MINUTES

JOINT COMMITTEE ON CHILDREN'S ISSUES

August 19-20, 2003
Room 313-S—Statehouse

Members Present

Representative Brenda Landwehr, Chair
Senator Nick Jordan Vice Chair
Senator David Corbin
Senator Paul Feleciano
Senator David Jackson
Senator Janice Lee
Representative Patricia Barbieri-Lightner
Representative Willa DeCastro
Representative Roger Toelkes

Member Absent

Representative Sue Storm

Others Present

See attached list.

Staff Present

Hank Avila, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Renae Jefferies, Revisor of Statutes Office
Almira Collier, Committee Secretary

Tuesday, August 19
Morning Session

The meeting was called to order by the Chair. After members of the roundtable (Attachment 1) and the Committee introduced themselves, the Chair thanked the participants for their willingness to participate and opened the meeting for comments regarding the challenges of providing mental health services for children in foster care and support for foster care parents.

In the initial discussion it was noted there are still gaps and issues that need to be addressed. Foster parents and licensed specialist clinical social workers in private practice recounted case scenarios, noting what they believe to be weaknesses in the foster care system and gaps in service that still exist. For example, a six and four-year old who are in their ninth placement in three years; two boys who have been in the system for several years, but who did not receive all of their immunizations and are now too old to receive them; and children with severe and multiple problems who were placed in a foster home in May with the foster parents still waiting to be contacted by someone in the system. The length of time it takes to get an evaluation and appropriate and adequate services for the child and the biological, foster, or adoptive family are still significant issues.

Foster Parents

Emphasis was placed on the need for in-home and community-based services for children, especially severely emotionally disturbed (SED) children, as well as support services for foster parents of such children. The importance of foster parents was stressed. The ones who help children get better are the people who live with them. Foster parents need to be seen as part of the team, need to be listened to, and need to be treated with respect and consideration. Experienced foster parents, who deal with the child 24 hours a day, seven days a week, want to be believed when they share what is happening with the child in their home, rather than being questioned about whether or not they are a good parent. The need to include foster parents in the initial interviews, to share with them what is happening in therapy, and to provide appropriate and adequate support for them was discussed. The impact of the services provided by mental health professionals and suggestions given to foster parents is minimized if foster parents do not understand what is going on in therapy, do not have input, and do not have the support to apply the suggestions they are given consistently. Throughout the discussion emphasis was placed on the need for all parties involved with a child to function as a team, to communicate with each other, and to respect each other.

In response to a question raised later, a foster parent stated she hesitated to participate today because she is scared of the local mental health center which turns foster parents in, does not support foster parents, and tries to get information out of the children which is then sometimes twisted. These are adults who should know better than to let children manipulate them. When the child is not provided needed services and begins to have major problems, the mental health center says it must be the situation in which the child is living. Answering a question, the foster parent said the child with 18 previous placements that she received has been in another foster home, with which she stays in touch, since May, and, as of last week had not received any services from the local mental health center. The probability of the current foster parent being able to maintain the child is doubtful. Reasons given by centers for delays in providing services to the child include: lack of funding and resources, inability to provide a therapist who can provide the treatment needed, or the inability to get the medical intake the child needs for medication.

Services for SED Children

It was noted when mental health services were made a part of the foster care contractor's responsibility, approximately $60 to $70 million was allocated for services. This was raised to over $125 million when the contracts were renewed. A question was raised as to why, if mental health centers are under contractual obligation to provide services, services are not being provided. In response, a representative of the Department of Social and Rehabilitation Services stated when the partnership between the child welfare system and the mental health system for serving SED children was implemented in October, 2001, the medical card was opened up for direct fee-for-service for this specific population. Children have to be referred to the community mental health center for an intake interview by the contractor who has done a preliminary evaluation. The medical card opens up the availability to services through the community mental health center.

In response to a question, a social worker in private practice stated in rural communities there are a limited number of social workers. Since the medical card is not open to social workers in private practice, this number is limited further. When a child she is seeing is determined to be an SED child, she has to refer them to the mental health center, and, in her area the center is not able to provide all the needed services. One child whom she had been seeing once a week was only able to be seen once a month by the community mental health center. In some cases a child can be without services for two months.

Using as an example reactive attachment disorder, it was noted there is a need to recognize the traditional 50-minute session in a clinic or office setting does not meet the needs of many of the children. There is a need to develop and utilize more appropriate and useful modalities of treatment. In response to a question, a social worker specializing in reactive attachment disorder stated the disorder involves the inadequate development of the frontal area of the brain, often caused by the mother using drugs or alcohol during the pregnancy, and compromising the ability of the child to make appropriate decisions. It is sometimes misdiagnosed as attention deficit disorder, which can be one of the symptoms. The inability to make appropriate decisions may not become apparent until the child reaches puberty. Helping these children and others with certain severe emotional disturbances is not hopeless, but it takes people committed to working within the context of the child's environment in an intensive and continuous way for a very extended period of time.

The discussion proceeded to issues relating to staff and staffing which directly relates to what services are available. Mentioned were the high turnover in social workers, especially for contractors; an inadequate pool of qualified people, especially in some professions and in some geographic areas, from which to recruit staff; the inability to utilize professionals in private practice in the community, especially licensed specialist clinical social workers because of reimbursement constraints; and not always being able to recognize all available resources or potential resources available to a family, *i.e*. identifying a friend or relative who can take family members to appointments.

It was noted the limitations on who can be reimbursed through the medical card has two significant negative consequences. It reduces the number of professionals in the community who can be accessed and it impacts continuity of care for some children, especially those being seen by a licensed clinical social worker prior to becoming a part of the foster care system. In some cases this may mean that in-home services which have been provided will be discontinued. Both the type of service and the therapist change. The need for legislators and the Department of Social and Rehabilitation Services to address this issue was noted.

Lack of professional staff trained to handle some specific types of problems such as attachment issues in some community mental health centers and what appears to be an unwillingness of some centers to provide services for children diagnosed with certain disorders, perhaps due to the high cost involved, were issues noted by roundtable participants. When the community mental health center has no one on the staff qualified to provide treatment for a child with a specific diagnosis such as reactive attachment disorder or fetal alcohol syndrome, where does a foster parent go? Foster parents shared the following scenarios. The foster children have made progress due to in-home services provided twice a week by a licensed specialist clinical social worker who is referred to as a friend of the foster mother rather than a social worker. This is intentional since foster children sometimes seem to fear or distrust social workers, those associated with the Department of Social and Rehabilitation Services, and the court. However, reimbursement issues will impact the continuation of this treatment. In another case, permission was finally given for the foster parent to sit in on the first and last ten minutes of therapy sessions after continual begging on the part of the foster parent. This was helpful since, with an awareness of the behaviors that might be exhibited as a result of what was opened up in therapy, the foster parent could anticipate, understand, and better cope with exhibited behaviors. In another case involving foster care, a contractor, when asked, paid for three sessions with an attachment therapist, but denied further

payment so the child had to return to the community mental health center where this specific service was not available. In another scenario, a request for a different type of help, which the foster parent felt was needed, was denied by both the contractor and the community mental health center. The center was willing to provide only maintenance therapy because the child did not relate to the therapist they chose for him. After a year, this child had to be placed in an institution. In another situation, an adoptive parent who did not receive needed support had to place the child out of the home for a period.

System Issues

Concern was expressed relative to how children come into the system which leads to fairly predictable outcomes. Because of the fragmentation between the Department of Social and Rehabilitation Services and the contractors, children often come into the system unnecessarily. Biological parents are not being given adequate services at the front end of the spectrum, resulting in children coming into and staying in foster care too long which often intensifies the problem and the destabilization of the child thereby requiring more extensive services. The system automatically takes on more responsibility for the child than it should, which means the social worker's energy must be focused on the child, and the parents, both biological and foster, are left out. More effort needs to be devoted to securing an investment on the part of biological parents, establishing realistic expectations of these parents, and helping them meet the expectations. Making biological parental involvement a part of the court order, which is enforceable, was suggested.

Another issue has to do with youth in middle to late teens with dramatic and disruptive behavior disorders often requiring the most expensive level of care who come into the system because of overwhelmed parents. Too often the youth ages out of the system and returns to the parents who have not been involved while the youth was in the system or made any changes while the youth was in care.

Having an adequate history which follows the child continues to be a problem. Responding to a question, a member of the staff of the Department of Social and Rehabilitation Services, referred to the educational enrollment form project reported on at a committee meeting last year. Relevant information about a child in foster care is entered into a data base in order that when the child moves the receiving school can access the information immediately and use it to meet the educational needs of the child. When addressing the broader issue of collecting more adequate data in the initial contact with families, the Department of Social and Rehabilitation Services realized that the genetic, medical, and history form used for adoption could be used for this purpose. One aspect of collecting information at the front end of the process that has to be considered is respecting the family's right to privacy and limiting government intervention and intrusion into a family as much as possible. Getting a history can be a slow and methodical process because to get a good history people have to have a certain level of trust.

A mental health center director noted when a child is being removed in a family crisis situation, the family may not be thinking too clearly and members hesitant to disclose certain types of information. Like the situation in an emergency room, the emphasis in such situations is on stabilizing and calming the situation. While the information is important, getting detailed information may not be the priority at this time. Also, it is difficult to get adequate information when taking a child into the mental health system if the foster family has had the child only a short time and does not have a history for that child. A representative of a contractor stated putting one of the most experienced staff at the front end of the process and establishing expectations has meant completion of an inclusive history within ten days using tools developed nationally and completion of case plans within twenty days of the child being placed. A mental health center director noted the contractor with whom they work goes to great lengths to get as adequate history as possible.

It was pointed out that sharing information once it is collected is impacted by issues of confidentiality, with professionals tending to err on the side of not sharing information even when this may be to the detriment of the child. The Judicial Council, currently working on the Code, is looking specifically at the issue of confidentiality and has learned the statutory provisions are not always interpreted in the same way by members of the partnership or in different parts of the state. It was pointed out, if the foster parent, who needs to know all the Department of Social and Rehabilitation Services knows, cannot be trusted with information, we should not be leaving a child with them. Children are best served when the grownups in their lives work together and develop relationships of trust and cooperative systems that allow information to flow between them. A committee member emphasized it would seem apparent that the more information a foster parent has, the better such parent can work in the interest of the child.

Another communication issue noted was letting people know what services are available and how to access them. There needs to be a simple way to inform a community about services and a simple way for people to locate services. Making it easier to find phone numbers was mentioned.

A committee member emphasized, although the progress being made should be recognized, attention still needs to be given to horror stories to determine where weaknesses and gaps still exist in the system and what steps need to be taken to address these. A foster parent pointed out the children who are not getting services are the children in their homes who have names. They are not just statistics. Begging for the services these children need or stating these children are entitled to the services too often does not seem to make a difference.

Mental health center representatives, one from a rural community in Western Kansas and one from an urban area, noted they are moving outside of the center into schools in their catchment areas, which are seen as a center of the community. This is where the children and teachers are and where parents seem to feel more comfortable.

Noting the lack of therapeutic foster homes available, the possibility of developing a network of group homes for those needing a high degree of structure and services, with two or three highly trained individuals living with the children was raised. This might help eliminate multiple moves from family to family. A foster parent stated there had been times when she had advocated that a child go to the hospital or be returned to his or her home because more services were available there. However, children need parents, and there are families out there who can meet the needs of the children if the children and the foster parents are given appropriate and adequate services and support. The question raised was, “What would the difference be between putting money in group homes versus using it to develop more therapeutic foster homes?”

Reference was made to the fact that because in some instances the state, through regulations, has taken away the option for the foster parent to be flexible in parenting foster children, some highly skilled foster parents are quitting. A story of a foster parent being told she could not require a child to go for a walk to calm down was shared. Children can at times be destructive, and a walk to cool off is helpful. Asked to respond, a representative of the Department of Health and Environment stated she could not speak directly to this case. When a situation is reported to the Department, perhaps by the child, a neighbor, a caregiver, or the mental health center, an investigation is made to determine if the care is appropriate for that child in that situation. Is the behavior required of the child outside of what would be considered therapy? The Department is concerned with punishment being used in the guise of therapy.

Directors of community mental health centers expressed concern about and a commitment to foster care issues, and noted some advances have been made due to diligent efforts on the part of the centers and the contractors since the partnership was formed. Efforts are being made to partner not only with the contractor, but also with foster parents, the community, and services

available in the community. However, this does not mean the centers are satisfied or do not realize there are still issues which must be addressed.

One center has a program that is mobile and takes the team approach, with a goal of wrapping as much service as is necessary and beneficial to the child in the home, the community, and the school. This center, which has significantly expanded both staff and programs, is able to provide programs to meet specialized needs such as children with attachment issues and fetal alcohol syndrome.

Throughout the roundtable discussion, from time to time, attention was directed to the issue of serving SED children and youth in the foster care system. It was agreed progress has been made since the beginning of interaction between the contractors and the community mental health centers. Statistics presented by The Consortium, Inc., indicate that 90 percent of the time, appointments for children referred to the community mental health centers are made within ten days of a referral, and 95 percent of the time are made within 14 days of the referral. In response to a question, it was noted that if the contractor feels the need is urgent, the child is usually seen within 72 hours. If the contractor feels it is an emergency, the center has three hours to respond, allowing for travel time. One rural center indicated its average response time in emergencies is 2.5 hours, including travel time. In response to a question, it was noted several factors may account for some of those falling outside of these parameters. A mental health center may offer a person an appointment within ten days of referral, but cannot offer the choice of time or therapist the client requests. Also, the person may not be able to keep the appointment offered for legitimate reasons or the social worker assigned to the case, who is required to be present, has scheduling conflicts that cannot be resolved. The rescheduling of the appointment, which is done directly with the mental health center, may fall outside the 10 or 14-day parameter.

Another indication of progress is that contractor representatives and mental health center representatives are meeting regularly, are learning from each other, and are beginning to understand each other and the problem each faces. Meetings between the groups have become productive.

Afternoon Session

The meeting was reconvened by the Chair, who indicated the roundtable discussion of mental health issues would resume.

During discussion it was noted some community mental centers have increased staff, expanded services, and developed additional sites. While this is easier for those located in or near a metropolitan area, those in rural areas are trying to address these issues also. The University of Kansas has initiated a rural mental health subcommittee, as part of the Steering Committee, to look at the special needs of children in rural areas and how to provide needed services for these children. The only way to be accessible, which is vital, is to be in the community and to educate community partners about what the center does and how services can be accessed. The system has been provided the flexibility to be creative in addressing challenges. While stories such as those heard today need to be addressed, attention needs also to be given to what is working and how to replicate these approaches in other areas. The Department of Social and Rehabilitation Services needs to provide appropriate data on which informed decisions can be made. One center is gathering data relative to consumer satisfaction. If there is a problem with receiving needed services or the services received, there is a grievance process in place for registering complaints. It was noted an opportunity for the mental health centers, contractors, and foster parents in each catchment area to discuss incidents that are challenging as well as things that are working would be helpful.

It was suggested, in collecting data, there needs to be a distinction between performance measures, which is what is currently being measured, and outcome measures which address what happened to the child. Did the child become self-sufficient or re-enter the system at another point, *i.e.*, the criminal system. The outcome measurement is more expensive and, to some extent, requires the cooperation of the child and family who have been in the system. The absence of outcomes relating to engaging families in therapy as a part of reintegrating the child into the family was noted. A question was posed as to whether not only the right outcomes are being measured, but whether the right people are doing the measuring. Being able to meet children's needs is an expensive business which makes it important for all players to be good stewards of the money allocated, based on adequate and appropriate data.

It was suggested the Legislature may want to give attention to how funding and regulations direct services if a child is in a therapeutic foster home. Currently, only the community mental health center can offer services to this group. Also, there appear to be restrictions on the use of the medical card that create a barrier to receiving appropriate services or services outside of the community mental health center. A private practice social worker stated, in Colorado and Missouri, licensed masters level social workers can be reimbursed through the medical card which gives people an option for service and provides additional service in the community. It was noted there are agencies that are not a community mental health center, that have licensed staff prepared and experienced in working with children. These agencies are potential partners, but cannot be reimbursed through Medicaid. Mental health center representatives spoke to contracts they have with various agencies and private providers. One contractor stated they have contracts with providers other than community mental health centers. Services are paid for through the contractor's per diem or contract rate.

Attention was called to the fact there is a multiplicity of regulations and guidelines at both the federal and the state level that are not interpreted consistently. The reality seems to be that interpretation depends, among other factors, on who is paying. At times rules and regulations, which may be based on global data, can be detrimental to the child or the child and his family. Moves may be in the best interest of the child, but the contractor is penalized for these moves. For example, the move puts the child closer to home which is desirable or the child needs a different level of care or a gradual step down in the level of care. However, each of these beneficial and, at times necessary, moves are counted against the contractor in terms of meeting the established performance outcomes. Guidelines are necessary, but latitude based on the child's needs without penalties is also needed if the best interest of each child is to be met.

Pointing out much of the discussion had centered on fine tuning parts of the system, the need to look at the whole picture and the inter-relationship of the parts was noted. A document resulting from a meeting between the state agency, contractors, and community mental health center directors to identify what is going well and barriers still there, including consequences resulting from the partnership, was mentioned. Making this document available to the Committee was suggested.

At the request of the Chair, one of the roundtable members from Wichita spoke of a steering committee in Wichita that contracted with the University of Kansas to facilitate an evaluation of the partnership, including an analysis of issues and how they can be resolved. Recommendations for policy changes resulting from the evaluation will be made to Social and Rehabilitation Services as appropriate. The report could be made available to the Committee after it is presented to the city council and the members of the partnership.

The special needs of special populations, *i.e.*, Spanish speaking and African-Americans, is another issue that needs to be addressed. Some community mental health centers have Spanish-speaking staff and African-American staff as a step in meeting the needs of differing cultural groups. In discussion of families, both biological and foster, there appeared to be consensus that focusing more resources, in the form of both staff and money, at the front end to keep children in in-home care

and doing a better job of engaging families will have an appreciable impact. Cases such as those heard today need to be followed up to see why the system failed.

A representative of an advocacy group called attention to the fact that members of advocacy groups and families are noticeably absent from the meetings between Social and Rehabilitation Services and the members of the partnership. Foster families are not invited and biological families are too afraid to come because the perceived bias against them is so strong. Groups involved in helping the families seem so invested in getting along that the families and their needs get lost.

Reference was made to an initiative referenced as "Family Group Conference Decision Making" which helps insert families into the process. The biological family, including extended family members and others involved with the child, *i.e.,* coaches and neighbors, after considerable preparatory work, are invited to participate in developing a case plan. The family is responsible for identifying the tasks that will be a part of the case plan. Research has shown that when family members identify the tasks, tasks are completed more thoroughly and in less time. Also, the Shawnee County Social and Rehabilitation Services office has redesigned the usual model by moving social workers from specific foster care and adoptive cases to prevention and to developing an intensive reintegration model. The family will spend five and a half hours a week for 32 weeks in fun activities, sharing a meal, and in separate activities for the children while coaching and mentoring for the parents takes place. The Department of Social and Rehabilitation Services noted a new initiative, family centered practice, is being implemented this week. Achieving the goals of this initiative will take retraining of staff in the ways they deal with families, think about families, work with families, and interact with families. There is a recognition that better ways of taking care of staff that work with families and children need to be developed if staff turnover is to be impacted positively. The best way to retain staff is by showing them the respect and support they are expected to give to families.

Mention was made of the Emporia project which focuses on intervention and working with biological families. Families initiated services and volunteered for the project. To date, as far as can be determined, none of the children involved has entered the foster care system at any point.

Another issue which needs attention is utilization of kinship families for placement. There is a bias, especially in some courts, which needs to be overcome.

Challenges relative to aging out of the foster care system were raised. Are these youth prepared to lead healthy, productive, and satisfactory adult lives. If they are not, the chances of their coming into the social services system at some other point, such as homeless shelters, local jails, and prisons, will be high. The Department of Social and Rehabilitation Services was asked for statistics relating to the number of youth leaving the foster care system, the reason for leaving the system, and any information relating to a system for tracking these youth after they leave the system.

Staff was asked to send the Department of Social and Rehabilitation Services the list of concerns voiced at the August 29, 2002, meeting, which appear to be the same concerns discussed today. The Department was asked to provide the following information about each concern: has the agency addressed the concern; if so, how; if not, how can it be addressed; if not sure how it can be addressed, who needs to be included in looking at how the concern might be addressed. The Chair gave an open invitation to continue the dialogue initiated today.

The Chair thanked all of the participants for attending and sharing their concerns.

The meeting was adjourned until 9:00 a.m., August 20, 2003.

Wednesday, August 20
Morning Session

The meeting was called to order by the Chair.

HealthWave-FirstGuard

Dennis Kasselman, Vice President, Market Affairs, FirstGuard Health Plans Kansas, presented written testimony (Attachment 2) noting there has been significant controlled growth in the Title XIX and Title XXI programs with a 209 percent increase over four years in the combined HealthWave. Working with the state and FirstGuard's many business associates, the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 were successfully implemented. The provider network has continued to expand, including some hospitals in bordering states. Emphasis is given to educating and serving all providers. Provider attendance at the "Roadshows", which offer the opportunity to share information about FirstGuard and how to work more effectively with Title XIX and Title XXI members, has increased each year. The provider use of the web site has also increased significantly. Electronic claims are paid within 5 days and paper claims within 10 days. Transitioning to a new pharmacy benefit manager, Express Scripts, in mid-2002, FirstGuard now has contracts with over 540 pharmacies with a participating retail pharmacy in each of the 100 counties that have a retail pharmacy. There is also a working relationship with Doral Dental and the Mental Health Consortium. In addition, an extensive transportation provider network has been established. In response to a question, Mr. Kasselman stated he would provide figures which show a comparison between last year's and this year's enrollment figures.

Services provided to members are a welcome telephone call which includes a simple health assessment with appropriate information being forwarded to a case management nurse; information about how the program works; how to access emergency services; and how to reach a customer care representative. Customer care provides 24-hour, seven days a week service assistance supported by a care management nurse and by FirstGuard's Medical Director as needed. There is a HealthWave member newsletter, "Heart and Soul," mailed twice a year that covers issues specific to HealthWave, how to better use services, and some specific health improvement recommendations.

Mr. Kasselman, after noting FirstGuard's care management team coordinates members' medical and health care needs, stated FirstGuard is committed to a care management model focusing on the appropriate management of chronic diseases, cancer, and pregnancy. FirstGuard, working with Paidos, a company that specializes in utilization review and case management of services specific to premature and complex infants, is providing a voluntary, proactive, and patient-focused Asthma Disease Management program for children that has a high participation and satisfaction rate; is working with the Department of Social and Rehabilitation Services and the Kansas Department of Health and Environment on several quality and cost-containment initiatives; and is continuing coverage of additional over-the-counter drugs when most states have reduced this benefit significantly.

FirstGuard, Mr. Kasselman stated, does yearly satisfaction surveys with each of the populations served. The percentage of members rating the Plan as excellent or very good ranged from 79.2 percent to 82.7 percent, exceeding the national averages for Medicaid based children's programs. The Chair asked that a comparison of ratings for the last three years be provided to the Committee.

The conferee noted, while FirstGuard understands the state's economic and budget constraints, there is continued concern for provider reimbursement levels, which are significantly below the national average, and the impact this may have on retention of providers.

In response to a question, Mr. Kasselman stated he could not be specific about the number of primary care physicians who have left the program in the last year, but it would be less than a handful. Each month a group looks at why the program lost certain physicians. The primary reasons are moving out of the state and retirements. A few do not want such a large government-based reimbursement package. Reasons for some physicians participating in Title XXI but not Title XIX since the programs have been combined include the history prior to FirstGuard taking over the program relative to payments, health plan credibility, and managed care. The stigma associated with Medicaid is diminishing, perhaps in part because of FirstGuard and the Kansas Medical Society working together to improve the image of this program.

The conferee, answering a question, stated FirstGuard nurse practitioners are included in the network, usually through a physician's credentialing program.

In response to a question, Mr. Kasselman stated FirstGuard feels comfortable that it is both complying with HIPAA guidelines relative to privacy and listening to and caring for patients. In the delivery of care, the health plan and the network providers do not need to get releases. When the member wants someone outside of this group to receive information, staff work with the member to get the appropriate forms completed and to explain the procedure and the reason for it to the member. Efforts are being made to minimize barriers, such as language and education, in this process. The guidelines as they now exist and as they are being administered are, for the most part, good protections for the members.

A question was raised about what can be done in cases in which a family is disqualified for HealthWave, even though they meet the income qualifications, because a parent is a state employee even though they cannot afford to include the children in the state employee health insurance plan. It was noted the prohibition against the inclusion of state employees is written into the federal law, but a state can make an exception. A factor is whether or not an employee has access to a health plan through the employer, which a state employee has. Staff was asked to track what happened to a bill to include state employees introduced in the Senate during the last two years.

Responding to a question, Mr. Kasselman stated requirements have been developed at the federal level to put all entities including those in the enrollment and the claims process on the same page relative to electronic transactions and systems. The entities must be sure the required information is collected and is transmitted in the required form. This is a good thing in terms of efficiency and accuracy, but it requires an investment. It was noted there apparently have been some problems in interpretation of the federal guidelines.

The conferee, in answer to a question, stated FirstGuard's contract is to work with the Department of Social and Rehabilitation Services in making certain that members' health care needs are met. There are certain outreach efforts that go along with medical management and working with the patient and the doctor that represent a good holistic outreach effort to resolve the member's health issues. Those within the plan are getting good information now and feel they can access FirstGuard. Communication with those who are not in the plan, but should be, is not a part of FirstGuard's contractual responsibilities. Other entities retain responsibility for this function.

Responding to a question, Mr. Kasselman stated transportation is part of a member's benefits, with some stipulations about when it is to be used. There is an approved list of providers provided by the state that is accessed when a request for transportation is made. Requests are processed through FirstGuard's customer care staff, and FirstGuard pays for the transportation.

Responding to a question, the conferee stated the first issue in providing proper care for pregnant women is knowing when a pregnancy occurs, which is often the most difficult step, in order that the pregnant woman can be put into the Guardian Angel program which ties her to a case management nurse. A short survey is used to determine if the member already has a physician, is

keeping all of her scheduled appointments, and taking care of herself. If she is, she is told how to access FirstGuard if she needs to. Once a pregnant member is determined to be a high risk, based on past health history or behaviors such as drug use, FirstGuard becomes proactive in trying to get her the type of prenatal care needed at each step of the pregnancy.

The conferee, answering a question, stated the way the University of Kansas and other major medical centers are beginning to connect with rural areas through telemedicine to bring specialists to the table is not a part of what FirstGuard is doing, although physicians from the University of Kansas Medical Center are a part of the provider network. It is something for FirstGuard to investigate in terms of how they might integrate services with this type of delivery system.

HealthWave-Doral Dental

Staff called attention to information showing dentists participating in the program by county provided by Doral Dental as requested at a previous Committee meeting. Copies are available for those members who request them.

Gary Mandernach, Executive Director, Doral Dental Services, stated Doral works with the Department of Social and Rehabilitation Services through a capitated risk agreement to provide dental administrative services to Title XXI members of HealthWave and to about 40 percent of the fee-for-service Title XIX members. On October 16, Doral will start handling all of the Title XIX members for Kansas. Doral, whose sole business is Medicaid dental services, also has a systems company which is responsible for keeping current with regulations such as HIPAA. Currently, Doral serves 5.5 million members in 18 states, and this number is growing rapidly. Doral started in Kansas July 1, 2001, handling the Title XXI program and about 44,000 members of Title XIX. Currently, they are responsible for administering dental services for about 30,000 in Title XXI and 55,000 in Title XIX.

Mr. Mandernach referred to a provider participation analysis for Title XXI (Attachment 3). In addition, he stated last year, 49 percent of the members received preventive treatment and 51 percent received all codes. The percentages are about the same for this year. Complete data for Title XIX is not available since claims currently can go either to Doral or EDS. Data will be available next year since all administrative services for Title XIX will be provided by Doral.

In response to a question, Mr. Mandernach stated dentist recruitment is a major issue for Medicaid around the country, particularly in rural areas. Doral is fortunate to have a strong working relationship with the Kansas Dental Association. A recruitment program has been launched. Discussions have started with FORBA, a group from out of state which is setting up a clinic in Wyandotte County exclusively for Medicaid recipients. The fact Kansas has a high rate of reimbursement compared to other states is a positive in recruitment. Currently, approximately 12 percent of the dentists in Kansas participate in the Title XIX and Title XXI programs.

Mr. Mandernach was asked to come prepared with a more complete presentation at any future meeting of the Committee.

Kansas Dental Association.

Kevin Robertson, Executive Director, Kansas Dental Association, presented written testimony (Attachment 4) covering current dental initiatives in Kansas, especially services for children. Mr. Robertson noted Kansas is one of very few states that does not have a specific state dental department, office, or official through which dental health information, oral health issues, and federal monies can be channeled. The Kansas Dental Association did secure federal grants to support a

person housed in the Kansas Department of Health and Environment. The CDC approved a three-year grant to hire a Dental Director, but the grant was not funded.

The Association and other organizations are in the final stages of forming a new Oral Health Coalition to promote partnerships and initiatives that work toward increasing access to oral health. Funds have been contributed to hire an Executive Director for this Coalition. Many pilot programs are already being considered. Access to Baby and Children's Dentistry (ABCD), a program started in Washington state, has been piloted in Salina, Wichita, and Lawrence with limited success. This is an effort to increase the number of Medicaid providers and treat more patients. Washington was able to offer a higher reimbursement rate to dentists participating which Kansas cannot do. However, the Association is creating more case management services for dental offices and providing more information relative to care of children. Mr. Robertson agreed to provide a progress report on the Coalition during the 2004 Legislative Session.

The Kansas Dental Association is working with the Kansas Dental Hygienists Association to draft rules and regulations to implement 2003 HB 2161 which allows certain dental hygienists to provide dental hygiene services in schools, Head Start, and other settings. In response to a question, the conferee stated that stakeholders are involved in the rules and regulations process. Another program is "Give Kids a Smile," a children's charity initiative during Children's Dental Health Month. The Association recruits dentists to provide free services to children and provides educational resources and toothbrushes to school nurses.

In cooperation with other dental organizations, Kansas Mission of Mercy, a program to provide free dental screening and care at a one-time dental clinic, was initiated this year in Garden City at the Finney County Fairgrounds with what was the largest free dental clinic in the world. Patients are not pre-screened for financial need, but the underserved population is targeted. Based on dental needs, patients are given a choice of receiving a dental cleaning, restorative care, or tooth extraction. Eighty-one dentists, 51 dental hygienists, and 85 dental assistants volunteered for the clinic which provided $554,000 of dental services to 1,734 patients. Approximately 150 community volunteers served free meals, provided translator services, helped with set up, and performed many other useful tasks. Exit surveys indicated that 21 percent of those receiving services were children. Mexican American Ministries was present to sign up Medicaid-HealthWave eligible families. The second Kansas Mission of Mercy clinic will be held at the Kansas Speedway which has donated its facility. Over 900 volunteers, 190 dentists, 130 dental hygienists, 190 dental assistants, and 380 community volunteers, have registered to assist in the free clinic. Representatives from 11 states will be present to observe this clinic. Tentative plans are to hold a third clinic in Southeast Kansas, possibly in Pittsburg at the University, this spring. The intent is to continue this program by providing two or three clinics per year. No fees are collected, but required dental forms are completed and kept and claims are submitted to insurance carriers and Medicaid. A detailed report compiling data received through exit interviews was done following the Great Bend clinic, and an analysis will be done following the Kansas City clinic. Copies of these reports will be made available to the Committee.

Responding to a question, Mr. Robertson said immediate follow-up is provided for any persons having problems following the clinic, but there is no ongoing follow-up. In Kansas City approximately 20 dentists have agreed to provide follow-up services for up to one month for people having problems following the clinic. The conferee, in answer to a question, stated about 99 percent of the professionals participating were Kansas licensees. Last year the Legislature passed 14-day temporary licensing legislation to allow out-of-state dentists, with very little hassle, to secure a temporary permit to provide services in a charitable clinic. This was done primarily to encourage other states to initiate this type of charity clinic program by allowing out-of-state dentists to participate in the Kansas clinics and learn from them.

Responding to a question, the conferee stated he feels there is adequate legislation at this time to support the program. However, some groups have been approached with the goal of making the one-day free services clinic more of a health fair rather than limiting it to dental services. This might involve legislation to include different groups of providers. After noting the Legislature had made this program possible by passing legislation during the 2003 Session to include dentists in this setting in the Kansas Tort Claims Act, Mr. Robertson showed a video of the Kansas Mission of Mercy clinic in Garden City.

Mr. Robertson, in answer to a question, stated the Kansas Dental Association had surveyed Medicaid providers asking how many Medicaid patients in a specified month had appointments and how many did not show up or canceled 24 hours prior to the appointment. The same information was requested for general population patients. About 36 percent of Medicaid patients were "no shows" compared to about 8 to 10 percent for the general population. Mr. Robertson and Mr. Kasselman were asked to provide the Committee further information relative to the number of people who make appointments but fail to keep them.

HealthWave–The Mental Health Consortium

Marty Kennedy, presented written testimony (Attachment 5) outlining the role of the Consortium in providing mental health services to the HealthWave population and statistics regarding the services provided and performance measures. The Consortium, founded to provide central contracting services for state agencies and other parties, has expanded to include a broad array of services. Through the contract with the Department of Social and Rehabilitation Services, services were provided to almost 7,000 Kansas children served by HealthWave in the past year. The Consortium has administered the mental health carve-out for Title XXI since its inception and has provided access and referral services for Title XIX since October, 2001. Enrollment in Title XXI is approximately 31,000 and in Title XIX approximately 60,000. Reference was made to charts showing inpatient and outpatient data for Title XXI clients (see Attachment 5). The four grievances filed during the second quarter were all resolved to the consumer's satisfaction. Compliance with access standards ranged from 100 to 75 percent. During the past year, a statewide broadband network has been implemented to enhance the delivery of telemedicine service through the community mental health system. Legislation is being proposed to bring the Consortium into the Kan-Ed network. Mr. Kennedy stated the Consortium is well positioned to add value to mental health service delivery for HealthWave participants and to provide the most appropriate care in settings across the state.

In response to a question, Mr. Kennedy stated the Consortium is a separate 501c3 and 501c4 organization. Under Title XXI the Consortium determines the provider network so primary referrals go to the appropriate community mental health center if the center can provide the service. If the center cannot provide the service, usually in a specialized area such as substance abuse, the Consortium can refer to other providers. In Title XIX, there is freedom of choice so the network includes all Medicaid providers. In Title XXI providers outside the community mental health center network can contract with a center to provide services.

Mr. Kennedy was asked to provide the committee statistics relative to how many referrals are to community mental centers and how many to private providers.

HealthWave-MAXIMUS

John Anzivino, Vice President of MAXIMUS and Project Director for the HealthWave project, presented written testimony (Attachment 6) providing an update on the activities within HealthWave. Under the current contract with the Department of Social and Rehabilitation Services, which has been extended for another three years beginning October 1, MAXIMUS provides enrollment services,

contract work for Title XIX, and eligibility determination for Title XXI. MAXIMUS also operates a customer service center; performs premium administration, including collection of premiums; and provides marketing support to the Social and Rehabilitation Services area offices. There has been substantial growth in the program over the past two years, undoubtedly influenced by the economic downturn. Another factor is the partnership with Social and Rehabilitation Services to improve access to the program. Currently there is a caseload of just under 87,000 compared to 75,000 a year ago. This has impacted the number of referrals, case maintenance actions, and renewals. Attachments to the testimony show the workload demand for applications, renewals, and case maintenance. Currently the major scope of work includes determining eligibility for new clients and continuing eligibility for renewals; collecting premium payments from clients for Title XXI; providing contract work for Title XIX clients; providing enrollment services for customers eligible for managed care; completing case maintenance for HealthWave cases; and providing customer service for all Clearinghouse customers. The HealthWave Mail Room continues to deal with high volumes of incoming and outgoing mail in a timely manner. Customer service call volumes have been increasing over the term of the contract, with a tremendous spike in the number of incoming calls since January. Calls have increased from an average of about 30,000 monthly to over 55,000 in July. The goal is to return all calls that have to go into voice mail within 24 hours. Calls dealing with eligibility issues are transferred immediately to the on-call eligibility counselors. The volume of calls has outpaced the ability to meet the demand, even by adding additional staff and authorizing overtime. Total premiums collected in the last fiscal year were $1,155,999, more than double the amount collected the prior year. Over the past year the eligibility staff completed 34,336 applications, 47,494 renewals, and 96,892 case maintenance actions such as address changes, adding pregnant women, and adding newborns. Additional statistics for all activities were provided in the written testimony.

The Quality Assurance and Training Department for the Kansas HealthWave Clearinghouse monitors daily operations, conducts training for staff, tracks policy changes, and alerts staff as to the implications of changes in program operations, reports on the overall project performance results, develops and compiles surveys, and monitors grievances received and referred. Training sessions are offered monthly for new and existing employees, with ongoing refresher courses offered as needed. Quality reviews are conducted weekly and monthly. Grievances are reviewed, and steps are taken to resolve eligibility issues. Other grievances are forwarded to the appropriate parties to handle. A state representative is copied on all referred grievances, and a quarterly report of grievances handled for referral or resolution is provided to the state. The number of grievances has increased, but that is related to the increased caseload and the increased number of applicants.

During fiscal year 2003, MAXIMUS performed all statewide marketing for the Kansas HealthWave program, with the Department of Social and Rehabilitation Services area offices handling outreach responsibilities. MAXIMUS was responsible for providing promotional items to the area offices for use during outreach events and for a statewide billboard campaign.

In response to a question, Karla Deckert, Operations Manager, MAXIMUS, stated application requests are mailed to most community-based organizations, health departments, and schools. Some are mailed directly to coaches who have been of great assistance since students are interested in getting physicals in order to continue in sports. Mr. Anzivino, answering a question, noted a majority of grievances are related to the person's eligibility status. Ms. Overstreet, MAXIMUS, noted other issues relating to quality, access to service, customer care, and staff are treated as grievances also. MAXIMUS handles internally only the eligibility grievances. Other grievances are referred to Electronic Data Systems (EDS), FirstGuard, or Doral.

Responding to a question, Mr. Anzivino stated the economy was the primary factor in the large increase in caseload a year and a half ago, but marketing and outreach efforts also played a part and continue to do so. Although the number of applications continues to increase, the impact of the increased caseload is now felt primarily in case maintenance and renewal activities. The system captures information relative to the geographic areas applications are coming from and this

information is passed on to the Department of Social and Rehabilitation Services which analyzes the data. The conferee, answering a question, noted there has been a trend in the number of persons reapplying with about 70 to 80 percent now reapplying. Renewal notices are mailed out 60 days in advance of the renewal date, and a reminder notice 30 days in advance of the renewal deadline. MAXIMUS, along with the state agency, is looking at other tools and processes to increase this percentage. There are multiple factors affecting whether or not persons reapply, however, experience would indicate that co-payment has not been a significant barrier. When a downward change in income is reported, an immediate adjustment is made to the co-payment.

In response to a question, Mr. Anzivino stated currently the preponderance of calls are related to the status of eligibility determination. Second highest in number are calls from persons inquiring about medical coverage or wanting to make changes in their assignment. Ms. Overstreet added that a wide variety of calls are received, including reporting a death, loss of job, or address change; ordering applications; and requesting material for health fairs.

The Committee was recessed until 1:00 p.m.

Afternoon Session

The Committee was reconvened by the Chair.

HealthWave-Social and Rehabilitation Services

Laura Howard, Deputy Secretary, Health Care Policy, Department of Social and Rehabilitation Services, presented written testimony on the quality assurance process for the child welfare and mental health partnership (Attachment 7). Ms. Howard noted that HealthWave has been in progress since January, 1999. In the spring of 2002, it was blended with the state's Medicaid capitated managed care program to provide a seamless managed health care option for families. The Department projects that over 100,000 children who were uninsured at some time during the period from January, 1999 to September, 2003 did gain access to physical, mental health, and dental coverage. The Department pays HealthWave contracted managed care organizations a capitated rate for each person enrolled in the plan. Each enrollee has a primary care physician to coordinate the person's health care service needs. The emphasis is on prevention.

The area offices, which play a key role in outreach, focus on activities that can best reach people who are potentially eligible for HealthWave and Medicaid. Outreach activities are coordinated with community-based groups that have the necessary infrastructures in place to reach targeted populations in each community. The Department has staff at six Wichita health clinics which serve low-income and uninsured patients and one staff person at Catholic Charities Emergency Services Center. These staff members inform the public about agency programs and assist people with the HealthWave application process. The Department continues to partner with a broad-based coalition that continues to work on how to leverage resources between agencies to reach children who remain uninsured.

The eligibility and enrollment process of the Kansas Medical Assistance programs has been reorganized. As of October 2003, EDS has become the enrollment broker for all medical programs, and the Clearinghouse at MAXIMUS will conduct eligibility screening for all medical programs and premium collection for all Title XXI families with incomes above 150 percent of the federal poverty guidelines. Steps have been taken to streamline the application and eligibility process and to assist area offices increase efficiency and improve customer service using the clearinghouse model.

The Centers for Medicare and Medicaid Services, which did an onsite review of the HealthWave Program in June of 2002, commended Kansas for meeting the overall objective to decrease the number of uninsured low-income children and for the extensive efforts to streamline the HealthWave and Medicaid programs into a seamless, blended program. HealthWave has also met all Balanced Budget Act compliance requirements. The Department of Health and Human Services Office of Inspector General will be evaluating all state medical assistance programs this year. The purpose of this evaluation is to determine whether states are enrolling Medicaid eligible children in Medicaid and to assess efforts to ensure children are enrolled in the proper program. The Department also completes an annual, federally-mandated, written evaluation of the Title XXI program and continues a relationship with the Kansas Health Institute which provides an independent evaluation of the Title XXI portion of HealthWave that will include information relative to the effect of HealthWave on vulnerable populations.

Eligibility levels for the State Child Health Insurance Program have been maintained so children in families up to 200 percent of the federal poverty guidelines who are not eligible for Medicaid are eligible for the State Child Health Insurance part of HealthWave. In response to Governor Grave's allotment process last year, the premium rates were tripled from $10.00 to $15.00 per month per family to $30.00 to $45.00 per family as of February 2003. However, in July of 2003, the premiums were decreased to $20.00 to $30.00. Approximately one-third of Title XXI families enrolled pay premiums. Efforts are being made to track the effect of premium changes.

HealthWave is a block grant program with a state match requirement. It is about 72 percent federal funds and 28 percent state funds. Each year since 1998 Congress has reallocated and redistributed funds to states that qualify under Title XXI. Provisions in the federal law allow for a three-year period to spend each year's federal allotment. Just before Congress adjourned action was taken to make sure that unspent funds from 1998 and 1999 continued to be available to states that had utilized their allotments. As a part of that, Kansas has received a redistribution of about $21 million from federal funds. Basically, funds that were not spent in other states were made available to states that are using their allocation. Based on the federal formula for the block grant, Kansas has received from $30 million to $21 million in federal funds. With the required State match this has meant an annual funding availability of from $30 million to $42 million. In the current fiscal year expenditures are projected at $54 million on HealthWave which is more than the federal allotment. This has been made possible because the unspent portion of the federal allotment in the early years was carried forward. Projections indicate the program should have sufficient resources until fiscal year 2007. This projection is dependent on Congress maintaining levels of funding and continuing redistribution of unspent funds.

In response to issues raised relative to state employee coverage during the morning session, Ms. Howard stated, under the federal law, if persons are eligible for the state employee health plan they can not be covered by the state child health insurance program. State employees could be covered within HealthWave using all state funds or by making changes in the Medicaid coverage so it would cover more of the population. The Department continues to have a dialogue with the Kansas delegation relative to this issue.

Ms. Howard, responding to a question, stated that not more than 10 percent of the Title XXI block grant can be spent on administrative and outreach activities. Kansas is spending close to that amount. Actual percentages and amounts since the program began will be provided to the committee. She stated data relating to federally projected figures of the number of uninsured children in the state, which is adjusted periodically, and state estimates of the number not enrolled will be provided to the committee. The initial expectation was that about one-half the uninsured children would be Medicaid eligible and one-half Title XXI eligible. Actual experience has been that two-thirds are Medicaid eligible and one-third eligible under the State Child Health Insurance Program. Answering a question, the conferee noted Congress originally authorized Title XXI for ten years, but funded only five years. Within the next year there will be discussion at the federal level about what

the child health insurance funding should look like. A challenge is that so many states are not spending all their allocation. Because the rationale for the formula used, which is different than that applicable to Medicaid, is difficult to understand, questions about the validity of the formula have been raised since the beginning of the program. Many of the states spending their allocation increased Medicaid eligibility, in some cases up to 300 percent of the federal poverty guidelines, which was one of two options given to states. The other was to create a separate program which Kansas did. Ms. Howard stated, in response to a question, that Title XXI includes prescription drug coverage since the Legislature mandated that Title XXI coverage has to be the same as that for Medicaid. All medically necessary services, which include prescription drugs, must be provided for children.

It was noted that when HealthWave was designed, it was hoped when children qualified for HealthWave small businesses could buy into HealthWave to provide insurance for employees. Ms. Howard stated the Legislature had passed legislation creating the Kansas Business Health Partnership and the Kansas Business Health Policy Committee on which a representative of Social and Rehabilitation serves. The Committee has unveiled a non-subsidized plan for small employers within the last year. The focus now will be on the issue of subsidies and what the role of Title XXI and Medicaid will be. For example, the employer would continue to provide coverage, but if the child is eligible for HealthWave, the state would pay the premium. It would be a subsidy for these children who would otherwise enroll in the State Child Insurance Program which should be more cost effective. There would have to be assurance that the package offered by the employer met certain standards. There are a number of policy issues involved which need to be worked through.

Child Support Enforcement

Candace Shively, Department of Social and Rehabilitation Services, provided written testimony giving an update on the Child Support Enforcement Program, a federal-state partnership, with attachments providing additional background information (Attachment 8). The Kansas program, based on Title IV-D of the Social Security Act, is designed to promote parental responsibility for the financial well-being of children; and is a multifaceted state, county, judicial, and private operation that must meet detailed federal requirements. Failure to meet these requirements can result in fiscal sanctions to the Temporary Assistance to Families and Child Support Enforcement programs.

Congress is currently debating the reauthorization of the child support program. There is a desire to move the child support program from a revenue-generating program to a more family first philosophy. With the welfare reform legislation, thinking turned to how to provide more supportive services to a family and passing more money through to families. There is a need to help non-custodial parents become financially responsible for their children. If parents are more financially involved with their children, they are more likely to be emotionally involved with them.

The Shawnee County pilot project, which has been recognized at the national level, is a good example of a family first model. This project is the result of the vision of a judge in Shawnee County who said that the remedies for non-custodial parents who did not pay child support had little effect on getting payment. The resulting project is a collaboration of several entities to transform unemployed nonpayers into working parents who voluntarily support their children. Some welfare-to-work funding from the Department of Labor was bridged with a Health and Human Services grant. About 300 non-custodial parents have been served and have generated $500,000 in child support collections.

Oklahoma's policy decision to open a new Oklahoma child support enforcement case only if there was at least one minor child in the home was discussed. This policy would include cases referred from out of state and could stymy Kansas' ability to collect support on behalf of Kansas children. Kansas, along with other states, voiced concerns to the Director of the Oklahoma Child

Support program and asked the Health and Human Services Regional Office if such actions were permitted under Title IV-D. Oklahoma has announced it would re-evaluate the policy change.

In closing, Ms. Shively stated, as policies are reviewed and adaptations are made to the changes in Title IV-D, Kansas is interested in pushing programs toward a more family first model, which means considering not just debts and assets but the broader conditions of families. In response to a question, the conferee stated there is a 4 percent cost recovery fee deducted from child support payments for administrative costs incurred. In some cases the court orders this fee deducted before the order is put in place. It was noted there is some feeling the person paying the child support should be assessed the fee.

Again referring to the Oklahoma policy, concern was expressed that federal sanctions are not being put in place against Oklahoma. It was recommended that Kansas continue conversations with Oklahoma. However, if Oklahoma does not change its policy by the end of October, Kansas should consider ceasing making collections for Oklahoma, after notifying Oklahoma of its intent, until Oklahoma complies with federal law. The conferee agreed to make a progress report on this issue to the Chair at the end of this month and to the Committee in October.

Responding to a question, Ms. Shively stated there is not funding to continue the pilot project in Shawnee County once the grant lapses. Alternatives for sustaining funding and replicating this project will be pursued since the pilot has moved the system in the right direction.

Community Mental Health Center Regulations

Laura Howard, Department of Social and Rehabilitation Services, stated the rules and regulations pertaining to mental health centers became effective July 1, 2003. When Social and Rehabilitation Services appeared before the Committee last year, these regulations were still in the proposed status. This was the first update in mental health licensing regulations in over ten years. Comments were received from the September 2002 hearing, and this Committee received testimony on the issue last year. Based on this input, some revisions were made. Probably the most significant related to affiliate agencies. Regulations, as first drafted, included provision for the state agency, which licenses community mental health centers, to begin licensing agencies affiliated with a community mental health center. This raised issues regarding the impact on agencies already licensed because of other activities, *i.e.*, hospitals, and caused considerable confusion. As a result, these specific provisions were pulled out of the regulations. This means the quality of services provided by affiliate agencies will continue to be the responsibility of the community mental health center with which the affiliate has an agreement. The Department will be getting a group together, now that the rules and regulations have been adopted, to review this issue.

Other modifications had to do with input relative to simplifying regulations pertaining to the grievance process. Another change dealt with the community mental health center's responsibility to provide services in the event of the inability or failure to pay. Use of "failure to pay" caused a lot of confusion so it was modified to focus on issues of inability to pay. Ms. Howard offered to provide the Committee with a summary of the changes that were made.

Responding to a question, the conferee stated the stakeholders, especially the community mental health centers, would say Social and Rehabilitation Services had simplified some of the provisions, but did not change everything they would have liked to have changed. However, the agency has worked with the centers on interpretive guidelines to show how particular regulations will be applied in a specific situation. These are scenarios and explanations that can be used in training. Also, although the regulations became effective in July, Social and Rehabilitation Services has established a six-month window as a teaching opportunity to make sure there is a common understanding and interpretation of the regulations before there is any enforcement action.

Ms. Howard, in answer to a question, stated one significance to being an affiliate is that social workers employed at the affiliate are eligible Medicaid providers. It is correct that there are some existing entities that were thought of as affiliates, but are not as is defined by law. The affiliates recognized under the law are in Shawnee County and Sedgwick County. Part of the confusion is that there are other situations in which community mental health centers enter into a relationship with other providers, *i.e.*, child welfare services providers, to provide some services through an affiliation agreement. Community mental health centers can also subcontract for specific services.

Attachment 9 is the information submitted by Dennis Kasselman, FirstGuard, in response to the request of the Committee.

September Meeting

The Chair announced the next meeting of the Committee on September 23 and 24, 2003. The first day will be a roundtable on foster care.

The meeting was adjourned.

Prepared by Almira Collier
Edited by Emalene Correll

Approved by Committee on:

October 30, 2003
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