move from an institution to the community. We need to use that expertise to improve the lives of Kansans with developmental disabilities.

On a personal note, I have a cousin who formerly lived at Kansas Neurological Institute. He is certainly not easy to serve but he now lives close to his parents in western Kansas. They are happier and, of most importance, he is happier.

In summary, people with developmental disabilities are healthier and their quality of life is better in the community. Closing both state hospitals and using all savings for community DD services would permit us to serve many more people who are desperately waiting for services, some as many as 3 to 5 years! We know how to close a DD institution and we know that Kansans with DD are better off in the community. What are we waiting for?

The Kansas Council is federally mandated and federally funded under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and receives no state funds. Members include consumers, family members and representatives of the major agencies who provide developmental disabilities services. Our mission is to advocate for adequate supports in the DD system so that individuals with developmental disabilities are able to live, work, and participate in the community.

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12-3

What Is A Developmental Disability?

(f) "Developmental Disabilities" means:

(1) Mental retardation; or

(2) a severe, chronic disability, which:

(A) Is attributable to a mental or physical impairment, a combination of mental and physical impairments or a condition which has received a dual diagnosis of mental retardation and mental illness;

(B) is manifest before 22 years of age;

(C) is likely to continue indefinitely;

(D) results, in the case of a person five years of age or older, in a substantial limitation in three or more of the following areas of major life functioning: Self-care, receptive and expressive language development and use, learning and adapting, mobility, self-direction, capacity for independent living and economic self-sufficiency;

(E) reflects a need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated; and

(F) does not include individuals who are solely and severely emotionally disturbed or seriously or persistently mentally ill or have disabilities solely as a result of the infirmities of aging.

January 1996, K.S.A. 39-1801 *et seq*

In layman's terms, Developmental Disabilities are physical or mental impairments that begin before age 22, and alter or substantially hinder a person's capacity to do at least three of the following:

1. Take care of themselves (dress, bathe, eat, and other daily tasks)
2. Speak and be understood clearly
3. Learn
4. Walk/ Move around
5. Make decisions
6. Live on their own
7. Earn and manage an income

Kansas Developmental Disabilities System Information

Year	Number Unserved	Number Underserved	Totals	Community Number Served	Costs Per person	State Hospital Number Served	Costs Per person
2011	2,444	1,047	**3,491**	*8788*	**$33,426***	*350*	**$157,532**

*** Based on approximate community costs of $293,750,575**

Info:	Number Served	FY2011 Allocation
Kansas Neurological Institute	156	$29,611,033
Parsons State Hospital	194	$25,525,167
Community:		
DD Waiver	8624	$290,250,575
ICF/MR	165	$3,500,000
TOTALS	9139	$348,886,775

Are People Better Off?
Outcomes of the Closure of Winfield State Hospital

Final Report (Number 6)
Of the Hospital Closure Project
Required by Substitute House Bill 3047

Submitted to:
The Kansas Council on Developmental Disabilities
And
The Legislative Coordinating Council

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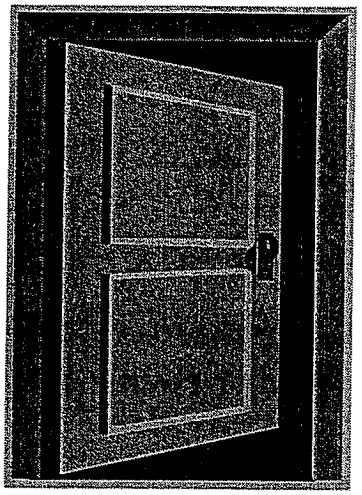
December, 1998

12-6

"In 1996, these people were surrounded by walls.
In 1998, they're surrounded by doors."



Citation

The quotation above is from David Loconto, a graduate student at Oklahoma State University. Mr. Loconto was studying the closure of Hissom Memorial Center in Tulsa, an institution that closed in 1994. He personally visited more than 200 Hissom class members in 1995 alone. For this citation, the dates have been changed to fit California's Coffelt years.

Acknowledgements

It is appropriate to recognize the contributions of many stakeholders during the past two years of our work. The staff of Winfield, the staff of the community providers, the leadership of the Developmental Disabilities Council and the Legislative Coordinating Council, relatives of the people who moved, and advocates on all sides, deserve our thanks. The most important acknowledgement, of course, must go to the more than 200 Kansas citizens who moved from Winfield to new homes in regular neighborhoods. These people welcomed our Visitors into their homes, allowed themselves to be interviewed where possible, and we thank them and wish them well.

Table of Contents

Executive Summary

This is the sixth of our seven reports on the closure of Winfield State Hospital and Training Center. It is concerned with scientific, quantitative answers to the questions: "Are the people who moved out of Winfield better off, worse off, or about the same? In what ways? How much?"

To answer these questions, we visited each person living at Winfield when our contract began. We measured dozens of aspects of quality of life and characteristics of service provision for each person. We used questionnaires and scales that have been used in many other studies over a period of 20 years in this and other countries. The reliability and validity of these measures is well established.

Movement of people with developmental disabilities from institution to community has been one of the most successful social movements of the baby boomer generation (Larson & Lakin, 1989, 1991). In contrast, in the field of mental illness, the nation's record in the sixties and seventies was a disgrace (Bassuk & Gerson, 1978).

The Kansas experience of the closure of Winfield has been far more successful than this consulting team predicted. There is good reason for Kansas stakeholders to be gratified. The table below summarizes the measured outcomes of movement of the 88 people for whom we were able to obtain "before and after" data.

Verbal Summary of Outcomes at Year One

Quality Dimension	Outcome	Direction
Adaptive Behavior Scale	Significant 1.7 point gain (5% up)	**V. Positive**
Orientation Toward Productive Activities Scale	Large gain 1.7 to 11.5 points	**V. Positive**
Challenging Behavior	Modest 2.7 point gain (3% improvement)	**Positive**
# of Services in Individual Plan	Up from 5.2 to 8.2	**Positive**
Hours of Day Program Services	Up from 4 to 18 hours per week	**V. Positive**
Hours of Developmental "Programming" in the Home	Down from 10 hours to 6 hours per week	**Negative(?)**
Integration	Large increase from 3 to 31 outings per month	**V. Positive**
Choicemaking	Up 50% from 27 to 40	**V. Positive**
Qualities of Life Ratings	Up from 68 to 78 (Now to Now)	**V. Positive**
Qualities of Life Perceptions of Changes	Up in every area but one – dental (Then and Now)	**V. Positive**
Staff Job Satisfaction	Up by 1.2 points out of 10	**V. Positive**
Staff Like Working With This Person	Up by 1.4 points out of 10	**V. Positive**
Staff Get Sufficient Support	Up 1 point (3.7 to 4.7, still low)	**Positive**
Staff Pay Rate	Down $4000	**Mixed**
Health Rating	Up from 3.5 to 3.8 out of 4	**Positive**
Health by Days Ill Past 28	Down from 3.2 to 0.8 days/28	**V. Positive**
Medications, General	Down from 5.7 to 4.9	**Positive**
Medications, Psychotropic	Down from 18 people to 6	**V. Positive**
Doctor Visits Per Year	Down from 22 to 6	**Unclear**
Dental Visits Per Year	Down from 2.3 to 0.5	**Negative**
Family Contacts	Up from 7 to 18 contacts per year	**V. Positive**
Individualized Practices Scale	Up from 47 to 72 points	**V. Positive**
Physical Quality Scale	Up from 76 to 86 points	**Positive**
Normalization	Large increase	**V. Positive**
Subjective Impressions of Visitors	Up on 4 out of 5 dimensions	**Positive**
Total Public Costs	Down about 15% From $109,000 to $91,000	**Positive**

Overview

For many years, like the rest of the nation, Kansas has conducted a gradual deinstitutionalization of people with mental retardation. Winfield State Hospital has recently closed. Most of the closure has been accomplished by helping people move into small integrated homes in regular neighborhoods. These people moved during the period between 1996 and 1998.

The present report is the sixth in our series, and it is the first that reports hard scientific data on the well-being of the people who left Winfield. The central question of this Report is "Are they better off?" We can now compare dozens of qualities of life measures for the people when they were at Winfield to the measures now, in their new homes. The specific primary questions for this Quality Tracking Project are:

- **Are the people better off, worse off, or about the same?**
- **In what way(s)?**
- **How much?**
- **At what cost?**

These are the central questions about well-being that any parent, friend, advocate, or caring professional must ask. But our research was also designed to formative (giving insights along the way) as well as summative (evaluating success at the end). Hence we have issued five reports along the way, based on interviews, surveys, focus groups, and knowledge of national models.

When the decision was made to close the institution, it was made for many complex and often political reasons. But at no time did any of the stakeholders plan or hope for harm to these people. To the contrary, most participants believed

(partly on the basis of 20 years of past research) that the peoples' lives would actually be enriched by movement from institution to community.

However, the political reality of the situation in Kansas included skeptics and critics. For all of these caring people on either side of the issue, for the media, for the legislature, for the executive branch, and for public accountability in general, this Report answers the central questions.

My name is Sharon Bird. My son Michael was a resident of Winfield State Hospital during its closure. At that time, the only services for the developmentally disabled in the community were sheltered workshops. Michael could not have participated in a sheltered workshop because of serious health issues and a lack of ability to comprehend the task at hand. There were many more hospital residents who were like Michael.

When Winfield State Hospital closed – despite our efforts to keep it open – some of the parents decided to develop a program to fit our children, instead of making our kids fit into the existing programs. Even before Creative Community Living was completely established, groups from several other states came to visit and set up programs using the CCL model.

Creative Community Living is the only program in Cowley and Butler counties that works the way we do. Our board of directors is 100% local and consists of 60% family members or legal guardians, and 40% business people. We feel that this is key, as we want the focus to be on our children, the people we serve.

When we started, we hired as many state hospital employees as we could. As time has gone by, the staff members who have stayed with us are the people who now lead our organization. They had or developed the skills to take us from an infant organization to the mature organization that we are at present. We not only serve the most medically fragile people in the community but also individuals with behavior problems. CCL later developed support programs for individuals who are very high functioning compared to the original clients. Although we support individuals with a variety of needs, they are all valued and challenged to reach their full potential.

What the families of the Kansas Neurological Institute are facing is very scary for them, because they don't know what their children's lives will be like in the future. But if they take steps to be a part of what their children do next, it may be the best their lives have ever been. They do not have to create a new organization, but they could.

Since Winfield State Hospital was closed, a number of new organizations have come to our state – some good and some bad. The parents can really be a big part of what happens. They just have to say this is what they can live with, and this is something they cannot. There is no one more important than the person being served. I know that because of what we parents did to start CCL.

Parents helped Creative Community Living get off the ground by serving on the board of directors, signing up their loved ones to be a part of CCL even though they only had my word that we could do this and do it well, and helping with the hundreds of tasks needed to make CCL a reality.

My son Michael is the happiest he has ever been. How do I know that when he can't say a word? I watch how he acts. Action can speak as loudly as words.

The state hospital gave very good care, but it was too large of a setting. What Michael and his friends have now is a home – their own bedrooms, a kitchen, a full house for just four people. With the right supports, anyone can live in the community.

I am very happy that I could help create a program such as CCL for my son and others with developmental disabilities. If I were to die today, my only regret would be that I was not able to do this for my oldest son who died at the age of 12 while he was living at KNI. Sometimes we're just a little too late.

Home and Community Based
Services Oversight
Date: 6-8-10
Attachment: 13

KANSAS
DEPARTMENT ON AGING

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

Joint Committee on
Home and Community Based Services Oversight
Sept. 8, 2010

Quality Care Improvement Panel Implementation
Martin Kennedy, Secretary

Statutory Composition of the Quality Care Improvement Panel

Organization	Notes
KS Homes and Services for the Aging	2 representatives
KS Health Care Assn	2 representatives
KS Health Care Assn	1 representative
KS Advocates for Better Care	1 representative
KS Hospital Assn	1 representative
KS Adult Care Execs Assn	Gov's Appointment
Skilled NF or family member of a resident	Gov's Appointment Recommendations from KABC and LTCO
KS Foundation for Medical Care	Gov's Appointment
KS Dept on Aging	Gov's Appointment Non-voting
KS health Policy Authority	Gov's Appointment Non-voting

Sen. Sub. for HB 2320 passed by the 2010 Kansas Legislature, directs KDOA to establish a Quality Care Improvement Panel. Among its charge, the panel is to administer and direct the expenditures of funds collected from nursing facilities through the quality care assessment.

The statute allows for the Governor to appoint one representative to the panel. It also provides for representation from several trade and advocacy organizations. The 11-member panel will elect a chair from among the members appointed by the trade organizations and shall serve without compensation or expenses. The panel is directed to report annually to the Kansas Legislature and the Health Policy Oversight Committee on, or before, Jan 10. At that time, the

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panel makes recommendations concerning the administration of the expenditures from the Quality Care Assessment Fund.

Requests for appointments and recommendations have been made and are due back to KDOA by Monday, Sept. 13. The names for the Governor's appointments will be forwarded the name to Gov. Parkinson for his consideration. It is my hope to convene a meeting of the panel in October.

KANSAS
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Martin Kennedy, Secretary
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Joint Committee on
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Sept. 8, 2010

Nursing Facility Incentive Factor for FY 2011

Martin Kennedy, Secretary

The Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $2.50 per diem add-on.

Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.25 per diem add-on. Providers that achieve a turnover rate at or below the 75th percentile will earn a $2.50 per diem add-on. Providers that have a turnover rate greater than the 75th percentile but that reduce their turnover rate by 10% or more will receive a per diem add-on of $0.25. Providers that have completed the full Kansas Culture Change Instrument Survey will receive a $0.38 per diem add-on. Finally, providers that have a Medicaid occupancy percentage of 60% or more will receive a $1.13 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

The table below summarizes the incentive factor outcomes and per diem add-ons:

Incentive Outcome:	Incentive Points:
1) CMI adjusted staffing ratio ≥ 75th percentile (4.80) or	$ 2.50
CMI adjusted staffing < 75th percentile but improved ≥ 10%	0.25
2) Staff turnover rate ≤ 75th percentile (29%) or	2.50
Staff turnover rate > 75th percentile but reduced ≥ 10%	0.25
3) Completion of the full Kansas Culture Change Instrument Survey	0.38
4) Medicaid occupancy ≥ 60%	1.13
Total Incentive Per Diem Add-on Available	$ 6.51

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Mark Parkinson, Governor
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Joint Committee on
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Sept. 8, 2010

Data on Non-Medicaid Nursing Facilities in Kansas
Martin Kennedy, Secretary

Number of Non Medicaid Nursing Facilities (NF)
and Hospital Based Long Term Care Facilities (LTCU)

		NF	LTCU	Total
January	2002	11	18	29
January	2003	11	13	24
January	2004	10	10	20
January	2005	9	8	17
January	2006	9	6	15
January	2007	9	7	16
January	2008	9	7	16
January	2009	11	7	18
January	2010	10	6	16
September	2010	9	5	14

The number of non-Medicaid Nursing Facilities and Long-Term Care Units of hospital are from the January director of each year along with the data from the September 2010 director for a more current snapshot.

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Home and Community Based
Services Oversight
Date: 9-8-10
Attachment: 16

INDEPENDENCE
INCLUSION
INNOVATION

INTERHAB

September 8, 2010

TO: The Joint Committee on Home and Community Based Services Oversight

FR: Tom Laing, Executive Director, InterHab

RE: Impact of removal of dental care from HCBS waivers

Thank you for taking testimony today on dental services. We appreciate your recognition of the gravity of dental service cuts for persons with developmental disabilities.

For a number for years, our association talked with policy makers about challenges of dental care for many persons with developmental disabilities. We celebrated the addition of that service to the waiver, during FY 2010, and felt great disappointment when the service was lost during the middle of FY2011.

This was a significant cut, the restoration of which we will support in the 2011 session; additionally, having discussed this matter with Oral Health Kansas, our association is also prepared to support their efforts to request that dental services be added to the state Medicaid plan in FY2012.

There is no rational public purpose which justifies the establishment of separate classes within the Medicaid-eligible population as regards dental health, which would position us as a State to identify and finance the dental needs of some and not others. Medicaid-eligible persons who lack dental coverage are less likely to secure adequate dental service, and therefore they inevitably are at a greater risk of requiring higher Medicaid expenditures which arise from an increase in health problems commonly triggered a lack of oral health services.

It was suggested at the last meeting that the State may need a study of the effects of a lack of dental services on general health, and therefore on Medicaid costs. We believe there is adequate research at present which would save the time and expense of yet another study which will only tell you what you already know, and illustrate for our members that which they experience daily in the community:

Bad dental care causes higher health costs. Medicaid dollars invested in dental care can be one preventative approach to fend off higher Medicaid costs down the road.

We urge your favorable consideration of efforts to restore this cut, and to adopt a more general and defensible approach for the coming years, by adding basic dental services to the state's Medicaid plan.

Home and Community Based
Services Oversight
Date: 9-8-10
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INDEPENDENCE
INCLUSION
INNOVATION

INTERHAB

September 8, 2010

TO: The Joint Committee on Home and Community Based Services Oversight

FR: Tom Laing, Executive Director, InterHab

RE: Provider assessments for HCBS services

We thank the members of the Legislature who supported the adoption of provider assessment legislation for adult care services in Kansas during the 2010 session. We understand your work is already paying dividends to Kansas by strengthening services for Kansas seniors by making it possible for providers to prevent quality erosion due to a lack of funding. We believe that you have further established the "proving ground" for provider assessments. It is our hope that your confidence in the methodology is one that will enable InterHab and others to work with you in 2011 to enact similar law for community services for Kansans with developmental disabilities.

Distinctions between the two efforts:

We commend supporters of the adult care home legislation for working through challenges inherent within that field, due to the mix of payers of the costs of individual care for persons residing in adult care homes. The nature of a provider assessment – to levy a like assessment on like services – invites conflict among those for whom the resulting benefits are widely different. It is a tribute to all who supported that effort that such conflicts were eventually reconciled. The result is a benefit to persons served and providers of service, at no additional cost to state taxpayers.

We are satisfied with our evaluation and those of our consultants that no similar conflict will exist in the DD provider network. Nearly all persons with DD who today receive comprehensive DD services are receiving them via the Home and Community Based Services waiver provided by Medicaid. As such, nearly every dollar assessed against providers will produce a benefit to persons served by those same providers.

It is not lawful to artificially create a means to assure a dollar-for-dollar return for those who are assessed. However, when the population served is almost entirely Medicaid-eligible, and when the service network is primarily a Medicaid funded service network, then it is clear that the outcomes will reflect that high degree of fiscal and programmatic homogeneity of the network.

Home and Community Based
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Date: 9-8-10
Attachment: 18

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Status of Advocacy at CMS to Allow HCBS DD Provider Assessment financing methodology:

Talks have continued over the past year with CMS by representatives of national DD service advocacy groups working to advocate for CMS to move forward on plans to allow a HCBS DD provider assessment.

There is no policy reason why this change has not been made. In fact, the policies of the federal government and the states today favor "least restrictive settings" and therefore all who have fairly examined this recognize that a financing policy runs counter to program policy is one that is in need of review, and ultimately change.

When provider assessments were first authorized, States were attempting to make Medicaid a more affordable and flexible funding source. The emphasis then was on hospitals, nursing homes and intermediate care facilities (ICFs). At that time, ICFs were the principal programs which utilized Medicaid for persons with DD. Therefore, ICFs were named in the original law allowing for State provider assessments. At that time, few states had significant investments in HCBS DD services; therefore, there was no clamor for additional funding latitude.

Today ICF service has shrunk dramatically. The pressure on States is now focused on adequate funding for expansion of HCBS services. Fortunately, when Congress allowed for provider assessments, they allowed new classes of service to be added by agency rule. It is that rule-making process with which our national offices are currently engaged, i.e. to establish by rule the addition of HCBS DD to the ranks of eligible programs to be considered for provider assessments.

We are as optimistic today as we were during the session that CMS will make the change needed to allow a provider assessment to be effectively adopted in Kansas.

Development of Kansas DD Provider Assessment:

Since June we have begun contacting providers that belong to other associations, as well as those not aligned with a professional association. To date there has been a broad receptivity to this initiative. The details will be shaped by such collaboration, and by any additional information we can get from CMS developments. It is our expectation we will be providing you and other legislators with drafts of consensus supported legislation for your consideration in the coming months, in time for pre-session consideration.

Thank you for this invitation to appear, and for your continuing interest in finding ways to tackle the financial challenges that face the community DD network.