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Testimony for the Corrections & Juvenile Justice Committee Chair – Representative Pat Colloton Thursday, February 9, 2012

Madam Chair and members of the committee, thank you for the opportunity to speak to you today about the needs of some very special Kansans. Lakemary Center is a not-for-profit organization based in Paola which has been in existence for over 42 years offering services to children and adults with developmental disabilities. Currently Lakemary offers a wide variety of children's programs from the early intervention of our Tiny K program to children's case management to our residential treatment program (PRTF). We also provide HCBS waiver services, both day and residential, to over 275 adults in both Miami and Johnson counties.

Our children's program has been the heart of Lakemary throughout its history and the PRTF Medicaid initiative has allowed us to reach a new level of excellence. Among the PRTF's in the state, Lakemary is the only one to exclusively focus on the needs of children with both developmental disabilities and the acute disabling psychiatric conditions that require a PRTF level of service. This is an intense 24 hour a day; 7 days a week program with much the same level of care that is offered in a psychiatric inpatient hospital experience. The interventions that are provided to these children make a long term difference in both their ability to return to a more normalized setting in their communities and to containing the costs which would otherwise be borne by public funds for the care and support of these disabling conditions over their lifetime.

You are aware of the controversial imposition of a managed care type program over the PRTF's last year which resulted in the disappearance of 200 children from the roles of this program in a few months' time. The mechanism for this dramatic change was the financial incentive offered to mental health centers to reduce PRTF utilization. The MHC's are the gatekeepers approving admissions and discharges. The State Medicaid Plan requires an independent objective gatekeeper. This incentive plan violates that agreement.

This type of "managed care" strategy imposed over a year ago has resulted in an extremely erratic application of admission standards. Also, there is a constant pressure to discharge children back to home communities without adequate preparation or the availability of the

therapy services necessary for that discharge to not only be effective but to be safe for the child, their family and the community.

The rational for this poorly thought out strategy was that there was over-utilization in a couple of smaller areas of the state. However this broad brush approach to a localized problem has had the predictable result of undercutting the effectiveness of the program resulting in increased recidivism due to failed discharge plans, and, in fact, causing several providers to make the decision to go out of business.

What is particularly egregious about the rush to remove children from the PRTF's prematurely is that the same entities doing the removal are charged with the responsibilities for after care treatment and are routinely denying or delaying needed service. This means that parents are left on their own with little support in trying to maintain the progress which a child has gained in a PRTF. Families who are reluctant to take children back in their homes because of legitimate safety concerns for their younger children or themselves are given the options of placement in a "shelter", referral to a ICF/MR, or Parson's State Hospital.

Many of you will recall that the PRTF program was created as a replacement to the old level IV, V, and VI children's residential treatment program plan which was considered obsolete. The previous program was funded by SGF only. Now there is 60% federal participation. In fact, the far less intense "step-down" option to a PRTF, the YRC, costs the same amount as SGF.

Madam Chair this sorry tale should be a graphic lesson as to the risk of imposing a poorly thought-out scheme for saving money on a fragile network of services that is the sole safety net for some of the most difficult and highest risk children in the state. This experience may help you understand why the rush to impose a medical managed care approach on these very same populations, when there is neither the demonstrated need nor the documented expertise required to do so, has produced such an outcry of concern.

My recommendations would include:

1. Eliminate the financial incentive link between mental health center funding and PRTF utilization.
2. Modify the PRTF Medicaid plan to allow for billing post discharge support and therapy services.
3. Separate DD & MI services from the KanCare umbrella.

I would be happy to answer any questions you may have.

Thank you.

Bill Craig, PhD
Lakemary Center
President/CEO