

MINUTES

JOINT COMMITTEE ON CHILDREN'S ISSUES

November 4-5, 2004
Room 313-S—Statehouse

Members Present

Senator Nick Jordan, Chairman
Representative Brenda Landwehr, Vice Chairman
Representative Sue Storm, Ranking Minority Member
Senator Henry Helgerson
Senator Dave Jackson
Senator Janis Lee
Representative Patricia Barbieri-Lightner
Representative Willa DeCastro
Representative Roger Toelkes

Members Absent

Senator David Corbin

Staff Present

Hank Avila, Legislative Research Department
Emalene Correll, Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Ann McMorris, Committee Secretary

Others Present

See attached list.

November 4

The meeting was called to order by Chairman Nick Jordan. He noted the format for the day was a roundtable discussion on foster care and mental health services for children and youth in the foster care system. Each person seated around the table was asked to introduce himself or herself by name and affiliation ([Attachment 1](#)). It was stated that the goal of the Joint Committee is to obtain information on how children's programs are working throughout the state from those who have an interest in the system of child welfare services. Participants were asked for

suggestions to improve or to change any of the program components. The Joint Committee on Children's Issues will review any suggestions when the Committee prepares its recommendations to the 2005 Legislature.

Staff called attention to the following information provided for members of the Committee:

- □ letters from Judith Ann Amacher, Liberal, and her son in regard to his mental health care ([Attachment 2](#));
- □ Attorney General's Opinion regarding Minors-Kansas Code for care of children ([Attachment 3](#));
- □ Memorandum from Tamara J. Hawk, LSCSW ([Attachment 4](#)); and
- □ Current Poverty Guidelines ([Attachment 5](#)).

Opening the roundtable discussion, the Chairman stated an open discussion on mental health and foster care issues was the topic of the day. There was no preset agenda since the discussion was intended to bring out issues that need attention.

Discrimination Against Persons With Disabilities

One of the roundtable participants stated that many of the persons around the table are aware of people with disabilities feeling that they are being discriminated against, or held to different standards when an investigation of abuse or neglect is being done. It was indicated that advocates for those with disabilities had started working in many arenas, including with Social and Rehabilitation Services, on the manual used to train social workers to do investigations. Advocates are also working on a curriculum on awareness of disabilities from the viewpoint of those with disabilities. The roundtable member said she wants the group to know there is still discrimination going on, whether it is meant to happen or just the result of lack of education. Advocates have some possible changes in state laws that they would like to see made.

The participant who raised the issue of discrimination was asked:

- Is there a difference between single-parent and two-parent families in discriminatory treatment; and
- Are there different standards when one or both of the parents have a disability.

In response, it was stated that current procedure does not involve doing a "family wrap-around" to see what is really needed, and to determine whether the parent or parents have the support and services needed. There is a perception, that due to the disability, social workers can come in and remove the children. Disabilities are used as the determining factor in the care of the child. A roundtable member stated the position of Social and Rehabilitation Services is that they never want to remove a child from a family unless there is an abuse situation. It was further stated that, if asked whether agency personnel have been sensitive to the disabilities of the parents in those situations, the answer would be probably not. The agency recognizes this and is trying to move forward to prevent this from happening in the future, but it needs to be recognized that it takes a long time to implement change and educate social workers across the state. The

state agency tries to make agency workers aware of individuals in the community who can help support disabled parents and give them a contact point.

Several examples of perceived discrimination were cited. In one instance, a parent wanting the children back, had accomplished what had been required by the court, but was then cited for having a bicycle in her living room to keep it from getting stolen. This was the reason given to the parent for the children not being returned. In another case, the children were sitting on the floor working on a school project, and the social worker cited the mother for poor housekeeping. The roundtable participant who gave the examples is blind, and has been told that blind people cannot raise children. Another roundtable member noted that there are mothers who never take their baby home from the hospital, because someone decides they are not capable of caring for the baby, but no training is offered to give them a chance to do so. In response to a question as to who reported the disabled mother to Social and Rehabilitation Services for investigation in the case of a mother who was not allowed to take her baby home, it was stated that the referral came from a physician or hospital staff. The opinion was stated that there are definite standards that the disabled are being held to that are discriminatory.

The roundtable members discussed family “wrap-around” services, counseling, and training—services that should be available for the disabled.

Mental Health Services

Mental health service issues were raised by a roundtable member who indicated services for children in the foster care system are inadequate or not available under the present delivery system. Family preservation, which may rely on counseling and other mental health services to keep a family intact, was also cited as an area in which services are inadequate or not available. Both the consumer and provider views were discussed.

In terms of consumer issues, the lack of experienced providers for certain mental health specialities was cited as being a problem statewide, as was the need for a child or family to change providers when the child enters the child welfare system, which may setback treatment that has been making progress through a private sector provider. The letter appended as Attachment 2 raises both issues from the viewpoint of the consumer, *i.e.*, the family came into the system with a care plan which had been in place for a period of time in another state and which was offered to the community mental health center designated under the state’s contract with The Consortium. The center was unable to provide the same level of care. As the letter notes, services were sporadic, and communication was almost nonexistent largely through lack of staffing. In this case, the youth involved has ended up in the juvenile justice system.

A roundtable member from western Kansas who is a clinical social worker noted, although services may be offered by contracting provider, in many instances there are no close facilities available, the child has to be taken out of school, the foster or birth family has to take time off work, and everyone has to travel several hours for a consultation with a psychologist who is an employee of the community mental health center. At the same time, there are mental health professionals who are licensed to diagnose and treat mental illness who are closer to the child in need of services, but who are not a part of the mental health center. It was suggested the medical card be opened up to mental health providers who are not psychologists and who are not affiliated with a community mental health center in order to improve services. Asked what type of provider would be available in this kind of situation, the individual who had made the suggestion replied that generally the provider would be a clinical social worker licensed to diagnose and treat mental illness. In a few cases, there are psychologists who are in private practice who would see Medicaid-related children and youth. Another roundtable member, who is the director

of a community mental health center, expressed concern about opening up the medical card to providers who are not a part of the community mental health center system. Another, who is also a community mental health center director, noted that in their facility they use television capabilities in order to minimize traveling, to provide psychological and other mental health services on site where no traveling is necessary, and psychological and mental health services can be provided on site. An employee of the Department of Social and Rehabilitation Services explained that efforts are being made by the agency in the area of technology to resolve the problems in western Kansas. Several counties in which no services are available except through travel were named by a roundtable member.

A member of the Joint Committee noted two things had already come out in the discussion, and they are not new since the Committee had heard the same things for the past four years. From the providers, the Committee has heard and continues to hear—we are going to expand services; we are already providing the needed services; or we are studying “it.” From the consumers, the Committee has heard and continues to hear—children need mental health services and they are not getting set up with services; we are in areas where the services cannot be accessed when children need them; and there are gaps in the services that are available. The one thing the Committee members have heard clearly is that there are providers out there whose services are not being utilized, because they are not a part of the community mental health center structure. The centers are not contacting these people to see if they are willing to enter into some type of agreement to provide services through referral or as an affiliate. The centers are opposed to opening up the medical card to private sector providers, but they are not utilizing those who may be available to provide services that are not easily accessed or are not available through the mental health center staff. It is time these issues are resolved. Another Committee member asked, if children are first and foremost priorities, and if providers who are outside the mental health system have met all the requirements to provide mental health services, how do we justify not opening up the medical card to other providers for children and youth in western Kansas or anywhere else they could be utilized? Are we saying that no services are better than services provided by outside professionals?

A roundtable participant, who represents consumers, stated children need mental health services, and they are not getting set up for these services, further noting that “we” are in an area where this service cannot be accessed when children need them. The majority of children who need mental health services are school age children and, to set up a 1:00 p.m. appointment, pulls the child out of a class which usually cannot be made up. That may work for the child in the summer when the child is not in school, but not during the school session. Another issue is, if the child does not mesh with the person providing services and voices discontent, the child gets taken off the mental health plan. The system is not working. Centers can hire all the workers they want, but if the workers are not accessible during family time for the people who need the services and work with them, then the system is not acceptable.

A mental health center director who was not a member of the roundtable recommended mental health services be provided at school, suggesting one thing that can be done is for the centers to figure out a method to deliver services at schools. A clinical social worker in private practice, also not a member of the roundtable, expressed concern with working with the child in the context of the school, unless the service was made available to the parents. She suggested she would not want a school to have access to or to decide on a service for her child.

The same individual started the discussion. So far, it seems to center around two issues:

1. Concern that opening up the Medicaid card to a maximum of about 1500 providers would result in there not being enough work, resulting in a shifting of

dollars, with a negative impact on the mental health centers and the work that is being done in each area; and

2. Who is qualified to provide services?

She noted she is currently authorized to provide services to persons who have TriCare, the federal employee health insurance, to the employees of any number of companies who are either self insured or insured through different insurance providers and is also a Medicaid provider, but, in the latter case, only allowed to practice under certain codes, and those codes are family preservation codes. She goes into homes and works with children and families. She works with adoptive parents. Finally, she stated, as we look at the long-term, what happens to the children?

A psychologist and community mental health center director noted that there is a different view of services provided in northwest Kansas. He enumerated the availability of services provided. A representative of the disabled reiterated it can take three to six months to get an appointment and noted, on the disability side of the world, this is forever. She asked why does it take so long to get in the system? Is there some way to unclog it? The individual who had spoken of northwest Kansas said that what actually causes delays in a psychological evaluation or service access is getting the necessary information from the care providers to be able to do an evaluation. He also stated his belief that one of the fundamental strengths of integrated mental health service, such as we now have, is one-stop shopping and efficiency. There would be difficulty in coordinating services and, in some instances, duplication if other providers can access the medical card. An example, under Medicaid regulations, a child receiving services would be required to see a psychologist which could result in a duplication of services.

Staff was asked to provide the Committee with a list of issues about mental health services identified in the past.

A member of the Joint Committee on Children's Issues noted in the 2004 Legislative Session that there was discussion of opening the Medicaid card to providers in private practice, resulting in the adoption of a proviso directing a study of the experience of other states and the conduct of focus groups around the state, culminating with a one-day summit with representation from all providers. The study is to be completed during the fiscal year ending June 30, 2005. It was noted we are taking almost a year to "study" a subject the Committee has been discussing for over two years. There is nothing in this proviso to prevent the Department of Social and Rehabilitation Services from coming back to the legislature at an earlier date with a proposal to open the card.¹

Another member of the legislature indicated that he had heard three issues that need to be resolved:

- collaboration between the contractors and the community mental health centers;

¹

Proviso from Chapter 184, Section 24(l) of the 2004 Session Laws:

"(l) During the fiscal year ending June 30, 2005, the secretary of social and rehabilitation services shall not expand the existing public mental health provider system by opening up the medical card for the provision of mental health services to other than the existing medicaid eligible providers of mental health services as of March 1, 2004: Provided, That the secretary of social and rehabilitation services shall work with the association of community mental health centers of Kansas, inc., to identify and address concerns related to service delivery, access and choice within the structure of the existing public mental health system."

- opening of the medical card yet preserving the gatekeeper concept; and
- determining whether we want case management and how do we do that case management.

A representative of social workers, who was not a member of the roundtable, explained the background for advocating for opening the Medicaid card to other providers. This has come about over a period of eight years when private social work providers have contacted the association to report that a family has contacted them for help, and the family has a Medicaid card, so the private social work provider cannot help them. What can they do? This may be a family in crisis who is seeking help. If the help is not forthcoming when they call, the opportunity to preserve the family may be lost. This is important to social workers who want to help the people in our community who have the least resources. These same social workers can serve anyone with Blue Cross-Blue Shield coverage, any other type of insurance who can bill Medicaid, and in certain circumstances, can bill for persons who are Medicare beneficiaries. In addressing the Social and Rehabilitation Services proposal of last year, the social workers association is troubled since the proposal creates another whole new system.

A member of the roundtable stated the Kansas Medicaid system is on an edge which makes foster care contractors, Social and Rehabilitation Services workers, and mental health centers nervous. It is possible to have discussion about the potential for affiliation, but it will not work out for everyone. Another member of the roundtable who represents an advocacy group indicated that many of their calls are from people not able to get services. That is not to say services are not out there. The issue may be accessibility, flexibility of schedule, etc. The organization receives about 300 calls a day—covering staff issues, funding issues, and numerous other issues. The calls are from all areas of Kansas. The letter in Attachment 2 is an example of the confusion and frustration she experienced with her son in the mental health system. She was unable to get medical records of her minor son, an issue that is more frequent than in the past. The school and mental health center did not work together on this child. Foster parents find they cannot get services for the children under their care.

Several round table participants spoke out about the fear of parents to speak up because they may lose their benefits. Parents are scared to talk about the lack of services or problems they may be having, because doing so causes services to be discontinued. The more a parent talks about wanting their child back home, the more services are yanked from them. Not only biological parents, but foster parents are scared to step forward because of repercussions.

Roundtable participants were urged to coordinate their concerns, and present the Committee with a combined proposal for change before the 2005 Session.

The roundtable was adjourned.

November 5

HealthWave

Scott Bruner, Director of Medical Policy, Social and Rehabilitation Services, provided background on the State Children's Health Insurance Program, also referred to as SCHIP and Title XXI. The program represents a federal-state partnership created to expand health insurance coverage to children whose families are not eligible for Medicaid based on federal poverty guidelines. Kansas implemented a separate Children's Health Insurance program in January, 1999, and integrated it with the state's Medicaid capitated managed care program in SFY 2002 for a combined program known as HealthWave (Attachment 6).

Mr. Bruner reviewed the eligibility requirements and medical services coverage available for pregnant women who qualify for HealthWave, the various options the state has available in terms of eligibility, and applicable federal regulations. As of October 2004, 33,941 children and youth were enrolled in HealthWave XX1 with total expenditures to date for SFY 2005 of \$18,668,816, and 50,338 children and youth were enrolled in HealthWave XIX, along with 10,368 adults with total expenditures to date for SFY 2005 of \$36,523,297.

There was considerable discussion of expansion of prenatal coverage for pregnant women and for the child during the perinatal period. Discussion centered on expanding eligibility for pregnant females based on the federal poverty guidelines. Mr. Bruner outlined the agency's estimates of potential additional persons who would be eligible for either Title XXI or Title XIX expansion. While an expansion of Title XXI would result in a better federal match rate, it would also result in depleting the total federal block grant allotment earlier than November, 2007. More importantly, under federal Title XXI, women who have even minimal health insurance cannot be covered.. The whole premise of an expansion is to be able to broaden the state's ability to insure more pregnant women who do not qualify for publically funded health care and cannot afford private sector health insurance. Any expansion would cover the unborn child to make sure there is prenatal care. The Committee asked Mr. Bruner to respond to questions about the services currently being provided under HealthWave, eligibility requirements for both the Title XIX and Title XXI portions of the programs, and current practices. It was noted, HealthWave and non-managed care Title XIX services are based on medical necessity. In general, experimental procedures or procedures that are not widely accepted by the medical community would not be covered.

As requested by the Committee, Mr. Bruner reported on the study done by EDS on the cost and feasibility of discontinuing the practice of monthly paper eligibility cards for children and youth who enter HealthWave through Title XIX, since such children and youth have 12-month continuing eligibility. If the monthly eligibility cards were discontinued, the Title XIX children and youth would be treated in the same manner as those whose HealthWave eligibility is based on Title XXI standards. Mr. Bruner and the Committee discussed the pros and cons of having First Guard Kansas issue plastic cards good for 12 months, as they now do for children and youth whose HealthWave coverage arises from Title XXI eligibility. Doing away with the paper cards would require a change in the system regarding medical services and eligibility, and a policy change. Currently Medicaid is spending \$700,000 a year on paper cards. If a policy change is made so all children and youth who qualify for HealthWave are treated the same, the change would not affect those Medicaid-eligible adults who opt for capitated managed care, since they do not have automatic 12-month eligibility (See Attachment 6).

Children's Cabinet

Jim Redmon, Interim Executive Director of the Kansas Children's Cabinet, noted three topics covered in his testimony:

- □ Smart Start;
- □ Approval by the State Finance Council of an evaluation of Children's Initiative Fund programs; and
- □ The allocation of dollars involved.

He distributed a document prepared by the Kansas Children's Cabinet and Trust Fund covering the Children's Initiative Fund Evaluation Plan (Attachment 7).

Issues for Committee Discussion

Legislative Research Staff reviewed the issues discussed at the Joint Committee meetings held on June 23, July 12, and August 25, 2004.

Committee Discussion and Recommendations on Foster Care and Mental Health Services

Following extensive discussion, the following preliminary recommendations were developed:

- □ Recommend further study by the Ways and Means and Appropriation Committees and the Judiciary Committees of each house on the issue of whether a child in a state funded program should receive funds from the estate of a deceased parent upon disposition of the estate through a will. There was insufficient time for the Joint Committee to study this matter in depth.
- Investigate further alleged retaliation against foster, birth parents, or service providers for making complaints regarding mental health services or requesting additional services.
- Recommend expansion of the pilot parent advocate program statewide, including a change in the name and removal of the sunset.
- Ask the Office of Judicial Administration to present a budget item to the Committees on Ways and Means and Appropriations to cover the cost of distribution of the CD developed by the Office to educate advocates and parents on procedures under the child in need of care code.
- Recommend the community mental health centers develop expanded services for children and youth in the child welfare program through agreements with private sector mental health service providers. The Committee intends that expansion of services include in the context of this recommendation both agreements with private sector providers who have experience and expertise in the treatment of specified mental health diagnoses, and private sector providers whose location within the community mental health catchment area can reduce travel time, time away from work and school, and service delay. The mental health centers should report progress on agreements to the Committee during the 2005 Session.

Next Meeting

Subject to approval of the Legislative Coordinating Council, the Joint Committee will meet on December 2 and 3, 2004. On December 2, there will be a roundtable of judges and Committee members. On December 3, the Committee will consider recommendations to be made to the 2005 Legislature.

The Committee was adjourned.

Prepared by Ann McMorris
Edited by Emalene Correll

Approved by Committee on:

December 3, 2005

(date)