Committee Recommendations to Consider

The following are recommendations that we would urge the committee to consider including in your final report to the 2012 Legislature:

1. Include language stating that PRTF's are a necessary and vital part of the Kansas Children's Mental Health System and a vital part of the continuum of care escalating from community-based services, Acute Care/Crisis Stabilization, PRTF services, and hospitalization.

   Update: Urge these committees to endorse this message to the Department of Aging and Disability Services.

2. Include language opposing the SRS 90% occupancy reduced resource package. If accepted this reduced resource package would further deteriorate the ability for children to receive PRTF services and would further destabilize the already vulnerable PRTF service delivery system.

   Update: This reduced resource package was not included in the Governor's 2013 budget.

3. Direct SRS to support and implement the recommendations of the PRTF task force outlined previously in this document and documented in more detail in the "PRTF Guidance Paper dated October 21, 2011."

   Update: SRS implemented the recommendations of the PRTF Guidance paper in November 2011.

4. Direct SRS to begin/continue formally tracking data about what is happening to the children being diverted from PRTF's as well as what is happening to the children when they are being discharged. This data should be reported at least quarterly to the PRTF Stakeholder Group. Data to be collected should include:
   a. Child's Custody Status (Parent, SRS, JJA).
   b. How quickly the first mental health service was offered after diversion.
   c. Exactly what services each child diverted is receiving in the community both in quantity and duration. (This can be used for fiscal forecasting).
   d. The adherence to the immediate provision of service standard for children being discharged from a PRTF as outlined in the "PRTF Guidance Paper dated October 21, 2011"
   e. Where each child being discharged from a PRTF is going, and also follow that child through all subsequent placements for 6 months. (IE. Home, YRC, Detention, Hospital)
   f. Exactly what services each child discharged is receiving in the community both in quantity and duration. (This can be used for fiscal forecasting).
   g. Data related to the failure to adhere to any standards outline in the Guidance Document or set by SRS and what is being done to remedy those failures.

   Update: SRS is collecting data, but unsure if data is being collected related to these specific points. SRS could share the data received with the committee. This data has not been shared in detail with the PRTF's.

5. Direct SRS to "fast track" and make a priority the implementation of a standardized intake form which could be used at any CMHC in Kansas. (This has been an on-going project off and on for many years and would help children and families' access community based services more effectively).

   Update: Unaware of any movement on this issue. Additionally, how intake will be handled under the three new managed care contractors needs to be the same. We would encourage the Department of Aging and Disability services to require the three MCO's to utilize the same intake forms which could be taken to any provider. This is particularly important for children in the custody of the State.

6. Include language stating that the committee believes that access/screening for all mental health residential care should be completed by one entity regardless of how many managed care contracts may be offered in Medicaid reform. Furthermore, all decisions for admission to residential services should be based on medical necessity, using the current screening tool and methodology, and not influenced by budgetary decisions.

Update: 1- In reading the managed care RFP we do not believe that the screening process, the screen itself, and who will provide the PRTF screen has been delineated by the state. We urge this committee recommend to the Department of Aging and Disability Services that the current screening process and the current screen being used be retained and required for use by the three MCO's in Kan-Care.

Update: 2- Additionally, the RFP does not specifically protect the current PRTF rate setting methodology and rate adjustment process. We recommend the committee urge the Department of Aging and Disability Services to maintain the current rate setting methodology as outlined in the Kansas State Medicaid Plan.

7. Include language stating that the mental health system has already suffered multiple cuts including $9.8 million from a rate reduction in FY 10, a $6.8 million cut in FY 11 and a $17 million cut in FY 12 totaling $33 million all funds reduction to the mental health system. Furthermore, we ask the committee to urge the 2012 Legislature to ensure the mental health system does not receive a larger proportion of the Medicaid reductions/cuts than does the physical health side of the Medicaid system.

Update: Recommend this committee monitor the implementation of Kan-Care to ensure it is implemented successfully and its outcomes promote good health for all children.

8. SRS should identify any gaps in the behavioral health and mental retardation/developmental disability system to ensure that the needed resources are available to all children and families.

Update: We are confident that Secretary Sullivan will examine all the systems under his authority and make recommendations for better coordination of care and if necessary will bring the needs of those systems to the legislature.

Attachment J.—State Quality Strategy

State of Kansas

KanCare Program

Medicaid State Quality Strategy

November 2011

5-3

	as approved by SRS.			
Inpatient Recidivism at 30 days, 90 days and one year post-discharge	The CONTRACTOR will monitor and report the percentage of re-admissions at 30 days, 90 days and one year from last discharge from each of the following categories: • State mental health hospitals, alternatives to state mental health hospitals, and Medicaid funded community hospital psychiatric inpatient programs for children and youth; • State mental health hospitals and Medicaid funded community hospital inpatient programs for adults; • Nursing Facilities for Mental Health; and • Psychiatric Residential Treatment Facilities. This measure will be considered as part of the CONTRACTOR's Outlier Management Program. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS. Any region and/or individual provider that falls within one standard deviation of the mean will result in a corrective action plan.	The number of inpatient discharges at 0-30 days and 31-90 days from last discharge of persons in the CMHC catchment area. Denominator: The number of inpatient discharges from the CMHC catchment area.	Hospital discharge reports, PRTF discharge reports, SRS-supplied discharge data	Quarterly
Average length of stay for Psychiatric Residential Treatment Facilities	Average Length of Stay for youth admitted to Psychiatric Residential Treatment Facility will be 100 days or lower. The indicator will be measured by regions as established by the CONTRACTOR as approved by SRS.	The CONTRACTOR will focus monitoring and performance improvement efforts on those CMHC catchment areas with higher ALOS than the statewide average. The CONTRACTOR will provide in its report an analysis of performance and a plan for performance improvement by CMHC catchment area	Numerator: Sum of days per child for children and youth discharged from Psychiatric Residential Treatment Facilities. Denominator: Total number of children and youth discharged from Psychiatric Residential Treatment Facilities.	claims data, IPS

Figure 3	
Utilization of Inpatient Services	
Item	**Details**
The number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.	
Numerator:	The number of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.
Denominator:	The number of members that were Medicaid or CHIP eligible and continuously enrolled for 11 of 12 months during the measurement period.
Data Source	MMIS and the State Hospital database will be used.
Benchmark/Goal	The CONTRACTOR will exceed the benchmark based on existing Medicaid data, as established by the State. Aggregated data will be used to determine the benchmark for this measure. Specifically, the rate will decrease by a targeted percentage.
Description of Monitoring Process	The measure will be reported using a validated system as defined by the State.
Monitoring Roles and Responsibilities	SRS will monitor the report.
Monitoring Frequency	Annual