Kansas Department of

Social and Rehabilitation Services

Gary Daniels, Secretary

House Social Services Budget Committee
January 23, 2006

Inpatient Psychiatric Treatment Facilities for Youth

Health Care Policy
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Chair Landwehr and Committee Members, I am Gary Daniels, Secretary of the Kansas Department of Social and Rehabilitation Services (SRS). Thank you for the opportunity to discuss current issues involving Level V and Level VI inpatient psychiatric treatment facilities, and Therapeutic Foster Care services for Kansas youth.

Current Picture

Kansas youth experiencing significant mental health and/or behavioral health service needs currently include these out-of-home psychiatric treatment options:

Level of Treatment	Juvenile Justice Authority (JJA) Custody Placements	Social & Rehabilitation Services Custody Placements	Non-Custody Placements	Totals
Level V	317 (75%)	90 (21%)	16 (4%)	423
Level VI	88 (31%)	123 (44%)	66 (24%)	277

Currently there are 17 Level V facilities, which can support up to 489 Kansas youth who exhibit behaviors classified as antisocial, oppositional, defiant, or aggressive, and who tend to be diagnosed with disorders such as severe conduct disorder, adjustment disorder, or developing personality trait disturbances. Their behavior tends to be aggressive and threatening, and they require a high degree of supervision and structure.

In addition, there are 10 Level VI facilities, which can support up to 300 Kansas youth who exhibit socially maladaptive behaviors generally as a result of past abuse and neglect, as well as severe emotional or mental disorders resulting in the need for more intensive psychiatric or medical treatment. These youth generally have a greater need for psychotropic medications and occasionally represent a danger to self or others.

And there are five agencies sponsoring Therapeutic Foster Care homes, with 10 homes that can support up to 20 Kansas youth who have unique care and treatment needs associated with medical, psychological, behavioral or psychiatric difficulties. This is a family-based service delivery approach, providing individualized treatment for youth who are at risk of placement in a more restrictive setting.

In the past, Community Mental Health Centers (CMHCs) have not been involved in the screening for or delivery of Level V or Therapeutic Foster Care services. Because of the critical

need for coordination of care and early, consistent access to mental health services for these youth, SRS has now requested CMHCs get directly involved in the screening for all of these youth services, and the CMHCs have been responsive to that request.

Context of Changes Coming

Consistent with an overall increase in monitoring, scrutiny and disallowance of existing agreements, CMS (Centers for Medicare and Medicaid Services) has advised Kansas that some core changes are required in the manner in which public mental health services are managed and funded. This includes reclassifying mental/behavioral health services provided to youth in 17 bed or larger congregate settings as IMD (Institutes for Mental Disease) services, following strict facility and programming requirements, using an approved rate methodology, and prohibiting other Medicaid services to be billed for people receiving IMD services.

"Extended Stay" Issues

Pursuant to our Medicaid State Plan agreement with CMS, there are some limitations to the number of days services can be provided in these facilities. In order to access shared funding through the Medicaid program, the state plan defined length of stay limitations apply, and they are 140 days for Level V facilities, and 180 days for Level VI facilities and Therapeutic Foster Care. Federal Medicaid funds cannot be claimed for days youth are in these facilities in excess of these limits. However, provider claims before January 1, 2006, were not subject to these limits and Medicaid claims have been processed and were submitted to CMS for days in excess of the limits. CMS has deferred the claims for federal funds for days in excess of the limits for children served through the child welfare contracts In the future it is likely CMS will defer additional claims in excess of the limits for other youth such as those in the custody of the Juvenile Justice Authority.

The following charts reflect the number of days youth stayed in Level V and Level VI settings, past the Medicaid limits, during the first half of FY 2006. It is believed this is due in part to a change made effective July 1, 2005, wherein the facilities were allowed to bill Medicaid directly for the services they provide instead of being paid by the foster care contractors as was previously done. SRS believes the steps described above will reverse this trend, significantly reduce lost Medicaid funds, and ensure appropriate services are provided to each youth.

	LEVEL V		LEVEL VI		TOTALS
FY 2006	Actual No. Youth Days > 140 Days	Actual Medicaid Cost of Extended Stays # of Days x $104.08	Actual No. Youth Days > 180 Days	Actual Medicaid Cost of Extended Stays # of Days x $210	Total Actual All Funds Cost of Extended Stays
July	737	$76,707	270	$56,700	$133,407
August	806	$83,888	318	$66,780	$150,668
September	854	$88,884	352	$73,920	$162,804
October	1,040	$108,243	449	$94,290	$202,533
November	1,231	$128,122	589	$123,690	$251,812
December	1,513	$157,473	859	$180,390	$337,863
TOTAL					$1,239,087
Lost Federal Medicaid Funding					**$750,391**

LEVEL VI

LEVEL VI EXTENDED STAY UTILIZATION FY 2006 YTD ACTUAL

FY 2006	Number of Youth > 180 Days by Day																														Person
Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Days/Mo.
July	8	8	8	8	8	8	8	8	8	8	8	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	10	10	270
August	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	11	11	11	11	11	11	11	11	318
September	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	11	13	13	13	13	13	13	13	13	13	13	13		352
October	13	13	13	13	13	13	13	14	14	14	14	14	14	14	15	15	15	15	15	15	15	15	15	15	15	15	15	15	16	17	17	449
November	17	17	17	17	17	17	17	17	18	18	18	18	18	18	20	20	20	20	21	21	21	22	22	22	22	22	23	23	23	23		589
December	23	23	23	23	23	23	23	23	23	23	23	23	25	25	25	25	25	26	27	33	33	33	33	33	33	33	34	35	35	35	35	859

LEVEL V

LEVEL V EXTENDED STAY UTILIZATION FY 2006 YTD ACTUAL

FY 2006	Number of Youth > 140 Days by Day																														Person
Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Days/Mo.
July	22	22	22	22	22	22	23	23	23	23	23	24	24	24	24	24	24	24	24	24	24	25	25	25	25	25	25	25	25	25	25	737
August	25	25	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	27	27	806
September	27	27	27	27	27	27	27	27	27	27	27	27	28	28	28	28	28	28	29	29	30	30	30	30	30	30	30	30	32	32		854
October	32	32	33	33	33	33	33	33	33	33	33	33	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	1040
November	36	36	37	37	37	37	38	38	38	39	39	39	39	39	39	40	40	43	43	43	43	44	45	46	46	46	46	46	46	46		1231
December	47	47	47	47	47	47	47	47	48	48	48	48	48	49	49	49	49	49	49	49	49	50	50	50	50	50	51	51	51	51	51	1513

These service limits are consistent with sound public policy related to services for youth, in that they strike a balance between responding to acute psychiatric or behavioral needs on the one hand and getting the youth stabilized, served in a least restrictive environment, and returned to his or her community in a timely and effective way. The youth receiving these services tend to have multiple and complex treatment needs, often of long duration. Functional and durable after-care plans are therefore quite challenging and must be carefully developed.

SRS is working closely with providers to ensure that these service limitations are met, that medical necessity for the level of service is demonstrated, and that appropriate mental health services are available for youth in need. In exceptional circumstances, some youth may need to be provided in patient psychiatric treatment beyond the Medicaid limit. In addition, these facilities have been used as a placement for some youth, not continuing to need inpatient psychiatric treatment but who are very difficult to serve. This may include youth who have a history of committing sexual offenses, or it may involve youth who in addition to psychiatric treatment needs also experience significant developmental disabilities. Some additional time may be needed to secure appropriate, alternative placement or to develop waiver-funded services for these youth.

SRS Response

Some ways in which SRS is addressing these issues are:

- Starting January 1, 2006, the Medicaid Management Information System was adjusted to edit out any Medicaid claims made in excess of the Medicaid limits, and SRS will pay for prior approved extended stays with state funds thus eliminating additional CMS deferrals.
- All youth for whom these services are being sought have been and will continue to be screened to ensure they need this level of inpatient psychiatric treatment.
- Prior approval for extended stays beyond the Medicaid limit are being provided for those youth determined to continue to need this level of care. Initially this approval was provided for all youth for whom extended stays were requested, to ensure that no youth was discharged before sound after-care plans could be developed. However, it appears that the presence of the screening process itself led to timely discharges for several youth.
- Regular continued stay reviews will be done for all youth receiving these services.
- No state funds will be used to pay for services not approved as meeting medical necessity, effective March 1, 2006. Youth being served by child welfare contractors who are not approved for initial placement or extended stay for this level of care, but who remain in these facilities after March 1, 2006, will be paid for by the contractors continuing those placements.
- SRS, child welfare contractors, community mental health centers, and community developmental disability organizations are seeking or developing alternative, appropriate services to meet the needs of youth who have been determined to not need this level of care.

This concludes my testimony. I will be glad to stand for questions from the committee.