KANSAS MENTAL HEALTH COALITION

Speaking with one voice to meet critical needs of people with mental illness.

Minutes

February 25, 2015 Monthly Meeting **Valeo Behavioral Health Center, 330 SW Oakley, Topeka, KS**

9:00 a.m.
Introductions and sign-in sheet David Wiebe, President
Financial Report Accepted Elsbury motion, Cagan second. Read Report. JoLana Pinon, Treasurer
Please renew your membership at KMHC website- the site will generate an invoice to pay by check. Contact Amy if you have questions.
Minutes of the previous meeting adopted. Cagan motion, Sweeney second. Read Minutes.

9:15 a.m. Reports

Advocacy Committee –Grassroots Advocacy Network - Sue Lewis -2015 Issue Papers are posted at the KMHC Website. Please Register for Advocacy Day- March 12. Have 220 registered now. Legislative Breakfast will be at 7:45 a.m. March 12 at the Statehouse. Advocacy Training Event will be held on March 11 at the Ramada.

Please forward the email blast / invitation to all of your email distribution lists. Next Friday afternoon, will be stuffing 400 packets at the Disability Rights Center.

Governor's Behavioral Health Services Planning Council –Wes Cole

Next meeting March 24 – focus on subcommittee reports in preparation for their reports to the Secretary. Still don't have a date for the site review. The bill for Tribal Representation on the Council has passed. Will be the Governor's trial liaison and right now that position is vacant. Will also meeting in April and May. May meeting will be very important. Will focus on the Children's Issues, similar to last year.

Vocational / Supported Employment Subcommittee Special Report - Each month *KMHC will dedicate about 20 minutes to a briefing on the GBHSPC Subcommittees Annual Reports.*

Doug Wallace, KDADS – distributed the charter and the subcommittee report.

Four goals: 1. MHCs use available resources to support getting consumers to work.

Recommendation #1: Educate CMHCs and other service providers about the availability of the Benefits Planning Academies. The Benefits Planning Academies are designed to train interested individuals in the various Social Security Administration work incentives in order to enable them to provide consumers with accurate benefits information.

Recommendation #2: Educate CMHCs for better clarification of billing Medicaid for Employment services.

Recommendation #3: Send out dates of Benefit Planning Academies to all CMHCs and encourage participation.

2. IPS Supported Employment model is the model of choice for the Kansas mental health system and is available at every Community Mental Health Center. (currently just under half have an IPS program / outcomes show double the competitive employment rates of other models)

New 2014: All MCO's will use the IPS Principles whether they are an IPS site or not. Any new employment initiative will apply the IPS Principles as listed:

1. Eligibility is based on client choice.
2. IPS supported employment services are closely integrated with mental health treatment services.
3. Competitive jobs are the goal.
4. Employment contact begins rapidly after clients enter the program.
5. Employment specialists build relationships with employers based upon client job interests
6. Job supports are continuous.
7. Consumer preferences are honored.
8. Benefits planning (work incentives planning) is offered to all clients who receive entitlements

Recommendation #1: Provide outcome information about CMHCs that implement Supported Employment IPS model. Incentivize the system for better employment outcomes.

Recommendation #2: Allocate funding from the Mental Health Initiative to make sure resources are in place to make IPS possible, with a commitment to job development.

Recommendation #3: Amend the state's 1115 waiver to include Personal Care Services for Employment

3. Training and Collaboration opportunities will be available across the state, to address areas of consistency of services and proper mental health and vocational rehabilitation training for all providers of supported employment services

4. Encourage KDADS and Vocational Rehabilitation Services to support Johnson & Johnson – Dartmouth Community Mental Health Family Advocacy Project

KDADS has received a grant from SAMHSA for expanding supported employment.

Report / Recommendations:

We are aware that CMHCs have elected to not use the program and some have de-adopted it (ComCare is an example) because the funding for the program does not cover the costs for some aspects – including building employer base / relationships.

Some are using certain parts of the program, but not working through KU for the fidelity to the program.

Penetration rate is around 1/3. Even CMHCs who have the recommended program don't have the resources to reach the target population.

SAMSHA Five Year Grant – implement IPS Supported Employment in two settings (targeting ComCare and Compass, urban and rural). IPS has traditionally been offered to adults with SMI who are able to pay for the services. Want to target adults with SMI and possibly co-occurring substance use addictions who are uninsured or underinsured. KDADS will convene a state-level SE committee to look at state level barriers to programs. Makes sense that the subcommittee would take on this role. Third role of the funds is to evaluate effectiveness.

Mental Health and Aging Coalition – Eric Harkness – not present

Children's Issues – Amendments to the SED Waiver - comment period ends Feb 25

10:00 a.m. Guest Report: KanCare 2.0 -Chad Austin, Kansas Hospital Association proposal for Medicaid Expansion KHA Handout 1 Handout 2

Three bills introduced this session: Rep. Ward – straight expansion to 133% of poverty level.

2020 Vision Committee – introduced a bill that included a funding mechanism with a provider fee.

HB 2319 – exempt from deadlines – KHA bill. Our members have struggled with how to move forward the discussion. Rescinds the legislative approval requirement. Instructs KDHE to submit an expansion waiver = KanCare 2.0. 28 states have moved forward with Medicaid expansion. Most recent was Indiana. Core principles for hospitals and others – suggesting it should be a demonstration program, cover up to 138% of poverty level (necessary to obtain the enhanced match rate), find dedicated funding sources to offset the state's share that begins in 2017. At the end of the last legislative session, several large hospitals and KHA board met with the Governor and requested permission to meet with then KDHE Secretary Moser to discuss a potential plan. Approved and began those meetings. Reviewed other states and the plans that have been approved by CMS. Created a tentative proposal that

There is a larger concept paper behind the concept paper here.

Premium Assistance for those who have access to employer sponsored insurance. (keeps them on private plans)

High Deductible Health Plan model – can lead to uncompensated care – would include a Health Savings Account that is largely state funded and open to individual contributions (similar to Indiana).

Financial Incentive ("skin in the game") – difficult for this population – perhaps include 100 to 138% level.

Incentives for healthy behavior – chronic conditions are expensive and often treated in the ER

Incentives for job search and training – one of the misconceptions we hear from legislators is that the expansion population are able-bodied adults. Actually, a large percentage of these folks are working adults and some who haven't yet received disability determination. This could be a tool to move them to more self-sufficiency.

Looking at adult education options – 30-40% of expansion population doesn't have GED. Could this help move people to more self-sufficiency.

Health Care Reform initiatives

What are funding sources that could be used to offset the state share, when that occurs in 2017?

Opt out provision if the federal match drops below 90% - program goes away? Reduce eligibility?

Also working with federal delegation to measure the potential for the feds removing that federal 90% contribution – not sounding likely. We are losing Kansas tax dollars to states who have already accessed this option.

By the time 2016 rolls around, there will be 30 or more states in the program and the likelihood of reducing contribution is low. However, those who have not accessed the program may lose the opportunity – the feds may choose to close the door.

Continue to visit with the Governor's office. One funding option that has been put forward is the provider assessment program. Assess hospitals fees, the fees are used to draw down additional federal funds as currently used in Medicaid. Could be increased.

Governor's office wants to see more details and wants the opportunity to run their own numbers.

KHA is putting more pressure on their members to reach out to legislators on the current bill.

$300 million federal dollars for 2016 / $400 + million for 2017. Job increases.

Fiscal impact analysis – REMI report – full report is available on the KHA website.

$13 million enhanced revenue to State. Could also minimize some of the state funded only grants, though not eliminated.

Use net state savings for the state match – want them to stay in health care, but could be used to plug other holes.

Cagan - Americans for Prosperity is supporting the Ks Dental Practitioners bill

Do they doubt the projections?

More an issue of distrust for the reliability of the federal share. Expect a reduction of the FMAP. Actually, there has only been one time that the FMAP was reduced significantly. There have been hundreds of times the feds have tried to balance budgets by adjusting reimbursement rates, not significant change to FMAP. The only time we saw the spike in FMAP was associated with the end of ARRA funding.

Westerlund – in the past few years, hospitals have closed down their mental health units. Do you think that Medicaid expansion might inspire more hospitals to open mental health units?

Don't know. These are typically financial decisions and depending on the balance, it might help. Certainly, it could help keep some of those open.

Lewis – mental health clients are responsible for a good portion of the uncompensated care that you've got.

10:30 a.m. KDADS Update:

-Carla Drescher, KDADS Behavioral Health Director

-Gina Meier-Hummel, KDADS Commissioner

Access to Mental Health Medications Issue - SB 123 / Work Group

A work group was formed to look at Medicaid mental health drug policy and held an initial meeting on February 17. Secretaries Bruffett and Mosier were both there. Not there to focus on the legislation – meant to focus on the recommended policies. Discussed some "guard rails" – forming an advisory committee, leaving alone patients who are already stable on their medications. Led into beginning discussions. Data was requested from MCOs for next meeting at March 10. Just getting off the ground. Mostly laying the foundation rather than looking at what the policy might look like – will be getting to policy.

Adams – much of the discussion was out of my realm. I am very troubled by the words used to describe a person's relationship with their medications – "compliance and adherence" instead of understanding and choice, education. I just think the conversation is wrong.

Cagan – how can we get a list of members?

I can get that. I know they were still working on a couple of additional folks.

Cagan – does the work group has a purpose if the bill fails?

This is irregardless of the bill. Something that needs to happen either way.

KDADS Revolving Loan Fund for Transitional Housing

Originally discussed an RFP, but now it will be a loan program to build capacity for crisis services or transitional living focused on meeting needs to divert folks from the hospital or to help people to have the resources they need when the leave the hospital.
Campbell explained that through the legislative budget process and visits with the Secretary, we have learned that this was designed to be able to re-invest the money from the sale of the Rainbow building ($1.9 million) and new money budgeted by the Governor ($1 million per year) to expand the availability for

How would the loan work? Could be someone who wants to purchase a building or remodel one for crisis services. Wouldn't be for services as much as for infrastructure. Has to be an assumption that the funds could be repaid. Interest would be very low, if any.

Cagan – there is priority ranking for certain counties? That was a different program = criminal justice grants. However, the state would obviously want to look at areas of need.
Is there engagement from the identified areas of need.
Yes, they are all working on strategic plans.
This is a discussion of the 11 communities picked out based on data showing high risk / high need. State reached out to them to look at trying to build infrastructure and community based engagement to address those identified problems. They will be eligible to go after some of the Governor's Mental Health Initiative funds/grants.

Mental Health Grant/Contracts Ended - Proposed Program

ASO RFP for SUD Block Grant – managing those funds. Pre-bid conference on March 10.
Behavioral Health Cost Analysis Study – RFP is written – waiting for it to be posted.
Prevention RFI is posted – due March 10.
How much money? Around $3 million depending on the funding.
Appears to be heavily focused on addictions and prevention.
Think as you move through it, you can see that it wouldn't be. There is a large section showing the history, but our goal moving toward the integration is for it to be global. Historically funded through substance use block grant, want to incorporate mental health promotion, suicide prevention, problem gambling.
Could have been getting federal block grant moneys for some of the services that have been provided with state-only dollars.
RFI doesn't seem to fit the services that are being rolled into this category. Advocates who are losing their funding stream are being told that to respond to the RFI, but it feels like pushing a square peg into a round hole. I want to be able to quote you to say that the comments from those who do not obviously fit - can be incorporated to attempt to adjust the RFP to make it more inclusive
Epstein - the information I'm hearing is that this is an issue of "doing more with less" Not enough resources to do anything well. Integration sounds good in order to pull these things together, but I feel like compared to other states we are moving so much slower. Think in terms of moving forward with suicide prevention, we are doing nothing.
True this is a result of allotments, but we think by working smarter with the dollars we have – we could be able to draw down additional grant funds. Looking at a number of initiatives to draw down more grant funding.
Think we shouldn't be thinking in the same terms we have always thought.
Fronsman-Cecil – Thanks for comments on the RFI. I am a big supporter of prevention, but unhappy to see it being take away from where we are spending it now. Have benefited so much over the years from the work of NAMI and Keys. What we do is not strictly prevention – support of families, community education, advocacy, local groups trying to put things together with schools. We do have MH First Aid and CIT, but there are so many other non-traditional efforts. Don't see how these funds address those kinds of issues. I feel under threat, as if things I know are important are going away. I will try to make some comments to the RFI and try to make it fit.
Wiebe – obviously there is a reprioritization of where money is spent.
Meier-Hummel – it is true that things are moving toward integrated services and outcomes based funding. Please submit all of your comments and we will consider it.
Westerlund – what is the definition of prevention

Drescher – should be clear in the RFI
Meier-Hummel – the RFI is the way of gathering information. We will form the RFP. We know what our holes are in the system by not funding particular grants. We do understand where gaps may form and will consider how we can direct funding to replace those important functions. RFI is one source of information and not the only source.
Adams – I am gratified that smart people are looking at this RFI. I am confused by it and overwhelmed by it. Have spent a good deal of time trying to figure out how our services are supposed to fit into this, and they really don't. Is it your intent that we should offer more prevention oriented services? The RFI would rule out everything we have been doing based on the questions.
Meier – Hummel – we will look at the scope of work that was being funded by those dollars. If, in the end, the federal government tells us that there is a limited way to spend those dollars, we will have to look at the scope of work that is already our scope of services available today and will have to look at available funding
Availability isn't until January?
Trying to tighten that time frame.
The moment the responses land, we will put our RFP out quickly. Those seeking funding will have to respond quickly. We know the schedule those folks need.
Ranney's article said January.
We hope this summer. We are pushing for the shortest route that we can get this done.
Cagan – friendliest way we can here. RFI is a square peg round hole situation. Two organizations at this table are dealing with a lot of fallout in the current system and we don't expect that fallout to go away. We think KDADS needs to consider: who at KDADS will take those calls. Who at KDADS will take the hands of these folks to walk them through the system. Generally, the people who call us have already called three or four people and have gotten the runaround. Those could be people at centers or at agencies who don't have the time for the hand-holding. Frankly, I don't think that KDADS has the appropriate staff
If the definition of prevention is preventing child suicide or preventing families from losing their children, then we are.
Meier_Hummel – that is prevention. Every intervention that you make is considered

SED Waiver work group submitted the proposal to CMS. Still waiting on comment period. The process that the group came up with:
CMHC identifies and does functional assessment. DCF does the financial eligibility. CMHC does the plan of care and provides the services. MCO approves or denies.
NEW: CMHC identifies and does functional assessment. Sends to manager at KDADS. Approved or denied. CMHC creates plan of care with family. MCO approves or denies. Then CMHC provides the services.
Main issue is timeliness. How to prevent delay at KDADS.
CMS rules say that there has to be an intervening step between someone assessing the person and providing the services. (It is a conflict of interest to have providers assess and create treatment plan – then provide the treatment plan, often referred to as the fox guarding the chickens.)
Need to get the blessing from CMS before creating the procedures. If those procedures can be timely, with backup staffing in place to avoid delays, this new plan should not create a significant barrier to treatment.
Similar issue to the CDDOs.

Important: The Waiver Renewal will be due from work group next – every five years. Internal Work Group has been working on this. The External Work Group will meet February 10. Carla will send the names of the group. This is an exciting opportunity. Do believe we can look at adding codes to our state plan – intensive outpatient services, day treatment programming.

NFMH Discussion – happy to report the agency has developed a charter, identifying work group members. Have a plan. Will look at role of NFMHs in the system. Email Carla if you want to participate.
Meier-Hummel: when we staffed cases at the state hospital, we saw people who needed to live in communities with supportive resources that might fit within the NFMH, but may need to look at alternatives or ways they could serve differently.

Amy – policy advisory groups go away. Conversations are wrong because they are third-payor focused.

Pick up any items that had were skipped earlier.

10:20 a.m. Lobbyist Report -

- The 2015 Kansas Legislature

Issues to weigh in now:

SB 123 – Senate will vote today at 2:30 p.m.

Providers will be on the phone for 30 minutes at a time on each case.

Seclusion and Restraint – House will debate the bill today. Will vote tomorrow.

Please send emails when you receive Action Alerts. If it isn't one of your areas of expertise, just send three or four lines about the issue at the time.

- Budget cuts – Appropriations and Ways and Means will revisit the recommendations from subcommittees when forming their mega-budget bills. Expect more adjustments to amounts when that happens.

- Taxes – won't act on tax proposals until after they hear the revenues for March.

- List of Legislation - website

Children's Issues – Amendments to the SED Waiver - comment period ends Feb 25

BCBS of Kansas – trend of limiting mental health services by private providers. Using prior authorizations to limit services, cursory peer reviews. Social workers, NAMI, and others are expressing concerns.

11:25 a.m. Announcements

11:30 a.m. Adjourn

2015 KMHC Meetings: 9 a.m.–11:30 a.m. Jan 28, Feb. 25, Mar. 25, April 22, May 27, June 24, July 22, Aug 26, Sept. 23, Oct. 21, Nov 18, Dec. 16 **Board Meetings:** 12 noon quarterly the 4th Wednesdays (March 25, July 22, Sept. 23, Dec. 16)

For more information, contact: Kansas Mental Health Coalition http://kansasmentalhealthcoalition.onefireplace.com
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