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Health and Social Services

G-1 Improving the Workforce within the Child Welfare System

The Special Committee on Foster Care Oversight (Special Committee) met during the 2020 Interim to discuss various topics related to the State's child welfare system. This article addresses the workforce issues within the system, including barriers faced and best practices from other states.

Child Welfare Professionals

The American Academy of Pediatrics defines child welfare professionals as foster parents and kin caregivers, pediatricians, other physicians in medical specialties, child advocates, psychologists, and therapists. In Kansas, this definition can be expanded to Kansas Department for Children and Families (DCF) employees who conduct child protective service investigations, staff who support grantee organizations, staff members of the Kansas Protection Report Center, and case management and prevention services staff through grantees.

Child welfare professionals range in their education level, employment, role within the system, and location. However, each professional is impacted by legislative requirements and DCF policies.

Barriers to the Workforce

Stakeholders reported various barriers that contribute to the current state of the workforce within Kansas' child welfare system. Some of the common reasons stated for the high turnover rate of child welfare professionals are burnout, unmet needs, and lack of support.

A National Association of Social Workers (NASW) report on child welfare described challenges to recruitment and retention of child welfare professionals, including low salaries, high caseloads, administrative burdens, risk of violence, and inadequate supervision (*https://www.socialworkers.org/LinkClick.aspx?fileticket=Mr2sd4diMUA%3D*). Although salaries increase with experience, many professionals do not stay in the child welfare system for an extended amount of time.

Many child welfare professionals spend more time on paperwork than with their clients; however, they do recognize that some paperwork is necessary. The number of caseloads per worker can range from 10 to 100 across the country; an excessive number of cases leads to burnout. Child welfare supervisors often have their own caseload or manage a significant number of employees, which leaves all employees without the support or guidance some professionals need.

Considerations

The Child Welfare League of America introduced the National Blueprint for Excellence in Child Welfare, which addresses workforce needs. Some of these needs include orientation and training programs, continuing education, annual performance evaluation, and reasonable workloads. Additionally, the Blueprint indicates employers should encourage self-care and provide wellness opportunities and stress management strategies. The Blueprint is available at *https://www.cwla.org/our-work/cwla-standards-of-excellence/national-blueprint-for-excellence-in-child-welfare/*.

During a presentation before the Special Committee, a representative of the Kansas chapter of the NASW suggested the State consider increasing recruitment and retention of child welfare professionals by offering financial incentives such as student loan forgiveness, tuition reimbursement, and free continuing education units. It was also recommended an annual survey be conducted to determine which incentives are utilized. The representative further recommended the State consider career readiness at the middle and high school level to introduce students to the profession, career paths within the system that provide opportunities for advancement, and field placement experiences to assist the tenure of the Kansas child welfare workforce. To assist with the unmet needs regionally, the representative recommended the Rural Opportunity Zone Student Loan Repayment Program could be expanded to additional communities where there is a greater need of support. Other suggestions included ensuring professionals have a work/life balance, maintain the recommended caseload size, and have access to supervisors and self-care in order to combat burnout, compassion fatigue, and secondary traumatic stress.

Legislative Changes

To positively impact the child welfare workforce, state legislatures are passing bills that affect training, caseload capacity, and other factors.

Kansas

In 2019, the Kansas Legislature passed House Sub. for SB 25 (the Appropriations Bill), which created 16 additional full-time equivalent child welfare staff positions. DCF reported that these positions lowered caseloads for frontline child protective services staff and increased the efficiency of service delivery. Additionally, DCF made policy changes to decrease the supervisor to caseworker ratio across the state to be more in line with the Council on Accreditation best practices.

The Kansas Legislature also passed SB 15 in 2019, which provided for licensure by reciprocity for social workers at baccalaureate, master's, and specialist clinical levels and amended the requirements for licensure by reciprocity for other professions regulated by the Behavioral Sciences Regulatory Board (BSRB). Applicants who are deficient in the qualifications or in the quality of educational experience required for licensure are allowed to obtain provisional licenses to allow the applicants time to fulfill remedial or other requirements prescribed by the BSRB. For several professions, the bill amended provisions related to temporary licenses for applicants who have met all licensure requirements except for taking the required licensing examination. The bill also amended the licensure requirements for a specialist clinical social worker to reduce the number of hours of postgraduate supervised professional experience required.

During the Special Committee, committee members recommended the creation of a workforce development task force or work group

to further examine improvements that can be made within the child welfare system.

Illinois

Illinois passed SB 1889 in 2019, which amended its Children and Family Services Act to continue developing and utilizing the Child Protection Training Academy that was originally established in 2015. The Academy is conducted by the University of Illinois-Springfield's Center for State Policy and Leadership. The Academy incorporates simulation training for recognizing and responding to cases of child abuse or neglect for mandated reporters. Cultural competency training is also provided through the Academy for the workforce's "response to and engagement with families and children of color." Additionally, development of laboratory training facilities, including mock houses, courtrooms, medical facilities, and interview rooms is also encouraged by the Illinois Legislature.

Maine

The Maine Legislature passed HB 595 in 2019 to require the Department of Health and Human Services to review caseload standards and develop recommendations. The Office of Child and Family Services (OFCS) determined it was understaffed in 2019 and 2020 and implemented a workload analytic tool to establish appropriate workload and caseload expectations. While this tool incorporates the number of reports, assessments, and children in care, it also takes OFCS's vacancy rate, the experience level of current staff, and geographical areas into consideration to determine the workforce's current capacity.

Virtual Workforce

In light of the COVID-19 pandemic, the National Child Welfare Workforce Institute created the Virtual Workforce Supports Resource Collection, available at *https://www.ncwwi.org/index.php/resourcemenu/virtual-workforce-supports*, which contains training and documents for child welfare professionals addressing supervising through distancing, hosting virtual meetings, tips for teleworking, and using video conferences for caseworker visits. Additionally, the National Conference of State Legislatures released child welfare resources, including "COVID-19 and Child Welfare: A Series of Virtual Meetings" (*https://www.ncsl.org/research/human-services/covid-19-child-welfare-a-series-of-virtual-meetings637256622.aspx*); one entry focused on supporting the child welfare workforce. The webinar examined issues such as the decrease in child abuse reporting, the lack of appropriate personal protective equipment, and the inability to directly engage with children.

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Health and Social Services

G-2 Reimbursement Rates under the Medicaid Home and Community Based Services Waivers

Overview of Home and Community Based Services Waivers

The Medicaid Home and Community Based Services (HCBS) waiver program is authorized under Section 1915(c) of the Social Security Act. Through the HCBS waiver program, a Medicaid beneficiary can receive a wide range of services designed to allow the individual to live in their home or community and avoid institutionalized care.

Services under the HCBS waiver program may be a combination of standard medical services and non-medical services. Standard services may include, but are not limited to:

- Case management (support and service coordination);
- In-home care (home health aide and personal care attendants); and
- Habilitation services (both day and residential).

Currently, 47 states, including Kansas, and the District of Columbia have HCBS waivers approved with the Centers for Medicare and Medicaid Services (CMS). The only states that currently do not have an approved 1915(c) waiver with CMS are Arizona, Rhode Island, and Vermont.

HCBS Waivers in Kansas

Currently, KanCare allows the State to administer all its HCBS waiver services through managed care. There are seven separate 1915(c) HCBS waivers: Autism (AU), Frail Elderly (FE), Intellectual and Developmental Disability (I/DD), Physical Disability (PD), Serious Emotional Disturbance (SED), Technology Assisted (TA), and Brain Injury (BI).

To participate in a HCBS waiver, the individual requiring services must be financially and functionally eligible for Medicaid. Individuals with income above $1,177 a month must share in the cost of care, called the “client obligation.” The client obligation is paid directly

by the client to a medical provider, not to the State of Kansas nor to a KanCare Managed Care Organization (MCO).

Individuals on the HCBS waivers receive services through individual providers, contracted through MCOs. Those providers are then reimbursed through KanCare for providing those services. Each service has a different category with different rates. Due to rising costs to provide these services, there have been efforts to increase the rates at which HCBS services are reimbursed. Additional information for each of the seven HCBS waivers follows.

Autism (AU)

The AU waiver provides services to children who have been diagnosed with Autism Spectrum Disorder, Asperger's syndrome, or pervasive developmental disorder not otherwise specified. Children are eligible for services from the time of diagnosis until their sixth birthday. Autism services are limited to three years; however, an additional year may be submitted for approval.

The AU waiver generally has five service categories, which represent different therapy services and respite care. The current rates range from $3.26 to $10.87 per 15-minute increment.

Frail Elderly (FE)

The FE waiver provides home and community based services to Kansas seniors as an alternative to nursing facility care. The waiver serves those individuals 65 and older who meet the Medicaid nursing facility threshold score and are financially eligible for Medicaid.

The FE waiver has approximately 17 service categories, which generally represent various personal care services and life management services. Services vary in reimbursement frequency and range from 15-minute increments for personal care services to once-a-month for more specialized services.

For more-frequent services, the rates range from $2.96 to $4.49 per 15-minute increment. Less-frequent services range from $17.30 to $125.04 per occurrence. These types of services range from medication reminders to financial management services.

Intellectual and Developmental Disability (I/DD)

The I/DD waiver provides services to individuals five years of age and older who meet the definition of intellectual disability, have a developmental disability, or are eligible for care in an intermediate care facility for individuals with intellectual disabilities. Those with a developmental disability may be eligible if their disability was present before age 22 and they have a substantial limitation in 3 areas of life functioning.

Services for the I/DD waiver are divided into approximately 14 service categories, which generally represent various personal care services and life management services. Services vary in reimbursement frequency and range from 15-minute increments for personal care services to once-a-month for more specialized services.

For more-frequent services, the rates range from $3.34 to $8.16 per 15-minute increment. Less-frequent services range from $16.31 to $125.04 per occurrence. These types of services range from medication reminders to financial management services.

Two common services are residential supports and day supports, which are each divided into tiered rates. Residential supports rates are reimbursed per day. These rates range from $46.14 to $208.81. Day supports are reimbursed in 15-minute increments. These rates range from $2.01 to $6.47.

Physical Disability (PD)

The PD waiver provides services to individuals 16 to 64 years of age who meet the criteria for nursing facility placement due to their physical disability, have been determined disabled by the Social Security Administration, and need assistance to perform activities of daily living.

The PD waiver has approximately 17 service categories, which generally represent personal care and life management services. Services vary in reimbursement frequency and range from 15-minute increments for personal care services to once-a-month for more specialized services.

Personal care services are generally reimbursed at $3.08 to $3.56 per 15-minute increment. Home-delivered meals are reimbursed at $6.04 per meal. Less-frequent services range from $17.30 to $125.04 per occurrence. These types of services range from medication reminders to financial management services.

Serious Emotional Disturbance (SED)

The SED waiver provides services to individuals ages 4 to 18 who have been diagnosed with a mental health condition that substantially disrupts the individual's ability to function socially, academically, or emotionally. The waiver is designed to divert the individual from psychiatric hospitalization to intensive home and community based supportive services.

The SED waiver has approximately seven service categories, which represent various therapy types and respite care. These services are generally reimbursed at $3.26 to $21.75 per 15-minute increment.

Technology Assisted (TA)

The TA waiver provides services to people through the age of 21 who require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital.

The TA waiver has approximately seven service categories, which represent various attendant care services. These services are generally reimbursed at $3.61 to $8.70 per 15-minute increment. The TA waiver includes a few less-frequent services, such as health maintenance monitoring and financial management services, which are reimbursed at $76.11 per visit and $125.04 per month, respectively.

Brain Injury (BI)

The Brain Injury (BI) Waiver is a habilitative/rehabilitation and independent living program with an emphasis on the development of new independent living skills and/or relearning of lost independent living skills due to an acquired or traumatic brain injury.

The BI waiver has approximately 16 service categories, which generally represent various personal care services and life management services. Services vary in reimbursement frequency and range from 15-minute increments for personal care services to once-a-month for more specialized services.

For more-frequent services, the rates range from $3.24 to $18.99 per fifteen-minute increment. Less-frequent services range from $17.30 to $125.04 per occurrence. These types of services range from medication reminders to financial management services.

Recent Changes in Provider Reimbursement Rates

Services through the HCBS waiver program are provided by a contracted entity, which is subsequently reimbursed for its services. Over the years, there has been an effort to increase reimbursement.

2019 Legislative Session

During the 2019 Legislative Session, the Kansas Department for Aging and Disability Services (KDADS) requested additional funding to increase the reimbursement rates for the BI waiver for FY 2020. The request did not make it into the Governor's Budget Recommendation.

During the Legislative Session, both the House Committee on Social Services Budget and the Senate Committee on Ways and Means Social Services Subcommittee considered providing rate increases for all waiver categories. During deliberations on the budget, the two chambers agreed on an increase of 1.5 percent for all

waivers. This increase was included in SB 25, the 2019 appropriations bill.

The effect of this increase was wide, ranging from a several cent increase for some non-specialized care services to a dollar increase for the more specialized care services.

2020 Legislative Session

During the 2020 Legislative Session, KDADS specifically requested an increase for both the TA and BI waivers. The increases did not make it into the Governor's Budget Recommendation.

The Legislature considered a rate increase for the Specialized Medical Care (T1000) service code for the TA waiver, taking it from its current rate of $31.55 to $37.00 per 15-minute increment. As a result, the Legislature added $6.4 million, including $2.7 million from the State General Fund (SGF), in SB 66, the 2020 appropriations bill, to increase the rate for that specific service code.

Additionally, 2020 SB 348 and 2020 HB 2550 were introduced. These bills would have increased the reimbursement rates for the I/DD waiver over the course of three years, with a set yearly increase beginning in fiscal year (FY) 2024. The bills were heard in the Senate Committee on Ways and Means and the House Committee on Social Services Budget.

While the bills did not advance beyond hearings in either committee, the Legislature added $22.1 million, including $9.0 million from the SGF, for a 5.0 percent increase in I/DD waiver services in FY 2021.

COVID-19 Pandemic and the June 25 Governor's Allotment Plan

On June 25, 2020, the Governor released her allotment plan due to projected shortfalls in state revenue resulting from the COVID-19 pandemic. The plan included several items added by the Legislature during the 2020 session being removed from the approved budget.

Among those items were:

- $9.0 million, from the SGF, for the 5.0 percent increase to provide reimbursement rate increases in I/DD waiver services; and
- $2.6 million, from the SGF, for the increase to $37.00 in the Specialized Medical Care (T1000) service code for the TA waiver.

The effect of the Governor's allotment plan was to remove the SGF contribution for these items. Since the SGF contribution would have been used to draw down additional federal funds, these allotments also resulted in the additional loss of:

- $13.2 million, in matching federal funds, for the 5.0 percent increase to provide reimbursement rate increases in I/DD waiver services; and
- $3.8 million, in matching federal funds, for the increase to $37.00 in the Specialized Medical Care (T1000) service code for the TA waiver.

These funds were removed from the budget; the reimbursement rates effectively remain at the FY 2020 levels for FY 2021.

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Health and Social Services

G-3 Impact of COVID-19 on Telehealth Advances

With the emergence of the COVID-19 pandemic in the United States in early 2020, both the federal government and the State of Kansas responded by issuing orders to waive regulations pertaining to telehealth to ease the access to medical care for individuals, in light of social distancing measures to prevent the transmission of COVID-19. This article provides an overview of the federal government changes to telehealth regulations, the Kansas telehealth flexibilities initiated as they relate to the KanCare program and executive orders, and other flexibilities related to prescriptions and Health Insurance Portability and Accountability Act (HIPAA) patient communications.

According to the National Conference of State Legislatures, telehealth is defined differently by nearly all states and even by different entities within the federal government. Generally, "telemedicine" refers to clinical services, and "telehealth" encompasses a broader scope and can refer to remote non-clinical services, including provider training, administrative meetings, and continuing medical education, in addition to clinical services. Telehealth and telemedicine can often be used interchangeably. The Kansas Legislative Research Department (KLRD) provides several memorandums concerning telehealth, including an overview on telehealth and telemedicine definitions, coverage of telehealth services in Medicaid and Medicare, and telemedicine laws and recent legislation in nearby states, which may be found at *http://www.kslegresearch.org/KLRD-web/Health&SocialServices.html*.

Federal Actions

Federal Legislation

On March 6, 2020, Congress passed the Coronavirus Preparedness and Response (CPR) Supplemental Appropriations Act 2020 [PL 116-123]. The CPR Act facilitated changes for telehealth services, allowing the Secretary of Health and Human Services (Secretary) the authority to temporarily waive or modify Medicare requirements related to telehealth services during the emergency period.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, enacted on March 27, 2020, included funds for the provision

of telehealth services and increased telehealth capacity through the purchase of equipment and other methods. More specifically, telehealth provisions in the CARES Act include:

- Appropriated $29 million for each of federal fiscal years 2021 through 2025 for the Telehealth Network Grant Program that awards eligible entities for projects that demonstrate telehealth technologies can be used in rural areas and medically-underserved areas. The program was extended from four to five years;
- Under Section 3701, for plans beginning on or before December 31, 2020, the Act allowed high-deductible health plans with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible;
- Granted the Secretary the authority to waive provisions with regard to payment for telehealth services and, for telehealth services provided during the COVID-19 emergency period, removed the requirement that providers of telehealth services have treated the Medicare beneficiary receiving telehealth services in the last three years;
- Allowed federally qualified health centers (FQHCs) and rural health clinics (RHCs) to provide telehealth services to Medicare beneficiaries during the COVID-19 emergency period;
- Allowed Medicare beneficiaries receiving hospice care to have a face-to-face encounter *via* telehealth with a hospice physician or nurse practitioner to re-certify continued eligibility for hospice care during the COVID-19 emergency period;
- Required the Secretary to issue clarifying guidance regarding the use of telecommunications systems for home health services, including remote patient monitoring, during the COVID-19 emergency period;
- Allocated $200 million to the Federal Communications Commission for salaries and expenses to respond to the coronavirus pandemic (COVID-19), domestically or internationally, including to support efforts of health care providers to address coronavirus by providing telecommunications services, information services, and devices necessary to enable the provision of telehealth services during an emergency period; and
- Allocated $180 million to the Health Resources and Services Administration to carry out telehealth and rural health activities, of which no less than $15 million was required to be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

Federal Regulations

In certain emergency circumstances the Secretary, using Section 1135 of the Social Security Act, can temporarily modify or waive certain Medicare, Medicaid, and Children's Heath Insurance Plan regulations using blanket waivers. The Centers for Medicare and Medicaid services (CMS) has continued to publish guidance on these changes. The full list of changes can be found at *https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf*.

The following are some of the major changes to Medicare telehealth policy made by the Secretary due to the COVID-19 public health emergency:

- Allows certain practitioners to bill for telehealth services that were not previously allowed. This includes physical therapists, occupational therapists, speech language pathologists, and others;
- Allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services and behavioral health counseling and educational services;

- Waives certain regulations for critical access hospitals regarding telemedicine and making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital;
- Allows physicians and non-physician practitioners to perform in-person visits for nursing home residents in skilled nursing facilities and visits to be conducted, as appropriate, *via* telehealth options;
- Allows physicians and other practitioners to render telehealth services from their homes without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location; and
- Removes limitations on where Medicare patients are eligible for telehealth during the emergency, in particular, allowing patients outside of rural areas and patients in their homes to be eligible.

Prescription Flexibilities

The U.S. Drug Enforcement Administration (DEA) Diversion Control Division issued guidance on many areas concerning controlled substances and electronic prescribing during the COVID-19 pandemic. The Controlled Substances Act contains exceptions to the general rule that a prescription for a controlled substance issued by means of the Internet (including telemedicine) must generally be predicated on an in-person medical evaluation. One of these exceptions is when the Secretary has declared a public health emergency.

As of March 16, 2020, and continuing as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted during an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable federal and state laws.

The DEA also announced that practitioners may prescribe buprenorphine to new and existing patients with opioid use disorder *via* telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in-person or *via* telemedicine. This exception lasts until the Secretary declares the public health emergency ended, unless the DEA specifies an earlier date.

HIPAA Flexibilities

The U.S. Department of Health and Human Services Office for Civil Rights (OCR) issued a Notification of Enforcement Discretion (Notification) regarding COVID-19 and telehealth communications. The Notification states HIPAA-covered health care providers may, in good faith, provide telehealth services to patients using remote communication technologies, even if the application does not fully comply with HIPAA rules. The OCR would exercise its discretion and would not impose penalties for noncompliance with the regulatory requirements under the HIPAA rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 public health emergency.

The Notification only applies to HIPAA-covered health care providers. A health care provider is a covered entity under HIPAA if it transmits any health information in electronic form in connection with a transaction for which the Secretary has adopted a standard. The Notification applies to all HIPAA-covered health care providers, with no limitations on patients they serve with telehealth, including those patients that receive Medicare or Medicaid benefits.

Under the Notification, covered health care providers may use popular applications to deliver telehealth as long as they are "non-public -facing." Examples of public-facing applications are Facebook Live and Twitch. Examples of non-public-facing video chat applications include:

- Apple FaceTime;
- Facebook Messenger video chat;
- Google Hangouts video;
- Zoom; and
- Skype.

Kansas Telehealth Actions

KanCare

On March 20, 2020, the State Medicaid Director sent a communication to CMS detailing the Medicaid requirements that pose challenges for health care delivery in Kansas during the pandemic. On March 24, 2020, CMS sent a response of the different approvals related to the requests, pursuant to Section 1135 of the Social Security Act.

In regard to reimbursement rates for distance sites, Kansas Medical Assistance Program (KMAP) General Bulletin 20045 states services delivered through telemedicine will be equivalent to identical services provided in person. The Medicaid fee-for-service fee schedule that is posted on the KMAP website will serve as the source for reimbursement by code. The bulletin states there will be no change in reimbursement levels for existing originating sites. In the instance that "home" is the originating site, then there will be no originating site fee paid for that claim.

The following are some of the flexibilities that Kansas may now utilize during the COVID-19 pandemic for telehealth services:

- No geographic limitations for telehealth services (*e.g.* services are not limited to rural or non-metropolitan service locations);
- Patient's home is now an eligible "originating site" or "patient site" for telehealth services;
- Other non-healthcare facilities (*e.g.* schools, work sites, libraries) are eligible as originating/patient sites;
- Originating and patient sites, other than the patient's home, can bill for a facility fee (this also applies to federally qualified health centers and rural health clinics);
- Providers are allowed to be reimbursed for certain codes when the originating telehealth site place of service is "home" (Place of Service code 12);
- A prior existing relationship with a patient is not required to provide telehealth services;
- Any eligible member service can be provided *via* telehealth when medically-necessary and appropriate;
- Patient co-pays and out-of-pocket costs still apply unless waived by the payer or plan (not applicable for COVID-19 services);
- Prior authorization is not required for telehealth services, unless in-person services also require prior authorization;
- For some services, providers may utilize telephone/audio-only visits;
- Verbal consent, and not requiring written consent of the patient for some services, is allowed; and
- The use of personal devices such as smartphones and tablets may be used to deliver telehealth services (Kansas allows for some, but they must be HIPAA compliant).

KMAP provides a detailed list of the changes made due to the COVID-19 pandemic. A full list of the bulletins and provider information can be found at https://www.kmap-state-ks.us/Documents/Content/Provider/COVID%2019%20.pdf.

While the majority of telehealth changes in Kansas are in place until the public health emergency ends or until further notice by the State Medicaid Director, some flexibilities have

expired. For example, certain dental codes that were approved for payment when provided by way of telecommunication technology by KMAP Dental Bulletin 20052 expired June 30, 2020.

State Employee Health Plan

The Kansas State Employee Health Plan (SEHP) issued a memorandum related to benefits and COVID-19. Effective through December 31, 2020, SEHP partners Aetna Better Health of Kansas and Blue Cross Blue Shield of Kansas will provide telehealth services with a virtual doctor's office. There is 24/7 access to this service and the member cost share is waived for any telehealth service.

Executive Orders

On March 20, 2020, the Governor signed Executive Order No. 20-08, which temporarily expanded telemedicine access and addressed certain licensing requirements to combat the effects of COVID-19. The order encourages physicians to utilize telemedicine and prevents the Kansas State Board of Healing Arts (Board) from enforcing any statute, rule, or regulation that would require physicians to conduct an in-person examination of a patient prior to prescribing medication, including controlled substances. The order allows for out-of-state physicians, who hold unrestricted licenses to practice medicine in the state in which they practice medicine and are not the subject of an investigation or disciplinary proceeding, to treat Kansans through telemedicine upon notice to the Board.

Executive Order No. 20-35 extended the provisions of Executive Order No. 20-08 until June 30, 2020.

The Office of Recovery

The Governor established the Office of Recovery within the Office of the Governor;it is composed of governor-appointed members representing the business community, economic development community, and the Legislature. The Strengthening People and Revitalizing Kansas (SPARK) Taskforce, a 5-member executive committee that makes recommendations based on the work of a 15-member steering committee, was tasked with making recommendations to the Governor on how $1.03 billion in state Coronavirus Relief Fund moneys, received through the CARES Act and appropriated in 2020 Special Session HB 2016, should be allocated. An Investment Dashboard on the Office of Recovery's website outlines the various programs and funding levels created to expend the money before December 30, 2020.

According to the Investment Dashboard, $10 million of the funds was allocated through the Department of Commerce to address broadband connectivity issues including barriers for telehealth and to create a Provider Partnership Support Program that works with internet service providers to expedient deployment of assistance for vulnerable populations and families (*https://covid.ks.gov/covid-data/*).

For more information on funding enhancements at the federal and state level for broadband expansion, see article N-1 Broadband Expansion.

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Health and Social Services

G-4 Mental Health Services in Kansas

Community Mental Health Centers

In 1963, President John F. Kennedy signed the Community Mental Health Act, which led to the establishment of Community Mental Health Centers (CMHCs) across the nation. The Kansas Mental Health Reform Act of 1990 initiated the state's transition from institutional to community-based mental health care. The Act deemed that Kansas residents in need of mental health services should receive the least restrictive treatment and the most appropriate community-based care through coordination among CMHCs and state hospitals.

After 1990, CMHCs served as the primary points of entry into the mental health system. As more patients used community-based services, the need for state hospital beds declined.[1] The Kansas Department for Aging and Disability Services (KDADS) still oversees the larger State-owned mental health institutions: Larned State Hospital (LSH) and Osawatomie State Hospital (OSH).

Today, Kansas has 26 CMHCs that primarily serve adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care. Anyone experiencing a mental health crisis but who lacks a mental health illness diagnosis can seek treatment at a CMHC.[2] According to KDADS, CMHCs offer "comprehensive mental health rehabilitation services, such as psychosocial rehabilitation, community psychiatric support and treatment, peer support, case management, and attendant care."[3]

Impact of COVID-19. As a result of the 2020 COVID-19 pandemic, CMHCs shifted to telehealth options for nearly all of their services. As the year went on, CMHCs reopened in-person service delivery but maintained telehealth services. According to the Association of CMHCs of Kansas, Inc., symptoms of anxiety disorder and depressive disorder increased during the first few months of the pandemic in the United States compared to 2019.

State Hospitals and Regional Care

Since 2015, LSH and OSH have been the only State-owned mental health institutions. LSH and OSH generally serve Kansans who

require longer-term inpatient acute care. The Care and Treatment Act for Mentally Ill Persons (KSA 59-2945 *et seq.*) provides definitions and guidance for admission to the state hospitals.

Moratorium Plan

In April 2015, the Secretary for Aging and Disability Services imposed a moratorium on voluntary admissions to OSH, as the hospital lacked sufficient space for involuntary, long-term patients. The census for involuntary patients was capped at 146. In 2018, OSH increased its capacity to 166 patients.

In January 2020, KDADS presented its plan to lift the OSH moratorium to the House Committee on Social Services Budget. The agency's plan includes increasing regional beds within the community. According to KDADS' plan, "Adding this capacity regionally will help serve patients closer to their home communities." The agency's goal is for regional beds to supplement OSH capacity with shorter stays in community facilities, limiting the number of patients sent to state hospitals. One of the long-term goals for KDADS is to fund more community-based and crisis outpatient services to reduce the need for institutional and other inpatient services.[4]

The proposed moratorium plan was included in the Governor's Budget Recommendation for fiscal year (FY) 2021. The plan included adding an additional 15 to 20 KDADS-contracted regional beds. Currently, KDADS pays for six beds among three of those centers: Freedom Behavioral Hospital of Topeka, Prairie View in Hillsboro, and Cottonwood Springs in Olathe. The plan also proposed an increase in OSH beds from 174 to 182, an increase in crisis stabilization beds from 100 to 125, and adding 30 crisis intervention center beds for a net system increase from 46 to 76 beds.

KDADS anticipates the additional bed capacity at OSH will allow the hospital to begin a Census Management Initiative pilot. The goal of this program is to determine how many adults with severe mental illness are screened as needing treatment but who are on the waiting list for inpatient hospital care. KDADS plans to use the expanded system capacity of both state hospitals and CMHCs to supply each patient with the most appropriate care.

Community Inpatient and Structured Care

Community Inpatient Care and Structured Care Environments are the two levels directly below the State Hospitals on the adult continuum of care. Structured Care Environments include crisis stabilization services, Nursing Facilities for Mental Health, Residential Care Facilities, sobering beds, and social detox beds. Community Inpatient Care includes crisis intervention, community inpatient psychiatric beds, medical detox beds, and substance use disorder treatment.

In 2017, the Kansas Legislature enacted the Crisis Intervention Act, which allows adults to stay in crisis intervention centers for up to 72 hours for emergency evaluation and treatment. The Act also requires a center to file an affidavit with the district court within 48 hours of admission if the patient meets the criteria to be retained. The center must discharge the patient if they no longer meet the criteria or if 72 hours has passed since admission. For more information on the Crisis Intervention Act and associated issues, see article H-4 Mental Health and the Criminal Justice System.

KDADS proposes expanding services at RSI, Inc. in Wyandotte County to designate it as a crisis intervention center. If RSI were to meet those service requirements, it could admit involuntary patients, decreasing the need for beds at OSH. This shift to community intervention services aligns with KDADS's broader goal of connecting patients to nearby treatment options in appropriate settings.

Kansas currently has five established crisis stabilization centers located in Kansas City, Topeka, Wichita, Salina, and Manhattan. These centers provide patients short-term mental health crisis care of 48 hours or less before they can transition to community-based care. Crisis stabilization is not traditionally provided in

hospitals, but it can be an alternative to psychiatric hospitalization.

Mental Health Treatment for Youth

Youth have access to several mental health treatment options throughout the state. Options include psychiatric residential treatment facilities (PRTFs), the Medicaid Home and Community Based Services waiver for Serious Emotional Disturbance, and Professional Resource Family Care. Each option is detailed in more depth below.

PRTFs. These facilities provide comprehensive mental health inpatient treatment for youth who cannot otherwise be served safely and effectively in a less-restrictive environment. They generally provide services for longer-term stays. There are currently eight PRTFs in Kansas.

The Children's Continuum of Care Task Force noted in its 2017 report that PRTFs had gradually shifted from treating chronic mental health illnesses to crisis stabilization. Additionally, from 2011 to 2017, there was a 65 percent decrease in the number of PRTF beds across the state, from 780 to 272. As a result, PRTF waiting lists have expanded. The Task Force recommended that PRTFs return to their original treatment model with a focus on chronic illnesses, rather than acute and crisis care. The 2020 Legislature added funding for 8 PRTF beds in Hays.

Medicaid Home and Community Based Services Serious Emotional Disturbance Waiver. The Serious Emotional Disturbance (SED) waiver is designed to assist adolescents who have been diagnosed with a mental health condition to avoid psychiatric hospitalization. Children with a serious emotional disturbance, who are financially eligible, and who meet admission criteria for a state mental health hospital are eligible for the SED waiver.

Services and supports under the SED Waiver may include attendant care, independent living and skills building, short-term respite care, parent support and training, professional resource family care, and wraparound facilitation.

Professional Resource Family Care. This service provides short-term and intensive supportive resources for the patient and their family.

In October 2015, the Centers for Medicare and Medicaid Services (CMS) ruled that Kansas was in violation of the federal Mental Health Parity and Addiction Equity Act because a third party (the CMHCs), rather than the Managed Care Organizations (MCOs), granted prior authorization for PRTF services in order for a provider to receive Medicaid reimbursement. After the ruling, the MCOs gained authorization privileges.

Child Welfare System Task Force

House Sub. for SB 126 (2017) directed the Secretary for Children and Families to study the child welfare system. The Child Welfare System Task Force was directed to convene working groups to study the general administration of child welfare by the Kansas Department for Children and Families. The Task Force made several recommendations related to mental health among Kansas youth:

- First, the State "shall require access to high-quality and consistent medical and behavioral health care for youth in foster care through the Medicaid state plan" by MCO oversight;
- Second, the State "should provide young adults age 18-21 with the option to seamlessly re-enter the child welfare system and ensure continuity in medical behavioral health and support services for youth who have exited the custody of DCF"; and
- Third, the State "should fully fund, strengthen, and expand safety net and early childhood programs through public services (DCF, mental health, substance abuse, and education) and community-based partner programs, and reduce barriers for families needing to access concrete supports."

Kansas Legislation Related to Youth

2016 SB 367 and the Establishment of the Juvenile Justice Oversight Committee

The Juvenile Justice Oversight Committee (JJOC) was established in 2016. Pursuant to KSA 75-52,161, the Committee recommends to the governor and legislature the reinvestment of funds that result from the reduction in the number of youth placed in out-of-home placements. Among the evidence-based programs funded through reinvestment include several aimed at mental health, including the Massachusetts Youth Screening Instrument to identify mental health needs and mental health training for staff who work with youth. The Kansas Department of Corrections administers the programs.

2019 HB 2290 and Suicide Prevention

In 2019, the Legislature passed HB 2290, which required the Office of the Attorney General to appoint a Kansas youth Suicide Prevention Coordinator and additional support staff to identify, create, coordinate, and support youth suicide awareness and prevention efforts throughout the state. The coordinator was empowered to develop web resources to facilitate communication with youth to promote safety and well-being, develop interagency strategies to help mental health stakeholders, coordinate efforts to prevent and address youth suicide, and disseminate information on suicide reduction, among other duties. Funding for the position was not included in the Governor's FY 2020 and FY 2021 budget recommendation. The 2020 Legislature added the position in FY 2020 and FY 2021 and directed the agency to use existing special revenue funds to fund the position.

Federal Law

In 2018, President Trump signed into law the Family First Prevention Services Act, which encourages the maintenance of families to preempt a child's entrance into the foster care system. The Act allows for federal reimbursement for mental health services, substance use treatment, and in-home parenting skills training.

Funding of Mental Health Services

Medicaid provides the largest source of state funding for community-based mental health services. CMHCs use certified Medicaid match funds to provide services for children with a Serious Emotional Disturbance, children referred to CMHCs by Children and Family Service contractors, and all other children and adults who are Medicaid eligible. Medicaid covers Targeted Case Management, Comprehensive Medication Services, Personal Care Services, Pre-admission Screens, Activity Therapy, Group and Individual Psychotherapy, Training and Educational Services, Crisis Intervention, Community Transition, and Respite Care. CMHCs also receive county funding through mill levies (up to two mills for mental health services) and other taxes.

Federal law generally prohibits states from using Medicaid funds for services provided to non-elderly adults in "institutions for mental disease" (IMDs). IMDs are any inpatient or residential facility of more than 16 beds that specializes in psychiatric care. However, the federal government provides mechanisms for states to finance certain IMD services. In 2018, CMS approved Kansas' application to waive the 15-day monthly maximum on substance use disorder treatment for IMD utilization. This waiver also allows the State to expand screening, brief intervention, and referral to treatment services as mitigation practices.

Crisis stabilization services are generally funded through lottery vending machine revenue. However, given this relatively new source of revenue, several of the crisis stabilization centers receive individual funds for their operations. These include centers in Wichita, Topeka, and Salina. RSI in Kansas City receives its own established fund.

During the 2020 Legislative Session, the Legislature passed the 2020 appropriations bill (2020 SB 66).

Included in the 2020 appropriations were the following items related to mental health:

- $1.5 million from the State General Fund (SGF) and $500,000 from the State Institutions Building Fund to open a 14-bed unit at OSH in spring 2021;
- $5.3 million, all from the State Institutions Building Fund, to remodel the OSH Biddle Building to allow KDADS to apply to CMS for federal reimbursement certification for 30 beds;
- $5.0 million, all from the SGF, to add the regional inpatient beds outlined above;
- $4.0 million, all from the SGF, to create 8 acute care psychiatric beds for youth in Hays;
- $2.0 million, all from the SGF, to increase grant funding for CMHCs;
- $1.0 million, all from the SGF, to create a PRTF pilot program at Ember Hope in Newton; and
- $750,00, all from the SGF, to establish a separate SGF account for funding the Douglas County Community Crisis Center.

Due to estimated shortfalls in state revenue caused by the COVID-19 pandemic, the Governor announced her allotment plan on June 25, 2020. Her allotment plan included several of the following mental health-related items:

- $2.5 million of the $5.0 million for regional beds;
- $2.0 million for additional CMHC grant funding;
- $1.0 million for the Ember Hope pilot program; and
- $750,000 to create a separate SGF account for funding the Douglas County Community Crisis Center.

1 2018 Mental Health Task Force Report.
2 According to the National Alliance on Mental Illness, a “mental health crisis is any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community.”
3 *https://www.kdads.ks.gov/commissions/behavioral-health/services-and-programs/community-mental-health-centers*
4 See the 2019 Report of the Kansas Mental Health Taskforce for the Adult and Children’s Continuum of Behavioral Health Care.

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