United Methodist Youthville

Psychiatric Residential Treatment Facility (PRTF) Services

Youthville

Giving Children Back Their Childhood

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Prior to the sharp reduction in PRTF referrals experienced since January of 2011 United Methodist Youthville provided Psychiatric Residential Treatment Facility (PRTF) and Secure Care services. On Youthville's Dodge City campus a 57 bed PRTF program was in operation with PRTF residents being able to participate in animal-assisted treatment, a working farm and ranch, and specialty treatment for youth with problem sexual behaviors and youth with mental retardation/developmental disabilities (MR/DD). On Youthville's Newton campus a 56 bed PRTF and a 12 bed Secure Care facility was operated along with an expressive arts program which was used as part of the resident's treatment. Youthville's Secure Care program in Newton is the only program in the state offering this level of care. Secure Care provides assistance to youth who have been adjudicated children in need of care and need to be served in a fully secure residential facility. These youth are generally not dangerous to self or others, but have been court ordered to be held securely, often times because they have a history of running from other placements and many have been involved in human trafficking.

However, when the sharp and unexpected decline in PRTF admissions began Youthville began making business decisions about how to adjust to the changing marketplace and converted one cottage on both the Newton and Dodge City campuses to Youth Residential Center II's (YRC II's). The Newton YRC II program served children in need of care and the Dodge City YRC II program served juvenile offenders. However, as the PRTF admissions started to stabilize the following outlines a very difficult decision that was made by the United Methodist Youthville Board of Directors.

News Release

Economic & Market Changes impacts Youthville Residential Services

(Wichita, KS. Oct. 26, 2011) –A reduction of statewide referrals by 250 youth from January through October to Psychiatric Residential Treatment Facilities (PRTF). This reduction in referrals has forced Youthville to make a tough decision. The agency is closing its PRTF and YRCII services on the Newton Campus. However, Secure Care, a specialized program for runaway youth will remain open.

- All PRTF and YRCII services provided by Youthville will move to its Dodge City location by November 30, 2011.
- 79 Newton employees will receive 60-day lay-off notices.
- Youthville's HR department will offer on-site support and help as many affected employees as possible to find a job at the agency's other locations.
- Youthville staff has developed a plan to make the transition as smooth as possible.
- Secure Care will remain in Newton.

"We regret the need to consolidate. We understand the disruptions that this will cause in personal lives, the agency's partners and Newton community," said Rev. Kent Melcher Topeka, Chairman of Youthville's Board of Directors. "However, low referrals are limiting the agency's business options. Although the downturn did impact our budget, the agency remains financially sound. "
Plans for Newton…

- Efforts are underway to develop new programs and services on the Newton campus.

"We appreciate all of the support from the Newton community we have received and we look forward to your continued partnership," said Shelley Duncan, Youthville President & CEO. "We assure you that Youthville staff remain committed to providing high quality programs to youth and families."

Youthville is a nonprofit agency, specializing in Foster Care, Adoption, Residential Treatment and Counseling. The agency's employees are passionate about its mission of Giving Children Back Their Childhood to those who suffer from abuse, neglect, abandonment, and trauma. The agency provided programs and services to more than 4,500 families in fiscal year 2011.

With this as the backdrop for Youthville's role in residential services I will begin outlining the timeline of events, the residential service delivery system, and the financial factors that led to the hearing today and provide some recommendations the committee could consider to move forward.

History of Psychiatric Residential Treatment Facilities (PRTF's) in Kansas

PRTF's were established after the Center for Medicaid/Medicare Services (CMS) ruled that Kansas was out of compliance with federal reimbursement claiming regulations relating to residential care for children. CMS ruled that the current residential system in Kansas which contained primarily two levels of care (Level V and Level VI) were operating as Institutes for Mental Diseases (IMD's) and in most cases would be classified as PRTF's under federal regulation. Additionally, CMS had been deferring payment to the State of Kansas for services being claimed in these facilities for multiple quarters before the system could make the transition to meet their standards. Initially, very few Level V or VI providers met the federal regulations to qualify as a PRTF. The state led a process to help the providers meet the CMS standards for PRTF's, for those who chose to provide that level of care, while providers who were not interested in being a PRTF were reclassified as Youth Residential Centers II's.

PRTF Designed Purpose

PRTF's were designed according to CMS regulations and 42 C.F.R. Part 441, Subpart D – Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs section of the Federal code. The PRTF's purpose is to:

- Provide comprehensive mental health treatment to children and adolescents (youth) who, due to mental illness, substance abuse, or severe emotional disturbance, are in need of treatment that can most effectively be provided in a psychiatric residential treatment facility, AND, all other ambulatory care resources available in the community have been identified, and if not accessed, have been determined to not meet the immediate treatment needs of the youth.

PRTF programs were designed to offer a short term, intense, focused mental health treatment to promote a successful return of the youth to the community. Specific outcomes of the mental health services include the youth returning to the youth's family or to another less restrictive community living situation as soon as clinically possible and when treatment in a PRTF is no longer medically necessary. The residential treatment facility is expected to work actively with the family, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate, treatment designed to meet the individual needs of the youth including those identified with emotional and behavioral issues. The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed.

Payment Rates

PRTF payments are Medicaid reimbursable (56.91% paid by Medicaid, 43.09% paid by State General Fund (SGF)).

- *How are PRTF costs set:* PRTF costs are based upon actual costs provided by the PRTF's to SRS as established by the CMS approved cost reimbursement methodology. Rates are updated biannually based upon actual costs.
- *What is the PRTF daily rate:* The average PRTF daily rate was $296.29 per child per day for January-July 2011, and includes all services that a child receives for room and board, mental health, and substance abuse treatment. The only services not covered in the daily rate are physical health care costs which are billed to the child's Medicaid Medical Card.
- *PRTF SGF cost to the State:* $127.67 plus the state share of the physical health medical card costs.

YRC II payments are not Medicaid reimbursable (100% paid by SGF)

- *How are YRC costs set:* The YRC II daily rate is static and set annually by the state (It has not changed since its implementation in 2007).
- *What is the YRC II daily rate:* The current YRC II daily rate is $126 per day and only pays for room/board and non-treatment services. Any treatment service is billed to the Medicaid Medical Card in addition to all of the youth's physical health care costs. When considering the total cost billed to the medical card the daily rate for YRC II actually costs $132.46 funded $130.79 from SGF, which is $4.79 more costly to the state than a PRTF placement per day.

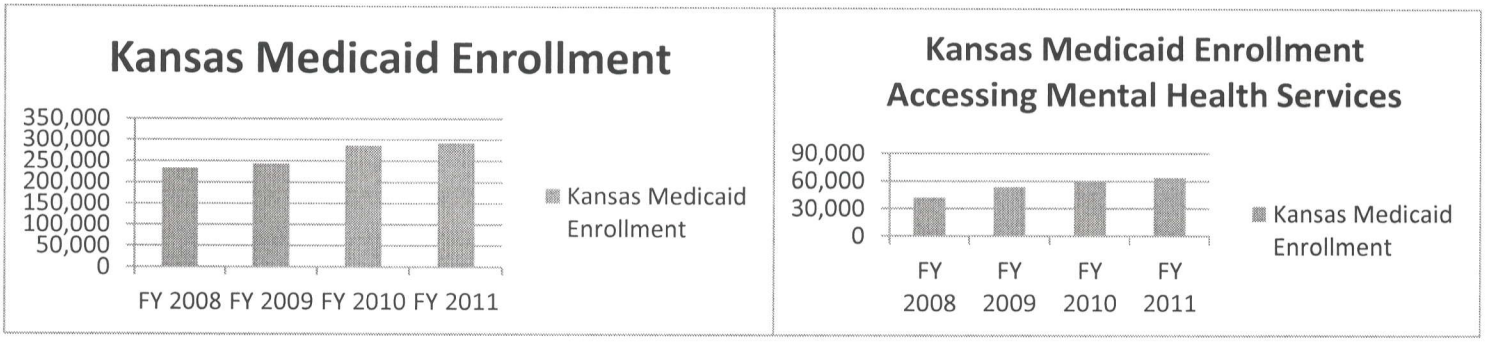
**The 4.79 SGF additional cost calculated from average Medical card costs provided by SRS mental health.*

Screening/Admission Procedure

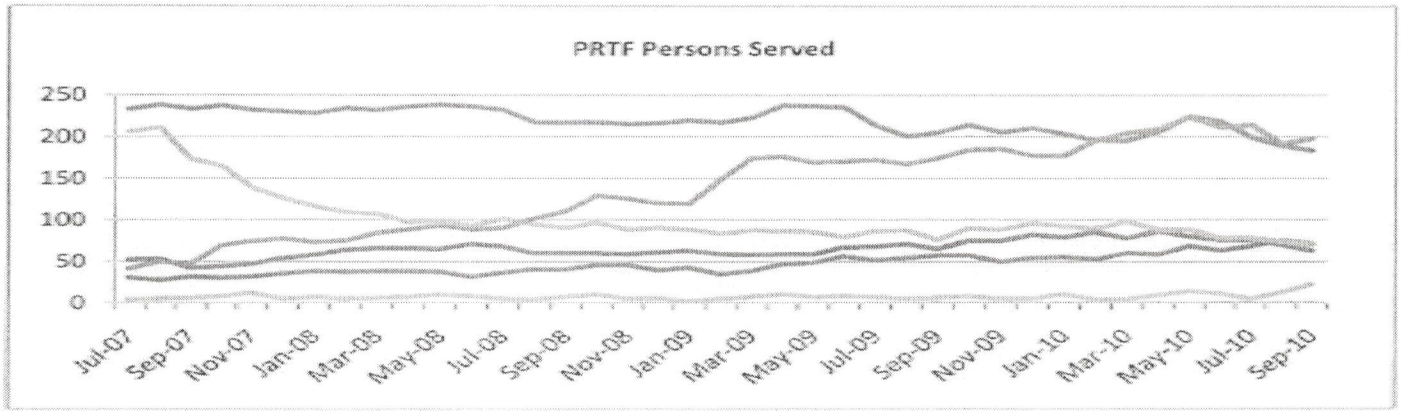
The Community Mental Health Centers (CMHC's) are the gatekeepers for the PRTF system. When the system was designed a group of stakeholders and CMHC's developed the screening tool to be used to allow a child to enter a PRTF. The screening was based upon the child's medical necessity to receive the services that couldn't safely be delivered in the community. If a child is determined to meet the criteria to be screened into a PRTF the initial authorization screen allows the child to stay there until they no longer meet medical necessity criteria or up to 90 days. If the child is approaching the 90th day of treatment they must be re-screened by the CMHC to remain in the PRTF. If the CMHC determines the child needs to continue with PRTF treatment the re-authorization screen allows up to 60 additional days before a child would need to be screened again. It is important to note that authorization periods have no bearing on when the child is released, as children are discharged as soon as possible. The authorization reviews do trigger discharge if the CMHC and PRTF disagree about the child's treatment progress and the child does not successfully re-screen for PRTF services.

Identified Concern

The SRS division of Mental Health has pointed to the growth in the number of children served in PRTF's as problematic. However, all PRTF utilization had been very flat or even had been reduced since the implementation of the new system in 2007 except for children not in state custody who are SSI disabled and very low income accessing care.



The growth in the number of youth who are in the custody of their parents being placed in PRTF's has been cited as troubling. However, while the number of youth in the custody of their parents being served by PRTF's has increased the number of youth in SRS or JJA custody being served has decreased. This increase in private placements and the decrease in the number of placements for youth in custody was always the plan for the PRTF system. Prior to PRTF's in order to receive medically necessary residential care paid for by the state the youth generally had to be in the states custody to access residential care. The changes in methodology now allow a child to remain in their parents' custody and engaged with their family. The ability of a youth to remain in the custody of their parents is a VERY positive change and actually costs the State less money to meet the kid's needs. Prior to this change many children were not receiving the care they needed to be successful in their community.



Eligibility Categories

Purple= Foster Care (SRS Custody)
Red= Child in Institution
Green= JJA (JJA Custody)
Black= Adoption Subsidy
Blue= SSI(Disabled)
Orange= TANF

SRS Mental Health Utilization Reduction Goals

SRS provided communication to KHS on January 12th, 2011 about the need to reduce Medicaid Mental Health expenditures and save $6.8 million in FY 2011 and $17 million in FY 2012 from PRTF's, out-patient, and in-patient mental health services and that through efforts to reduce utilization, "There must be no increase in the number of persons admitted to state mental health hospitals or PRTF's as a result of utilization management efforts." Additionally, "Targeted improvement in community-based services is conservatively expected to result in an overall five percent reduction in admissions to inpatient and residential treatment in the last quarter of FY 2011 and another seven percent in FY 2012." Below is the provider notice from KHS notifying service providers of the directive to decrease usage.

Special Provider Notice

KHS KANSAS HEALTH SOLUTIONS

April 5, 2011 www.kansashealthsolutions.org

>> Notice of changes to fee schedule payment rates

After reviewing utilization data, the Department of Social and Rehabilitation Services has directed KHS to reduce spending on outpatient mental health services and other mental health services by $6.8 million for the current fiscal year, which ends June 30, 2011. The easy answer for KHS would be to reduce outpatient payment rates across the board for all Providers. As with last year's 10 percent rate reduction, this approach is not in the best interests of our Members or our Providers. Instead, we are focusing on targeted reductions while maintaining positive outcomes for Members.

The first step in a more robust utilization management process was KHS' implementation of the pre-authorization service limits that became effective April 1.

Second, KHS is working with certain high-volume Providers to establish a utilization target based on each Provider's experience with regard to key measures, including, but not limited to, service intensity, penetration (percent of Members served), PRTF use, state hospital use, and recent increases or decreases in billing volume. Using data presented by KHS and their own internal information, these Providers will develop and implement a customized plan to achieve utilization targets.

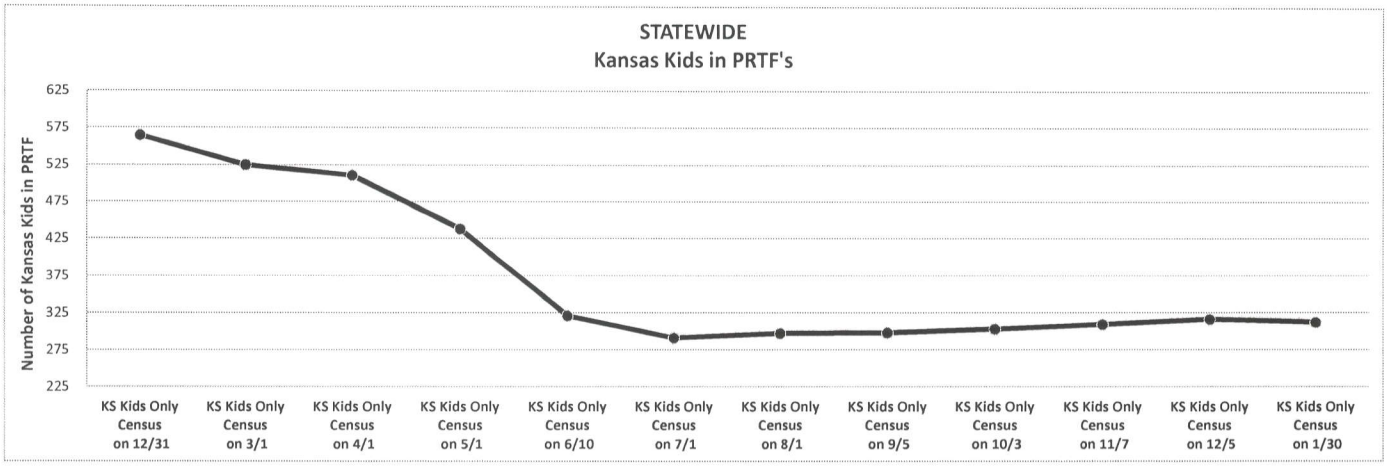
KHS will carefully track utilization, and it is our sincere hope these measures will prove sufficient to meet the expected utilization targets. If, however, these utilization efforts are not sufficient, KHS will implement Provider-specific payment rate reductions not to exceed 25 percent for dates of service from May 1, 2011, to June 30, 2011. Rather than reducing rates for those Providers who have achieved cost savings and efficiencies in their practices, these rate reductions will target those Providers with greater opportunities for improvement. If additional savings are needed, KHS will calculate each Provider's specific rate reduction based on those key measures identified above. KHS will not impose reductions beyond those required to meet the utilization targets. Each affected Provider will receive written notice of the reduction at least five business days before it becomes effective, along with an explanation of the calculation used to determine that Provider's rate reduction.

As required by the Provider Agreement, KHS hereby gives notice to Providers that fee schedule payment rates will be reduced by 25 percent for dates of service from May 1, 2011, to June 30, 2011, either concurrently or retroactively. Again, such rate reduction will be implemented only if sufficient utilization management cannot be achieved by other means. Even if reductions are imposed by KHS, a Provider's rate of reduction may be less than 25 percent or may be imposed only on certain services based on key measures for that Provider.

~ Michael Goldberg
Chief Executive Officer

PRTF Census Change Since January 1, 2011- Kansas Kids Only

(PRTF Census had been very steady around 600 for Kansas kids since July 2008 when the new system was fully implemented. Out of state admission numbers are frequently counted in the PRTF cost reports submitted to SRS but distort the data related to Kansas kids accessing this level of care. This data excludes out of state kids in Kansas PRTF services.)



Facility Name	Location	Licensed PRTF Capacity	Kansas Kids Only Census on 12/31	Kansas Kids Only Census on 3/1	Kansas Kids Only Census on 4/1	Kansas Kids Only Census on 5/1	Kansas Kids Only Census on 6/10	Kansas Kids Only Census on 7/1	Kansas Kids Only Census on 8/1	Kansas Kids Only Census on 9/5	Kansas Kids Only Census on 10/3	Kansas Kids Only Census on 11/7	Kansas Kids Only Census on 12/5	Kansas Kids Only Census on 1/30	Number of Kids Decreased Since 1-1-2011	Percent Decreased
Crittenton Children's Center	KC MO	65	9	6	5	2	0	0	0	0	0	0	0	1	(8)	-89%
Florence Crittenton	Topeka	26	18	19	15	9	7	9	9	6	7	6	8	8	(10)	-56%
Lakemary Center	Paola	70	62	62	61	55	54	54	47	53	52	53	54	51	(11)	-18%
Marillac	Overland Park	52	49	47	39	33	22	24	35	32	33	32	36	25	(24)	-49%
Ozanam	KC MO	75	15	18	15	10	5	1	2	0	0	1	1	3	(12)	-80%
Prairie View	Newton	28	17	19	18	13	8	9	17	12	12	11	11	13	(4)	-24%
Riverside	Wichita	49	51	46	53	52	30	26	26	18	16	13	15	15	(36)	-71%
Spofford	KC MO	40	13	13	12	8	2	1	2	2	0	3	3	6	(7)	-54%
St. Francis Salina	Salina	34	31	29	30	21	21	21	15	16	15	28	26	18	(13)	-42%
TFI Pathways	Topeka	49	46	46	35	24	23	28	30	38	38	38	31	40	(6)	-13%
TLC	Olathe	61	59	49	54	44	30	24	30	28	32	41	49	47	(12)	-20%
UMY- Dodge	Dodge City	57	49	41	37	34	28	27	26	29	30	36	29	39	(10)	-20%
KVC-Praire Ridge	KC KS	48	43	33	33	39	22	14	19	18	19	32	39	33	(10)	-23%
KVC-Wheatland	Hays	12	12	10	9	6	2	5	4	5	7	7	6	5	(7)	-58%
FACILITES WHICH HAVE CLOSED OR ARE SCHEDULED TO CLOSE																
1-New Hope	Norwich	48	16	15	22	19	17	10	Facility Closed in August						(16)	-100%
St. Francis Ellsworth	Ellsworth	34	30	30	28	27	20	20	14	15	18	8	8	8	(22)	-73%
UMY- Newton	Newton	56	45	42	45	42	21	18	21	26	24	Facility Closed in December			(45)	-100%
TOTAL		**841***	**565**	**525**	**511**	**438**	**312**	**291**	**297**	**298**	**303**	**309**	**316**	**312**	**(253)**	**-45%**

****Populations as reported by each PRTF.**

Closing/Consolidations

1- New Hope announced closing on August 18th. (48 Beds)

2- St. Francis announced Ellsworth closing & consolidation to Salina on October 6th. (34 Beds)

3-Youthville announced Newton closing & consolidation to Dodge City on October 24th. (56 Beds)

Length of Stay

Some claim children are staying too long in PRTF care. However, treatment begins immediately upon admission to the PRTF and a treatment plan is developed with the input of the CMHC's, PRTF staff, and other important individuals in the child's life. The treatment team then continues to meet to ensure the child is discharged as soon as possible. If a child stays beyond 90 days the child would have had to be re-screened to ensure they continue to meet medical necessity requirements.

The increased scrutiny of PRTF's has resulted in a significant drop in the lengths of stay. Additionally, some children have been discharged from care against medical advice of the PRTF physician/psychiatrist. In these cases the PRTF can advise the family or child's custodian about their ability to appeal the screening discharge decision.

Community Based Services and Ongoing Concerns

The claim is being made that children and youth who were, and are now not, being screened into PRTF's are receiving all the services they need in the community. The CMHC's have reduced budgets and many have reduced staff. It seems unreasonable to believe they have excess capacity to serve these children who are in need of highly intensive specialized services. Law enforcement, schools, YRC II providers, parents, and people who work with youth in the community have all reported seeing kids with more severe needs in the community and questions are occurring about why these kids aren't getting the treatment they need to be stabilized to ensure their safety and the safety of the public. Additionally, people have stopped referring children for screening because they feel many children are being rejected. Everyone need to stress that if a child needs services they should be referred for a screen rather than assuming the outcome will be negative. The treatment services being provided to children in state custody should be provided to ensure the child is well enough to live safely in the community and to help ensure stable community placement. Unstable placements and "placement hopping" not only worsen the child's mental health stability but also make it impossible for the child to attend school, which has much more far reaching consequences.

SRS reports that they have reviewed 484 PRTF screens. Of those screens 312 were approved for admission and 172 were diverted from PRTF care. Of those 172 screens in 28 cases, or 16 percent, the children either had their screen overturned, or unfortunately had to access a higher level of care prior to being admitted to a PRTF.

---3 Screens were modified by SRS MH and the child was allowed PRTF admission
---9 Appeals were made and the screen was overturned by KHS.
---5 Youth were placed in a mental health hospital shortly after being denied PRTF admission and then after their mental health hospital stay, were allowed to be admitted to a PRTF.
---11 Youth were placed into a PRTF shortly after being diverted.

PRTF Task Force

As a result of the sharp decline in PRTF admissions, and the concern expressed by multiple systems about what was occurring so suddenly, SRS took a very positive step and created a task force to make further recommendations about changes that needed to occur regarding treatment within PRTF's. The stated goal was for this task force to make recommendations to SRS about how the PRTF system should move forward.

Members of the task force were: 4 Representatives from CMHC's, 4 PRTF Providers, a SRS Children and Family Services employee, a JJA employee, 2 KHS employees, a family advocacy organization, and SRS MH Staff. The group, while not always agreeing, was able to compromise and recommend the following changes/clarifications:

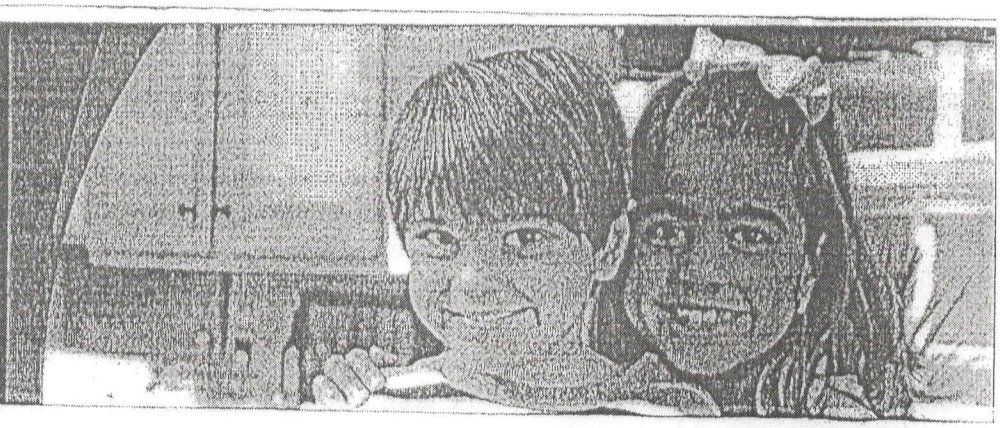
- PRTF services should be based solely on clinical need and not on cost or potential savings.
- Reasons appropriate for PRTF admission: 1. Clinical evidence of suicidal or homicidal ideation/aggressive behavior related to mental illness in the last 30 days. 2. Behaviors that are unmanageable in a community-based setting and require 24-7 intensive clinical intervention. 3. The child/family has a history of inadequate follow through on elements of a treatment plan such as failure to take medications, follow a crisis plan, or maintain family integration. 4. The CMHC is unable to deliver the needed services.
- Reasons appropriate for continued stay in a PRTF: 1. Discharge criteria hasn't been met. 2. The child doesn't need a higher level of care and no lower level of care or community-based services are appropriate.

- Further strengthen language requiring discharge planning to begin at time of the child's admission and that a treatment plan must be in place within 14 days as developed by the PRTF, CMHC, and the child/family.
- Discharge planning shall be thoughtful and worked through thoroughly to ensure the child has mental health and medication management appointments made in the community two weeks prior to PRTF discharge.
- If a child cannot be discharged safely to immediately available community-based services then the treatment team should discuss a limited longer stay to ensure a smooth transition to a lower level of care.
- Define immediate provision of service expectations for children discharging from a PRTF.
    - Crisis services should be provided any time they are needed.
    - Medication Management appointments must be scheduled for within 25 days of discharge to ensure medications can be filled before the child has been discharged from the PRTF for over 30 days.
    - Children and families shall be offered a face-to-face mental health service the same day or the day after discharge from a PRTF.
    - The child shall receive a therapeutic intervention by a Licensed Mental Health Provider or private provider within 3 days of discharge and an intake will include a therapeutic intervention.
    - Targeted Case Management will be provided within 4 days of discharge.
- A child's case will remain open at their home CMHC to allow for a smoother transition between the PRTF and the community.
- PRTF's will be required to inform families about advocacy organizations with whom they may want to get involved.

Final Fiscal Savings Achieved Through Reduced Utilization

The following is an excerpt from the KHS Annual Report reporting on their success in implementing the SRS directive to reduce costs. The savings goal was exceeded by $3 million. KHS reports 1/3 of the total savings came from diversions of PRTF admissions.

KHS was given the goal of saving $6.8 million in the final months of FY11, which it achieved and exceeded



Focus on: Savings for Kansas

In the spring of 2011, SRS requested that KHS lower expenditures and save $6.8 million from its projected mental health expenditures for FY11.

KHS worked with its Provider network to develop individualized plans for the network's 30 highest-volume service providers. These 30 Providers represent more than 90% of all expended dollars. The Providers and KHS developed individualized plans to make improvements specific to their situations.

KHS also instituted new initial benefit levels during the last quarter of the fiscal year. Most of the benefit levels were devised to address the outliers at the highest 5% of utilization. The large majority of Members (people enrolled in Medicaid or MediKan), therefore, were not affected by these levels. Providers can request exceptions for Members who need more services. The KHS Clinical Utilization Department processed 3,921 exception requests in the last quarter of FY11, 70% of which were for Members to receive additional hours of individual therapy. All Providers were challenged to rethink the effectiveness of the mix of services they provide KHS Members.

Initial KHS projections showed the company had expected to pay $206 million in claims in FY11. SRS asked KHS to keep that amount to $199 million, and the company is expecting claims for services received in FY11 will not exceed $196 million, well below the $199 million target.

Committee Recommendations to Consider

The following are recommendations that we would urge the committee to consider including in your final report to the 2012 Legislature:

1. Include language stating that PRTF's are a necessary and vital part of the Kansas Children's Mental Health System and a vital part of the continuum of care escalating from community-based services, Acute Care/Crisis Stabilization, PRTF services, and hospitalization.
2. Include language opposing the SRS 90% occupancy reduced resource package. If accepted this reduced resource package would further deteriorate the ability for children to receive PRTF services and would further destabilize the already vulnerable PRTF service delivery system.
3. Direct SRS to support and implement the recommendations of the PRTF task force outlined previously in this document and documented in more detail in the "PRTF Guidance Paper dated October 21, 2011."
4. Direct SRS to begin/continue formally tracking data about what is happening to the children being diverted from PRTF's as well as what is happening to the children when they are being discharged. This data should be reported at least quarterly to the PRTF Stakeholder Group. Data to be collected should include:
    a. Child's Custody Status (Parent, SRS, JJA).
    b. How quickly the first mental health service was offered after diversion.
    c. Exactly what services each child diverted is receiving in the community both in quantity and duration. (This can be used for fiscal forecasting).
    d. The adherence to the immediate provision of service standard for children being discharged from a PRTF as outlined in the "PRTF Guidance Paper dated October 21, 2011"
    e. Where each child being discharged from a PRTF is going, and also follow that child through all subsequent placements for 6 months. (IE. Home, YRC, Detention, Hospital)
    f. Exactly what services each child discharged is receiving in the community both in quantity and duration. (This can be used for fiscal forecasting).
    g. Data related to the failure to adhere to any standards outline in the Guidance Document or set by SRS and what is being done to remedy those failures.
5. Direct SRS to "fast track" and make a priority the implementation of a standardized intake form which could be used at any CMHC in Kansas. (This has been an on-going project off and on for many years and would help children and families' access community based services more effectively).
6. Include language stating that the committee believes that access/screening for all mental health residential care should be completed by one entity regardless of how many managed care contracts may be offered in Medicaid reform. Furthermore, all decisions for admission to residential services should be based on medical necessity, using the current screening tool and methodology, and not influenced by budgetary decisions.
7. Include language stating that the mental health system has already suffered multiple cuts including $9.8 million from a rate reduction in FY 10, a $6.8 million cut in FY 11 and a $17 million cut in FY 12 totaling $33 million all funds reduction to the mental health system. Furthermore, we ask the committee to urge the 2012 Legislature to ensure the mental health system does not receive a larger proportion of the Medicaid reductions/cuts than does the physical health side of the Medicaid system.
8. SRS should identify any gaps in the behavioral health and mental retardation/developmental disability system to ensure that the needed resources are available to all children and families.

Committee Recommendations to Consider

The following are recommendations that we would urge the committee to consider including in your final report to the 2012 Legislature:

1. Include language stating that PRTF's are a necessary and vital part of the Kansas Children's Mental Health System and a vital part of the continuum of care escalating from community-based services, Acute Care/Crisis Stabilization, PRTF services, and hospitalization.

   Update: Urge these committees to endorse this message to the Department of Aging and Disability Services.

2. Include language opposing the SRS 90% occupancy reduced resource package. If accepted this reduced resource package would further deteriorate the ability for children to receive PRTF services and would further destabilize the already vulnerable PRTF service delivery system.

   Update: This reduced resource package was not included in the Governor's 2013 budget.

3. Direct SRS to support and implement the recommendations of the PRTF task force outlined previously in this document and documented in more detail in the "PRTF Guidance Paper dated October 21, 2011."

   Update: SRS implemented the recommendations of the PRTF Guidance paper in November 2011.

4. Direct SRS to begin/continue formally tracking data about what is happening to the children being diverted from PRTF's as well as what is happening to the children when they are being discharged. This data should be reported at least quarterly to the PRTF Stakeholder Group. Data to be collected should include:
   a. Child's Custody Status (Parent, SRS, JJA).
   b. How quickly the first mental health service was offered after diversion.
   c. Exactly what services each child diverted is receiving in the community both in quantity and duration. (This can be used for fiscal forecasting).
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   e. Where each child being discharged from a PRTF is going, and also follow that child through all subsequent placements for 6 months. (IE. Home, YRC, Detention, Hospital)
   f. Exactly what services each child discharged is receiving in the community both in quantity and duration. (This can be used for fiscal forecasting).
   g. Data related to the failure to adhere to any standards outline in the Guidance Document or set by SRS and what is being done to remedy those failures.

   Update: SRS is collecting data, but unsure if data is being collected related to these specific points. SRS could share the data received with the committee. This data has not been shared in detail with the PRTF's.

5. Direct SRS to "fast track" and make a priority the implementation of a standardized intake form which could be used at any CMHC in Kansas. (This has been an on-going project off and on for many years and would help children and families' access community based services more effectively).

   Update: Unaware of any movement on this issue. Additionally, how intake will be handled under the three new managed care contractors needs to be the same. We would encourage the Department of Aging and Disability services to require the three MCO's to utilize the same intake forms which could be taken to any provider. This is particularly important for children in the custody of the State.

6. Include language stating that the committee believes that access/screening for all mental health residential care should be completed by one entity regardless of how many managed care contracts may be offered in Medicaid reform. Furthermore, all decisions for admission to residential services should be based on medical necessity, using the current screening tool and methodology, and not influenced by budgetary decisions.

   Update: 1- In reading the managed care RFP we do not believe that the screening process, the screen itself, and who will provide the PRTF screen has been delineated by the state. We urge this committee recommend to the Department of Aging and Disability Services that the current screening process and the current screen being used be retained and required for use by the three MCO's in Kan-Care.

   Update: 2- Additionally, the RFP does not specifically protect the current PRTF rate setting methodology and rate adjustment process. We recommend the committee urge the Department of Aging and Disability Services to maintain the current rate setting methodology as outlined in the Kansas State Medicaid Plan.

7. Include language stating that the mental health system has already suffered multiple cuts including $9.8 million from a rate reduction in FY 10, a $6.8 million cut in FY 11 and a $17 million cut in FY 12 totaling $33 million all funds reduction to the mental health system. Furthermore, we ask the committee to urge the 2012 Legislature to ensure the mental health system does not receive a larger proportion of the Medicaid reductions/cuts than does the physical health side of the Medicaid system.

   Update: Recommend this committee monitor the implementation of Kan-Care to ensure it is implemented successfully and its outcomes promote good health for all children.

8. SRS should identify any gaps in the behavioral health and mental retardation/developmental disability system to ensure that the needed resources are available to all children and families.

   Update: We are confident that Secretary Sullivan will examine all the systems under his authority and make recommendations for better coordination of care and if necessary will bring the needs of those systems to the legislature.

Attachment J.—State Quality Strategy

State of Kansas

KanCare Program

Medicaid State Quality Strategy

November 2011

	as approved by SRS.			
Inpatient Recidivism at 30 days, 90 days and one year post-discharge	The CONTRACTOR will monitor and report the percentage of re-admissions at 30 days, 90 days and one year from last discharge from each of the following categories: • State mental health hospitals, alternatives to state mental health hospitals, and Medicaid funded community hospital psychiatric inpatient programs for children and youth; • State mental health hospitals and Medicaid funded community hospital inpatient programs for adults; • Nursing Facilities for Mental Health; and • Psychiatric Residential Treatment Facilities. This measure will be considered as part of the CONTRACTOR's Outlier Management Program. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS. Any region and/or individual provider that falls within one standard deviation of the mean will result in a corrective action plan.	The number of inpatient discharges at 0-30 days and 31-90 days from last discharge of persons in the CMHC catchment area. Denominator: The number of inpatient discharges from the CMHC catchment area.	Hospital discharge reports, PRTF discharge reports, SRS-supplied discharge data	Quarterly
Average length of stay for Psychiatric Residential Treatment Facilities	Average Length of Stay for youth admitted to Psychiatric Residential Treatment Facility will be 100 days or lower. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS.	The CONTRACTOR will focus monitoring and performance improvement efforts on those CMHC catchment areas with higher ALOS than the statewide average. The CONTRACTOR will provide in its report an analysis of performance and a plan for performance improvement by CMHC catchment area	Numerator: Sum of days per child for children and youth discharged from Psychiatric Residential Treatment Facilities. Denominator: Total number of children and youth discharged from Psychiatric Residential Treatment Facilities.	claims data, IPS

Figure 3	
Utilization of Inpatient Services	
Item	**Details**
The number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.	
Numerator:	The number of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.
Denominator:	The number of members that were Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period.
Data Source	MMIS and the State Hospital database will be used.
Benchmark/Goal	The CONTRACTOR will exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure. Specifically, the rate will decrease by a targeted percentage.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual