Kansas Department of

Social and Rehabilitation Services

Gary Daniels, Secretary

House Appropriations Subcommittee on Level V & VI
March 8, 2006

Level V & VI Inpatient Psychiatric Treatment Facilities and Therapeutic Foster Care Services

Health Care Policy
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Chair Bethel and Subcommittee 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.

Five agencies sponsor 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.

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.

In the context of responding to these CMS requirements, SRS is working in close partnership with the Juvenile Justice Authority (JJA), the Division of Health Policy and Finance (DHPF) and other stakeholders to build solutions that support a shared vision of the preferred future for these critical youth services. Services will be delivered in the amount, scope, duration, and intensity to meet the mental health needs of Kansas youth in the least restrictive appropriate setting. They will be based upon comprehensive and coordinated assessments, and will be driven by sound and effective evidence-based programming.

"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.

The following charts reflect the number of days youth stayed in Level V and Level VI settings, past the Medicaid limits, during the first seven months of FY 2006. It is believed the increase through December 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 below will reverse this trend, significantly reduce lost Medicaid funds, and ensure appropriate services are provided to each youth.

FY 2006	LEVEL V			LEVEL VI			TOTALS
	Average Youth Per Day > 140 Days	Actual No. Youth Days > 140 Days	Actual Cost of Extended Stays # of Days x $104.08	Average Youth Per Day > 180 Days	Actual No. Youth Days > 180 Days	Actual Cost of Extended Stays # of Days x $210	Total Actual All Funds Cost of Extended Stays
July	24	737	$76,707	9	270	$56,700	$133,407
August	26	806	$83,888	10	318	$66,780	$150,668
September	28	854	$88,884	12	352	$73,920	$162,804
October	34	1,040	$108,243	14	449	$94,290	$202,533
November	41	1,231	$128,122	20	589	$123,690	$251,812
December	49	1,513	$157,473	28	859	$180,390	$337,863
January	30	930	$96,794	27	837	$175,770	$272,564
TOTAL							$1,511,651
Lost Federal Medicaid Funding							**$915,456**

The 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 Response

SRS is working closely with providers to ensure that appropriate mental health and behavioral support services are available for all youth who need them, that specific service limitations are met, and that medical necessity for the level of service is demonstrated. In exceptional circumstances, some youth may need to be provided inpatient 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 has been and will continue to be needed to secure appropriate, alternative placement or to develop waiver-funded services for these youth.

Some of the specific ways in which SRS is addressing these issues are:

1. Starting January 1, 2006, the Medicaid Management Information System was adjusted to edit out any Medicaid claims made in excess of the Medicaid limits. SRS will pay for prior approved extended stays with state funds thus eliminating additional CMS deferrals.
2. 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. Providers have been assured that these services will continue to be approved for any youth who continues to need them.

3. As any youth approaches the maximum length of stay in these settings, if appropriate discharge and after-care cannot be accomplished, a review to assess medical necessity for continued stay will be conducted.
4. 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. There are only 14 SRS-placed youth whose continued stays have not been approved as meeting medical necessity.
5. 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. As we continue to build toward the preferred future in meeting the needs of Kansas youth, effective ways to meet the extraordinary needs of some youth will be included.

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