Missing Tools for Efficient and Effective
Employment for Persons with Disabilities in Kansas

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This is an analysis of needed changes to current policies and funding to ensure Kansans with Disabilities receive employment supports and services efficiently and effectively. The goal is for every Kansan possible to receive the supports and services necessary for him or her to become employed in a real job alongside other citizens in the community, to become working taxpayers, to make a living wage, to lessen dependence on government supports and entitlements. The following will ensure "the juice is worth the squeeze," that supports and services are cost effective and beneficial, that they significantly reduce costs that would otherwise be born by taxpayers, expenses taxpayers are already paying because too few people with disabilities who want to work and can work are working.

This is **Deliverable Two: an analysis of changes needed, answers, to redirect taxpayer resources to integrated employment outcomes.** These changes will move persons who can and want to work out into the mainstream of working American life. While these analyses will include changes to current services, what is strikingly evident is Kansans with disabilities, their families, the providers of services, and state officials are missing services commonly used in most states to prevent unintended service cost overruns. Glaringly missing, is full implementation of participant direction, commonly known as Self-directed Services for Persons with Disabilities; this Missing Tool #3 in this Analysis is discussed extensively.

This analysis includes substantial time, effort and rationale to make the case for Kansas to modify every waiver, nearly every Medicaid service, create new and

extensively revise an existing residential waiver, and add a new state plan amendment. These changes would allow persons with disabilities and their families to self-direct their services, to decide who will provide services and who will touch their son or daughter with a disability.

It is critically important that Kansas not make the mistake of assuming that the decision to move services and supports, including long-term care supports for persons with developmental disabilities, under managed care means the state has turned the waivers or state plan amendments over to managed care corporations. It is true that moving funding to managed care will allow increased flexibility in how waiver and state plan amendment funding may be used, but the funding source remains federal and state match funding through waivers and state plan amendments. Kansas is encouraged in this analysis to make extensive changes to these waiver and state plan amendment Medicaid vehicles, to give the managed care corporations, the providers of services, and particularly persons with disabilities and their families more flexibility, including new services.

It is not the case that Kansans taxpayers are investing too much or inadequately in the lives of citizens with disabilities (Kansas ranks 27th among all states in fiscal effort, Braddock, D., Hemp, R, and others (2013) *State of the States in Developmental Disabilities 2013,* The American Association on Intellectual and Developmental Disabilities). A problem in Kansas is a good investment in some areas, like residential group homes, while investing very little in supports and services that foster independence and the need for less taxpayer support, like customized and supported employment. Kansas invests less than one-third of the average state in integrated community employment (Braddock, 2013).

The most fundamental change facing the systems that provide services to persons with disabilities in Kansas is not financial as is commonly believed. It is a significant shift in federal policy through the Medicaid Final Rule and the Workforce Innovation and Opportunity Act. What formerly passed as worthy of taxpayer investment in

the United States ($56 billion annually) and for Kansas (a half billion dollars annually), working on goals and objectives in a disability specific facility, program, or home, has changed. These new laws are requiring a community orientation based on outcomes, results. This means citizens should be learning how to become more independent and interdependent in the context of a life shared with all Americans, and specifically now by law, not in environments that have an isolating effect, potentially day centers, sheltered workshops, affirmative industries, enclaves, mobile work crews, etc.

The notion of successfully completing individual objectives from a written plan of services, while remaining out of the context of the living and working life enjoyed by all Americans because that's what the state pays for, is found inadequate and has an isolating effect on persons, in potential violation with the expenditure of both federal Medicaid and Vocational Rehabilitation taxpayer resources (Federal Register Volume 79 Number 11 (2014, January 16) Part II Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Part 430, 431 etal. Final Rule.)

The growth in residential supports and services, almost exclusively group homes in Kansas, has been with the best of intentions, to ensure Kansans with developmental disabilities in particular, are not served in even more costly and ineffective institutional settings, such as state operated Institutions and nursing homes. And, while Peter should never be robbed to pay Paul, an analysis of needed employment changes cannot be divorced from considering how community residential services could be provided with more efficient options, additional choices for people with disabilities and their families to consider. Kansas has done an excellent job protecting persons, providing safety and security when persons are asleep. It is past time to consider how to provide equally high quality employment and other related supports when citizens with disabilities are awake.

Missing Tool # 1: A new Supports Waiver for Persons with Developmental Disabilities and Changes to the Current Residential Services Waiver

Families, persons with developmental disabilities, residential services providers, and state officials in Kansas may be caught in an all or nothing approach. This all or nothing approach—you take care of him or her or we'll take care of him or her, may have created an unnecessary fiscal cliff in Kansas, where people get too few services and supports to keep him or her in a family home *or* they get residential group home services outside of the family home. When there's an opening in a residential group home, families are advised that they better take it, ready or not, because the wait has already been long. And, the person and his or her family waiting behind you and your family will surely jump at the opportunity of a group home placement if you don't.

Operating a Developmental Disabilities system by moving people with disabilities out of their family's home when there is an available opening, which may at first seem like a natural idea, may trap everyone into a very narrow and specific goal—a place in a group home. Lifelong employment may have become an after thought at best in 2015. It is an untrue "reality," that employment is mere wishful thinking.

That goal again—secure a group home placement—from the perspective of people with disabilities and their families is a safe and secure residence, throughout the remaining years of an adult with disabilities life, out of harm's way once the family can no longer directly care for him or her. Many Kansas families would say this is what they have been waiting for and, without question, securing a place in a group home is a worthy accomplishment. But it's importance is likely elevated due to Kansas lacking a more robust menu of choices for in-home, family, and community supports that are evident in states with two waivers—a supports waiver without out-of-home residential services and a residential waiver.

Families in states that have a supports waiver with a much broader menu of in home and community access services approved by the Centers for Medicare and Medicaid Services (CMS) have a more natural planned transition from the family home to the community, often putting employment first, ensuring one has a good job in the community. In states that have both a supports and a residential waiver the significant costs of a group home placement or other out of home residential alternative is eased until the person with disabilities and the family is ready.

From the perspective of providers, group homes are an excellent alternative to nursing homes or state operated institutions and they're correct. Residential group homes save taxpayers' money when compared to those more costly institutional alternatives. But residential group homes are built on economy of scale economics. To remain financially sound, it is necessary for group homes to remain at full capacity. Some persons, including some providers in Kansas, have said families don't carefully consider what happens during the day when their loved one is not in the group home.

It is often the case that persons with developmental disabilities in Kansas spend their days in a day center or workshop with other people who have a disability and their nights in a group home living arrangement with other people with disabilities. This scenario, with people transported on a bus together, running daily between the group home and the day center/sheltered workshop, with little community involvement besides group forays out and back to the day center, means people have little or no time to become a part of the community life of work, recreation, and living as do other Kansans without disabilities.

There are alternatives to this facility or center-based system in other states that Kansas should consider. It is also true that some providers provide supported employment, but when they do, it is often subsidized by other services they provide, fund-raising, donations, etc., because the rate of payment is too low to meet the costs of the service. In fact, 99.3% of all Medicaid Community funding for persons

with disabilities in Kansas is spent on something other than community employment. Kansas Medicaid must change to become an effective partner with Kansas Vocational Rehabilitation to comply with the Workforce Innovation and Opportunity Act of 2014 on behalf of persons with disabilities.

From the state officials' perspective, the group home placement may be considered as a job well done. In many aspects it is. While some states have persons with disabilities in state run institutions, nursing homes, board and care, or even potentially dangerous personal care homes, Kansans with developmental disabilities for the most part either live with their families or live in an adequately funded residential group home. Persons with behavioral health needs have less access to safe and adequately funded residential care, either nursing facilities for persons with mental health needs or residential care facilities.

Most states, while recognizing the value as Kansas does of having residential group homes as a part of the community residential services continuum, recognize group homes as but a part of many potential options. Other residential options could include: supported living, to ensure persons live with their families or other potential loved ones for as long as they wish; host homes, also know as adult foster homes, to ensure the person is in a family environment in a real neighborhood; supervised apartment living, and other independent living arrangements with needed security and support. Kansas ranks 49th among all states and spends 34 times less than the average state on supported living and personal assistance services, residential support alternatives to group homes (Braddock, 2013, *State of the States*).

The keys to making these choices possible, moving out of the family home only when the family so desires without fear of losing a potential future group home placement option *and* having many different residential services options once the time is right to move, is a second waiver, a Supports Waiver, missing in Kansas, that does not contain a residential component. A Supports waiver is used by states,

beginning in Colorado twenty-five years ago, to address the specific problem Kansas is facing: persons being given a dichotomous choice of either remaining with their families or moving to a group home when there's an opening. Colorado families then and now, as Kansas families then and now became totally focused on ensuring their loved ones are provided a safe place to live when families can no longer care for them. A secure and safe place to live throughout a lifetime is very important, rightfully so, but when it becomes the total goal, the end all focus, it can diminish the importance of a lifetime as an adult in the community where citizens with disabilities live, work, and participate as do other Americans.

Critically, it may trap people with disabilities into what has been termed a "Disability World" where persons live in a home he or she share's with many other people with disabilities and when awake routinely leaves to spend time at a government funded day center or sheltered workshop only with other people with disabilities, back and forth every day of the week, forever.

A Supports Waiver, a second 1915 (c) waiver, should be written and submitted that would allow persons with disabilities to remain in the home of his or her parents with needed support, while providing a natural, when the time is right, opportunity for persons to access a wide choice of residential option through a separate residential waiver. The Supports Waiver (without a residential group home component) should at minimum contain the following services in addition to those day support services currently within the Residential Supports waiver: 1) Self-Directed Services; 2) Financial Management Services; 3) Community Guide or Support Broker Services; 4) Supported Employment, including Customized Employment; 5) Community Access Services; 6) Goods and Services; 7) Education and Training Services; 8) Benefits Counseling Services; 9) An Exceptional Allocation and an Exceptional Rate Protocol; 10) Nursing Services; 11) Non-residential transportation services; and 12) Conflict-free Case Management. These services would not necessarily cost more. They could be paid for by rebalancing the current service spending.

Changes to the current 1915 (c) residential waiver should include all twelve services listed above, a provision to not allow the Self-directing of Residential Services or Nursing Services, and the following additional, not self-directed residential services options: Host Homes, Independent Living Services, and Supported Living Services. Note: whatever CMS approved platform Kansas chooses, 1915 (c) and/or (i), and/or 1115, or other, the foundation for successful employment for citizens with disabilities it should include these "missing tools," these twelve CMS-approved services.

Potential Cost of Needed Changes: None, rebalancing of existing resources under managed care, or a legislature approved time-limited investment to assist in rebalancing all service and supports to more impactful less restrictive, and a less costly system of participant-directed supports and services.

Providers of services to persons with disabilities in group homes may fear and not support any idea that reduces group home reimbursement, that such rebalancing, even if relatively miniscule and with the assurance that every penny would remain in disability services, could signal to some that every dollar is not needed. Agreed, every dollar is needed and their potential concerns are not without foundation. Nothing in this report suggests that any funds should be removed from the disability system and in particular group home funding (It would be great if more funds were added as families, people with disabilities themselves, and their community providers save taxpayers a literal fortune annually when compared to institutional/nursing home costs of the not too distant past!), but without rebalancing day/sheltered/support services so that more of those particular funds are spent on integrated community supports, it is likely that employment services will continue to deteriorate and the overall disability system in Kansas will come under increasing scrutiny as a system that isolates at variance with the 2014 Medicaid Final Rule.

Rationale for each new Service:

Self-directed Services should:

a) Increase the performance outcomes of Kansas's providers of services by giving people with disabilities and their families the "power of the purse" as citizens in our democracy and economic system use it in all other walks of American life. This means people with disabilities and families themselves will decide who in Kansas, among qualified providers, will provide services to their loved ones and whether that service or support is worthy of continued financial investment.

b) Increase the numbers of choices, providers of services, by authorizing payments to providers based on that provider having the skills necessary to provide the needed service. This means individual providers who provide services to three or fewer people and discrete skills providers, such as an employer being paid to teach and train someone how to do a particular job, neither with a Medicaid number, can be paid to provide a Medicaid service via a Financial Management Agency who does have a Medicaid authorized number.

c) This also means only persons who are qualified to provide a service would be authorized to provide services. Family members, relatives, and friends who do not have the specific skills, training, experience, and education to provide a service should not be able to be reimbursed by Medicaid for providing a service. Families having the "power of the purse" does not negate the fact that the money in the analogous "purse" are taxpayer resources coming from federal Medicaid that requires services be provided only by persons having the specific skills to provide the service. All families have a need for resources to lessen the costs of providing care to their children (the loss of income to families who have children with significant disabilities is well-documented) and persons with children who have significant disabilities are not alone with this need. Ordinary and customary caretaking, and sometimes extraordinary caretaking, is different from having the skill to provide supports and

services. Persons may be qualified by licensing, accreditation, certification, or as having the skill and community standing to provide such service if asked by other citizens. In some limited circumstances, this could be a family member.

d) Decreases the costs and improves the quality of services as more of the payment for services would be the costs of the direct service personnel and less so the cost of administrative overhead, physical plant, operation, and maintenance.

e) Significantly increases the quality of current providers of services as providers previously working at the pleasure and standards compliance of state government officials will additionally be working to ensure the pleasure and expected outcomes of their customers, people with disabilities and their families. Excellent providers of services are ensured that people with disabilities and their families will authorize expenditure of funds and payments to their organization, their business will grow, while other mediocre or substandard providers will likely see a decrease in business.

Financial Management Services should:

a) Allow Medicaid payments to individual persons and businesses who do not have their own Medicaid Vendor number, but who have the discrete skills and experience necessary to deliver an authorized Medicaid service. The fiscal intermediary, the Financial Management Service, would be a contracted authorized vendor of such services by the State Medicaid agency.

b) Collect FICA, disability insurance, issue end of year tax statements, and make payments to authorized providers within pre-authorized budgeted limits

Community Guide or Support Broker Services should:

a) Not be connected to any organization or entity but is employed directly by the person with disabilities and/or his or her family and works exclusively for him or her.

b) Locate qualified, willing, and able providers for a particular service or supports written in the person's individual plan of services.

c) Construct an individual budget based on the person's individual allocation,
d) Monitor projected budgeted usage, utilization management, via Financial Management Services monthly reports,
e) Communicate needed changes, including a change in provider, to the Conflict Free Case Manager

Supported Employment/Customized Employment should:

a) Be provided at a rate of payment based significantly on the salary of the direct support Employment Specialist/Job Coach
b) Be provided at a rate to encourage providers to deliver Supported and Customized Employment services ($42-$52 per hour, not the current $12 per hour) offer the person and families a choice of providers, and be adequate enough to ensure low or no turnover among Employment Specialists/Job Coaches
c) Encourage advanced Customized Employment methodologies, including Discovery and Vocational Themes, and consumer owned businesses. Customized Employment is included by law in the Workforce Innovation and Opportunity Act.
d) Utilize the individual placement model of Supported/Customized Employment only, known as IPS for persons with behavioral health needs, transitioning current enclaves/workcrews by dividing the rate paid for individual employment by the number of persons being supported at the site. For example, a $48 per hour individual placement model rate becomes $8 per hour if there are 6 persons working in the employment enclave at a business, or are members of a workcrew.
e) Have a fiscally neutral individual hourly rate for support and follow-along services, meaning the Vocational Rehabilitation hourly rate of between $42 and $52 per hour and the Support and Follow-along hourly rate paid for through Medicaid funds are exactly the same and utilized transparently through a joint agreement as required by WIOA.

f) Be routinely budgeted for between $4000-$5000 for ongoing support and follow-along costs annually, saving taxpayer's significant expense when compared to previous day center costs.

g) Ensure persons work at prevailing competitive wages at a statewide average of 26 hours per week with most persons working at greater than 19 hours per week.

h) Have staff development and training built into the individual rate at not less than 3% of the rate. Staff development and training must be outside consultants and training, out of state conferences, etc., to build Employment Specialist/Job Coaching skill and efficiency.

Community Access Services should:

a) Provide community-based wraparound support access for persons to gain membership and participation in clubs, groups, associations, churches, and businesses as they are accessed by other citizens

b) Be a viable alternative to facility-based day or sheltered workshop services

c) Help citizens with disabilities develop increased social capital, access to the places, opportunities, attractions, and venues as are other citizens who do not have apparent disabilities

d) Work hand in glove with employment supports to increase and support employment success

e) Be a time-limited outcome/results based service that builds ongoing support capacity in clubs, groups, associations, and churches so that paid human service support is not continuously necessary

Goods and Services should:

a) Provide limited individual ability to purchase one time annually goods that are essential but are not considered as self-employment start up costs

b) Provide one time, infrequent, or irregular essential services necessary for continued competitive employment

Education and Training Services should:

a) Provide limited individually determined education and or training services to community members, businesses, organizations, etc. directly associated with a particular person's employment or employment interest
b) Cannot be used for education and training of human service personnel

Benefits Counseling Services should:

a) Ensure a full understanding and accountable record of Social Security and other benefits to encourage compliance with all applicable rules and regulations
b) Help debunk myths, myths about the loss of Social Security, myths about the loss of Medicaid health benefits, etc. and other reasons given that discourage individual competitive employment of person eligible for ongoing government support and benefits, in particular citizens with developmental disabilities and citizens with behavioral health needs.
c) Work to ensure policy changes are made by the state to incentivize working and personal independence

Exceptional Allocation and Exceptional Rates Protocol should:

a) Ensure persons with the most significant disabilities are given the exact amount of financing needed to provide effective services, including employment
b) Make certain that provider's are reimbursed fully the costs of providing services to citizens who have the most significant challenges
c) Ensure taxpayer dollars will be spent precisely as needed, ending a categorical and tiered financing system. Tiered funding financially rewards keeping persons in the highest paying possible tier.
d) Dramatically increase safety and support for persons with the most significant disabilities, ensuring that every citizens, even those with extraordinary and expensive challenges, will have the financing to ensure his or her safety, well-being, and steady progress
e) Reduce the use of pharmacological approaches and significant costs for persons with the most significant behavioral challenges

Nursing Services should:

a) Stop persons with more significant medical challenges being served alongside others with significant similar needs and in facilities for persons with similar needs
b) Recognize there is a significant difference between having a disability and a disease, thereby using nursing services only on an as needed basis instead of a constant facility or program basis.
c) Open up the entire menu of waiver services, including employment, for persons with the most significant medical challenges, allowing each person to receive the nursing support necessary in any environment to access any impactful service, including self-employment through customized employment, while making certain any medical need will be met.
d) Stop funding from being increased due to a categorical placement in order to receive nursing services, with funding now being increased only as needed for specific medical/nursing services in any environment, including the natural community employment setting.

Non-residential Transportation Services should:

a) Locate transportation financing within the person's individual allocation and budget, independent from residential or day services
b) Ensure transportation to and from the place or places of employment
c) Be flexible enough to include public transportation with support and reasonable and economical payments to friends and family for the cost of transportation

Conflict-free Case Management should:

a) Ensure services and supports delivered by providers of services go beyond providing services with the best intentions and caretaking, to services and supports, such as supported and customized employment that have a meaningful and positive impact, that ensure inclusion of citizens with disabilities alongside other citizens.

b) Increase accountability through the authority to detach from services that are not working, to choose from among other providers those providers that deliver effective service and support outcomes.
c) Approve of the plan of services, budget, and individual providers of services. Continuously monitor to ensure results, improvement, and lessening need for services and supports.

Missing Tool #2: A Universal Comprehensive Assessment of Supports Need, the Supports Intensity Scale (SIS).

A Universal Comprehensive Assessment of Need that follows and is an addition to any assessments used to determine eligibility is critically needed to ensure Kansas citizens with developmental disabilities have a basis for an effective plan of services and an equitable distribution of financing for supports and services. The SIS can assess each citizens support needs and is the basis for goals, objectives, and a sound plan of services. Citizens with disabilities too often receive a plan of services that is a continuation of the plan they had the year before, sometimes over many years the same or similar plan.

In Kansas, citizens with disabilities, including citizens with developmental disabilities, are currently being assessed with the interRAI, an instrument built to adequately assess the medical and nursing related care needs, primarily for persons who are aging and who live in nursing homes. Persons with developmental disabilities live in the community, are young, and are *increasing* their abilities, while citizens who are aging are trying to *maintain* their health and physical integrity as these decline, usually through home health care, assisted living, or nursing home care. People who are aging and persons with developmental disabilities require very different supports and services, very different personnel with very different skills, based on a very different assessment of need.

Kansas should consider whether too much of the resources spent on behalf of persons with developmental disabilities are being spent on and driven by the InterRAI assessment of medical, health, personal or caregiving supports typical for persons who are aging rather than employment, typical of persons of working age. The InterRAI corporation has a creatively worded way to say whether it is adequate to analyze the characteristics of person with intellectual or developmental disabilities or whether it should ever be used to create individual support plans of services for persons with intellectual and developmental disabilities:

"The interRAI ID is a minimum assessment for use by professionals supporting persons with ID. It is not simply a questionnaire for analyzing the characteristics of the population, nor does it necessarily include all of the information required to construct a support plan." –interRAI online brochure.

The ongoing fiscal danger to Kansas of applying an assessment such as the interRAI to persons that have a disability, not a disease, not a medical condition as would be the case of someone who meets PASSR criteria to be admitted to a nursing care facility, is the catalyst it may be to "medicalize" service and support needs, to significantly drive up costs of services that could be accomplished far less expensively with far better results using developmental, rehabilitative, habilitative, and psychosocial methodologies such as supported and customized employment.

The SIS, a reliable and valid comprehensive functional assessment of support needs, was built to assess the amount of support the person needs in frequency, time, and duration—intensity—allowing the annual assessment of the effectiveness of the previous year's plan of services. Not surprisingly, the SIS includes an entire section on the assessment of Employment needs.

In addition to ensuring an individual plan of effective services based on each person's exact needs, the Supports Intensity Scale has been successfully used by States for the equitable allocation of taxpayer resources. It can be used in Kansas to

ensure each citizen is assigned the amount of resources necessary relative to other citizens who have similar need for resources. Too often citizens with disabilities are allocated resources based on when they entered services, how much money was available at the time, what the amount of payment to a particular provider has historically been, what the slot or opening in a particular program has historically been paid, where they fit into one of five funding tiers, what his her disability label is, or what the evaluation used to determine eligibility (not actual needs) found. This current system in Kansas means that persons with the exact same needs may be allocated taxpayer resources that are far greater or far less than similar citizens with the exact same needs.

The SIS remedies this inequitable distribution of state and federal funds problem and may be confidently and effectively used to determine individual support needs, to write an excellent plan of services, and to allocate a fair amount of resources to persons with developmental disabilities based on each person's exact needs. About 7% of persons with very significant behavioral health and or medical needs may not have his or her needs for services and the fair allocation of services effectively assessed by the SIS. This is due to limitations of the SIS in determining extensive behavioral health and or medical support needs. For this reason the SIS is often supplemented by an additional Health Risk Screening Tool (HRST). For these persons, about 7%, the Exceptional Allocation and Exceptional Rate protocol is used to annually assign the exact amount of services and supports at the provider's individually determined and authorized costs. It is expected that about 7% of persons with the most significant disabilities, while small in number, will need about 15% of the entire amount allocated for services in the state, with 93% of persons utilizing the remaining 85% of available resources.

Missing Tool # 3: Separation of the Individual allocation of taxpayer resources based on individual assessed need from the rates paid to providers based on the actual cost of the service the provider is delivering.

In combination with an Individual comprehensive assessment of supports need, Self-Directing services, including all employment related services and supports would bring accountability and more efficiency. A key to effective self-direction is having each person's individual allocation based on his or her needs relative to others. This individual allocation of funding for services based on relative need *before assigning services* acts as an individual budget cap, thereby insuring a fair distribution of resources base on individual need and protection for State Medicaid and the managed care corporations against budget hemorrhages. Individual capped allocations, based on need, fairly distributes state and federal funding for services in a reasonable and actuarially sound manner, preventing unanticipated cost overruns by the state and state Medicaid budgets.

Within the total amount made available by the government for these purposes, persons with greater assessed needs relative to others are allocated more funding to purchase services; persons with lesser needs are allocated fewer funds. It ensures that states efficiently and economically use federal funds, a Medicaid requirement. It lessens the complexity of managed care oversight, translates easily to monthly utilization management reporting, and insures against the loss of real direct services revenue.

Kansas, like many states, currently combine the person's allocation of services with the rates paid. This means that the taxpayer's cost for services is contingent upon which service category or tier the person is placed in. The taxpayer payment for services is not based on the provider's exact cost of services. This method of payment incentivizes placing persons in the tier of services that a. Pays the most; b. meets most the person's needs but not all, leaving some needs unmet; c. Puts the person in a tier of services that contains the cost and expenses for services and

supports the person doesn't need in order to get the services the person does need; d. In practice, locks the person into a particular tier or service category, e. promotes overpayment of taxpayer Medicaid funds for services by incenting providers to fill positions at the lowest costs possible to widen the gap between the rate of payment and the actual cost of the service, f. Encourages payment of Medicaid funds for services not rendered, as in ongoing follow along support in supported employment that pays for hours worked, even if the provider gives few or little support.

The 3rd, 8th, and 9th Federal Circuit Courts have weighed in and ruled that payment *rates* [emphasis added] must be based on costs (not assessed need), while the individual allocation of resources is based on each individual's assessed need (Perkins, Jane (2000) Assuring High Quality Home and Community-Based Care Through Medicaid Reimbursement Provisions, National Health Law Program.) This individual allocation of funding based on assessed need is the total amount of funding reasonably expected to be needed for the year. This individual allocation is the amount that makes up the bottom line of the person's individual budget, apriori, before services and supports are chosen.

One of the best, most taxpayer economical and simple to understand methods to fund services and supports for person's with disabilities is to <u>first allocate funding</u> for services based on individual assessed need, with persons who have greater needs receiving a larger allocation and persons with less assessed needs receiving a smaller allocation and <u>separately set rates</u> based on allowable provider costs. Providers who pay more for direct personnel that deliver results and have low staff turnover experienced staff, have good benefits, receive higher rates for the same service, while other provider's who pay poorly or have extraordinarily high administrative overhead get paid less per hour.

For all services and particularly employment services, for Kansas, it is best to replace the tiered Medicaid rate system and the Vocational Rehabilitation milestone payment system. Providers should be paid an hourly rate for individual person-

specific services (not always face-to-face). The extensive background and logic details of how to construct a individual allocations based on needs and fair and equitable individual provider hourly rate based on costs is beyond the scope of this Deliverable Two and will be shown thoroughly in the Deliverable that follows as a part of this project. Suffice to say at this juncture, an average hourly investment (provider payment) for the billable work of an Employment Specialist/Job Coach would be between $42 and $52 per hour in Kansas, with the assurance that greater than two-thirds will be used for that person's salary.

The conundrum that remains, to be discussed and resolved in a future deliverable for this project, is the problem that States including Kansas have, and those that help states, in setting reliable and valid rates or payments. Most are typically unable to answer very simple questions: How was the rate calculated? What is the rational mathematical justifiable reason for paying $44 per hour rather than $28 per hour, or of paying a $1000, $1500, or $2500 for a particular milestone or performance payment through Vocational Rehabilitation, instead of $1250, $625, and $3000? How do you set reliable and analytically defensible rates for new services, services that have never been delivered in Kansas before? Does the amount you (the state) are paying getting you (the state) the results you want with the taxpayer's money? What is the amount providers should be paid to ensure they deliver a cost-effective outcome with the investment of taxpayer dollars? It is understood that one group of persons may have less or more disabilities than another group of persons, and so they are currently grouped in different funding tiers, but why $9000 instead of $7000 or $14,000 instead of $22,000? What is the cost justification for paying $9000 for persons in one tier and $14,000 for persons in another tier? What are the logical and rational cost and defensible mathematical calculations that came up with these amounts?

The new and simple hourly rate methodology coming in a subsequent Deliverable for this project would mean the rehabilitation costs to Vocational Rehabilitation would be approximately $8400 to $10,200 for Supported and Customized

Employment, more than the sum of all current milestone payments. The average and annual support and follow along costs to Developmental Disabilities, Behavioral Health, or other State agency would be approximately $4000-$5000, a substantial, more than 50% per year taxpayer savings compared with current annual costs.

One way of promoting spending resources on Supported and Customized Employment is ensured through good and usually higher rates, rates that pay providers for the actual costs of these more expensive services that ultimately and quite dramatically lower future ongoing support costs permanently (Cimera, R.E. (2012) The Economics of Supported Employment: What New Data Tells Us. *Journal of Vocational Rehabilitation*). Simply put, the rates of payment for supported and customized employment are too low in Kansas to produce the intended results.

Some provider costs in Kansas may be different from other provider costs, so their payment rates would be different. In addition to wage differences, some employers of Employment Specialists/Job Coaches provide health insurance, paid vacation, illness pay, retirement investments, tuition reimbursement, communication and office equipment, mileage reimbursement and ongoing training and support. These benefits help to retain a qualified and capable workforce. Other providers of services give none of the above benefits to Employment Specialists they hire.

Some States, including Kansas pay statewide provider milestone payment rates for Vocational Rehabilitation payments, individual job coaching hours usually authorizing 30-35 hours (at a cost of about $1000 in Kansas), followed by tiered payments on the Developmental Disabilities support and follow-along side, some based on pre-determined levels of disability and the hours the person is working. In Kansas providers are offered $12 per hour for support and follow-along services. Some providers choose to bill the pre-set day habilitation rate. The actual provider costs of a particular service or the amount of service and support given is not considered, is not the basis for payments, and can vary widely depending on what

the provider pays the direct service employees, including benefits, and how many hours of services are provided.

When a state sets statewide payment rates in the manner Kansas does, providers of services may be encouraged to pay very different wages and benefits to their employees, like Employment Specialists, who all perform the exact same work. If Kansas began determining individual provider rates based on what the state determines as reasonable individual provider's costs, then more of the funding can go, by design, to the salaries and benefits of the person doing the direct support and importantly, providers will always be paid enough to meet their costs based on what the state determines as reasonable.

Missing Tool #4: Universal Self-Directed Participant Services

Self-Directed services are a way for Kansas citizens with disabilities to control their own resources. It allows persons with disabilities and their family or guardian to control the money budgeted for services, hire providers to deliver services according to his or her individual plan, and change providers as needed. The individual may choose to self-direct all, some, or none of his or her funding. He or she must have access to traditional facility providers, traditional community employment only providers, non-traditional small providers who serve one, two, or three people, and discrete skills service providers, usually considered simply as employers, found in the person's community.

Three keys to successful Self-Directed services of any kind, including employment, are: 1) Hiring a Community Guide or Support Broker, which is optional and recommended; 2) A Conflict Free Case Manager; and 3) A Medicaid authorized Financial Management Service to pay the bills, collect FICA, and issue tax statements.

Typically resources are given from the state to the provider, almost always through government authorized Medicaid or Vocational Rehabilitation via regional authorities. In contrast, Self-Directed Services providers receive funding with approval from individual persons with disabilities and their families.

Everyday most Kansans pay for or directly authorize (self-direct) the purchase of services, supports, products, food, or goods, on his or her own behalf. Unlike this common American society practice, persons with disabilities in Kansas have rarely paid for or directly authorized any service, support, or activity on his or her own behalf as is common in many states. The funding and decision on who is paid to provide a Medicaid service in Kansas in most circumstances has been chosen and authorized by the State, leaving the person with disabilities the choice to accept the state authorized providers or go without services. This is the situation; despite legal federal safeguards that encourage States to expand providers as the population grows in section 1902(a) of the Medicaid Act.

> These include safeguards against unnecessary utilization of services, assurance that payments are consistent with efficiency, economy, and quality of care, and that payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such services are available to the general population in the geographic area (42 U.S.C 1396a(a)(23); 42 C.F.R. 431.51).

Kansans would consider Self-Directed employment services as a mainstream American way to fund services. They'd see nothing radical about citizens with disabilities having "the power of the purse," the same as all Americans, to purchase needed employment services and supports, from the same persons that others, persons without disabilities, would seek and purchase their employment services and supports. With Self-Directed employment services, citizens in Kansas would receive services, supports, and products from persons and providers they choose, in exchange for money. This choice is coupled with the ability to take their business

elsewhere, like all Kansans. The widespread us of Self-Directed employment services would bring new accountability and respect for the wishes of citizens with disabilities in Kansas who want to work in the community.

Self-Directed Services may be difficult to understand for persons familiar with the State setting single statewide rates for services and authorizing payment to providers. But it is easily understood by Kansans who have never worked in human services because it is exactly how the rest of society works, people authorize payment for services rendered within the limits of their budget. In Kansas as everywhere, you get paid if you do what you promised you would do. In the traditional and current human services system the authorized provider agencies are funded by the state, authorized to deliver services by the state, not the customer. With Self-Directed Services, Kansas providers would be authorized to deliver services and increase business by getting paid to deliver what the customer expected.

In the current system providers of services only go out of business when the state says they have done something wrong, if they harm several people with disabilities or use taxpayer money illegally. In a Self-Directed System a provider goes out of business when customers decide they don't want to buy those services or products anymore.

For Kansas citizens with disabilities to have a desirable job, one that others wish they had, we should consider using paid support from people who know those good jobs, the employers as discrete skills service providers. This means paying employers as discrete skills service providers and paying the Employment Specialist/Job Coach when they need to work alongside the employer *concurrently.* The Employment Specialist can break large tasks into smaller learnable tasks using systematic instruction and has experience and knowledge about disability specific issues related to that person. The Employer has unique and discrete skills to teach the person the job the person is learning how to do. But this teamwork is just not

possible unless persons with disabilities and their families can Self-direct their own resources and have the option of choosing uncustomary Medicaid providers, people to work with their son or daughter who already work, who are employers, with the know how to teach their son or daughter the actual work he or she wants to do.

What is needed is a fiscal intermediary contracted by the Kansas State Medicaid office. Self-Directed services require the state Medicaid agency to contract with one or more (usually one) fiscal intermediary, called a Financial Management Service. The Financial Management Service can pay authorized payment requests that are in the person's individual budget based on the person's individual plan of service. With an independent Financial Management Service, it isn't necessary for the individual direct service provider to have a Medicaid number, just as it isn't necessary for individual direct service personnel working at a facility to have their own personal Medicaid number. All that is necessary is for the direct service provider to have the required skills to deliver the needed service, and the service be specifically included in the person's individual service plan and individual budget. Federal Medicaid, The Centers for Medicare and Medicaid Services, CMS, requires people to have proven skills and experience to deliver a needed Medicaid service in order for states to pay for the Medicaid service, using federal matching funds.

Kansas Medicaid is encouraged to consider Self-Direction of almost all waiver and Medicaid state plan services by supplying a Self-Directed identifier to most Medicaid codes, certainly Customized and Supported Employment Services, Transportation [critical for employment success], Community Access Services, and potentially every wraparound support service included in the previous list of twelve (above), that ensures continued employment success. Ensuring specific Self-Directed Medicaid codes are available for use by persons who have the needed specific skills (technically the Financial Management Agency as the fiscal intermediary) could increase providers, especially in rural area, and significantly increase choices at no additional Medicaid or taxpayer costs.

People with disabilities in Kansas may be prevented from reaching his or her employment potential, when well-intentioned policies around health and safety mandate services only be delivered by pre-qualified, accredited, and state approved providers and their employees. The very persons who have the needed skills and abilities, employers with talents to help any other citizen, including citizens who do not have significant disabilities, should not be precluded, seen as dangerous or made to submit to background checks in order to help citizens with disabilities, as they would help any citizen if asked.

Kansas, like many states, has protected citizens, possibly themselves, and possibly a long-standing disability services provider network through: licensing, certification, qualification, accreditation, authorization, formal approvals, and coding requirements that limit who can provide a needed service. This although persons working in human service agencies rarely have the knowledge needed to teach the more complex tasks of very specific very good jobs, other than food service, waste disposal, cleaning, etc. To protect persons who are vulnerable, Kansas may have gone too far and excluded opportunities, denied access as required by the Medicaid Act, for citizens with significant disabilities to receive Medicaid paid training and support from persons such as his or her employer, with reasonable accommodations, as it is afforded to other citizens.

In the United States, people are able to choose from among both private and public entities for services. This may not really be the case in practice in Kansas for services and supports for persons with significant disabilities. States are required to ensure persons eligible for Medicaid services have free choice of qualified providers of Medicaid services (42 U.S.C 1396a(a)(23); 42 C.F.R. 431.51). Kansas may have unknowingly diminished the free choice of qualified providers through state-authorization, certification, approval, and other qualification processes. These well-intended safeguards are currently excluding community employers from Medicaid payment for services rendered, even though they are best qualified to teach and train someone with a significant disability how to do a particular job. And, Kansas,

like all States, is prevented from improperly limiting provider fees (who receives payment if qualified or the amount of the payment) Medicare and Medicaid Guide, Extra Edition No. 596 (Oct. 5, 1990) at 390.

Self-Directing Employment Services is a recommended shift from a Provider-Centered system, where the state of Kansas or its authorized emissaries contract with and pay pre-qualified providers pre-determined statewide rates of service, to a Self-Directed Person-Centered system where people with disabilities themselves use a Discovery process to find, contract with, and pay the exact providers they need, paying a fair payment based on what the state determines are allowable provider costs. This includes discrete skills providers (employers) who are qualified as they deliver similar needed services to other individuals in the area, including persons who do not have significant disabilities, at community established and sometimes negotiated rates for a service.

Self-Directed Employment Services can help control Medicaid costs in Kansas. Self-Directed Services are the financial foundation of a Person-Centered System where the person and the person's loved ones decides who is going to get paid to help them. Kansas Medicaid should consider, as good as stewards of the taxpayer funds, setting variable rates for the same or similar services for persons with disabilities depending on provider actual costs to deliver that service. This is something all State Medicaid Agencies understand well in setting different rates for nursing homes based on costs.

Missing Tool # 5: Consistent Well-Qualified Personnel

Self-Directed Employment Services begs for the Kansas State Medicaid agency to set a uniform formula of reasonable allowable costs (salary, benefits, overhead, administrative, etc.) for providers to justify rate of payment. It is not against the law for Kansas to set a statewide rate, as Vocational Rehabilitation does currently at $34 per hour, with milestone payments for employment services that total $4500,

followed by a $12 per hour support and follow along services fee through Developmental Disabilities Services. But it is potentially a violation of the economy, efficiency, and access pillars of Medicaid if such rates do not have documentable individual provider costs, and aren't reasonable enough to create adequate access to providers.

Adequate Employment Services rates will result in less staff turnover because it is critical to have payment rates to meet the Medicaid expectation of access to providers of the service. In fact it is the law. High staff turnover that may result in missing, limited, inexperienced, or relatively unskilled staff providing services may be considered a violation of the Medicaid expectation of access to providers of the service (Arkansas Medical Society v. Reynolds, 6F .3d 519,530 (8th Cir. 1993).

Having a Medicaid number or being an authorized Vocational Rehabilitation vendor means the provider is authorized to bill for a Medicaid service. Merely having an available employment service provider in the area where a person with disabilities lives, with the provider having billing capability, does not automatically mean the State has provided the person with a disability or their guardians with access to employment services.

Kansas has organizations with Medicaid numbers and a billing system with employment codes. But that is different from actually providing access to a needed employment service as evidenced through substantial State Medicaid and Vocational Rehabilitation billing and payment data that would show (it does not) that Kansas' relative investment in Supported and Customized Employment for persons with disabilities, compared to other government authorized purchases with the taxpayer's resources is adequate.

Access to employment services means a qualified person is available to deliver a needed employment service with acceptable quality, resulting in acceptable beneficial outcomes, and a good return on the taxpayer's investment. Paying direct

services personnel adequately to avoid high staff turnover is critical to achieve these beneficial employment outcomes.

All Medicaid payments to any provider must be in accordance with Section 1902(a)(30)(A) of the Medicaid Act "that payments to providers are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers." For example, the Vocational Rehabilitation payment rate of $34 per hour for Supported or Customized Employment will allow providers to hire an employment specialist at wage of approximately $12.26 per hour for full time employment with reasonable benefits. But this amount equates to a full time salary of $25,509 per year and is likely an inadequate amount to pay for hiring and retaining qualified employment specialists and job coaches in Kansas.

Quality Employment Specialists or job coaches are almost exclusively the sole representative of a provider organization, must have extraordinary ability and experience to teach someone with a significant disability using systematic instruction how to perform at the same standard as someone without a disability, arrange employment supports, and be able to communicate effectively in places of businesses in order to ensure long-lasting employment. Most successful Employment Specialists in the United States have at least a bachelor's degree, more than two years of experience as an Employment Specialist, and have continuing education and training to improve their skills. For all intents and purposes, their professional requirements are equivalent to a schoolteacher, but their pay is not equivalent. Less successful Employment Specialists or Job Coaches are paid between $9-12 per hour, equivalent or even less than a teacher's aide, may have other job duties, have a high school education, are kind, are often recognized at annual meetings or dinners, and do the best job they know how.

Missing Tool # 6: Four different types of Traditional and Non-Traditional Providers

Providers of Self-Directed services are customarily classified into two groups: traditional providers and non-traditional individual providers. Traditional providers are usually: 1) larger providers of services where most citizens with disabilities go to a facility to receive their supports, but not always. Some traditional provider offer Supported Employment services but usually on a much smaller scale and serve fewer persons than they serve in their facility-based programs. Another type of traditional provider that many consider exemplary; 2) provides all services in natural community settings, usually through Supported Employment or Community Participation or Community Access services that build the person's access to community life.

Non-traditional providers are of two kinds: 1) those that deliver services, like Customized and Supported employment only to 1-3 people annually; and 2) those that deliver discrete specialty services, which provide a very specific skill, like the employer. Both of these non-traditional providers do not have a Medicaid number. They use a fiscal intermediary; the Financial Management Services agency State Medicaid has a contract with to provide this financial service that allows them to be paid.

It is important to know that All Providers in Kansas whether traditional or non-traditional, must meet the same requirements. Traditional providers routinely apply different requirements of persons who work on behalf of persons with disabilities: a nurse, an Employment Specialist, someone contracted to build a support or accommodation, etc. all have different requirements. These requirement differences are not in conflict with the Medicaid Act that requires states to define minimum service provider qualifications that apply across the service delivery models and those individuals who self-direct are subject to the same requirements as other Medicaid enrollees (Federal Register Volume 79 Number 11 (2014, January

16) Part II Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Part 430, 431 etal. Final Rule, 2992.

The Act is not saying everyone in Kansas needs to be licensed or certified, or an employee of an accredited agency, no matter his or her role or purpose, whether they are Self-directing services or not. Nurses should be licensed, but not everybody is a nurse. Employment Specialist should be certified, but not everybody is an Employment Specialist. Discrete skills providers, employers, should be able to prove their competency to deliver the needed skill, but not everybody is a Discrete Skills Provider.

Non-traditional providers in Kansas who are individual persons who work with 1-3 people should meet reasonable health, safety, and accountability standards, like background checks, basic first aid, emergency protocols, and other state requirements, but not extensive or to the extent necessary that a state requires of persons employed by traditional providers of services who serve large numbers of persons with disabilities in a facility or state Institution. Persons providing discrete skills to persons with disabilities, usually a co-worker also employed by the employer, should not have to meet the exact same requirements as a Rehabilitation agency provider, but must meet appropriate requirements as determined by the state, usually proof of competency and good standing in the community.

The Act is explaining that requirements, even reasonable and different requirements depending on the direct service provider and location, must be applied uniformly whether Self-Directing or not. It is not saying that every person who provides a service on behalf of someone with a disability must meet the exact same requirements no matter the service. Again, not everybody is a nurse. Not everybody needs a license. Not everybody is a Rehabilitation Agency. Not everybody needs to be CARF, The Council, or JACHO accredited, because not everybody is a hospital. The Act is saying that reasonable and different requirements depending on the work, location of the direct service provider, and

the service, must be uniformly applied whether Self-Directing services or not. If someone Self-Directs nursing services, then it must be from a nurse that is licensed.

Missing Tool # 7: Clear Guidance When Families Can and Cannot be paid to provide Services via Self-Direction

Self-Directed Services do allow families to become paid providers of services in certain yet limited circumstances. A provider of a Medicaid services must have the skills necessary to provide the service. Some families in some states have seen Self-Direction of their son or daughter's services as an opportunity to be paid something for the countless hours of extraordinary support and care they provide to their own son or daughter with a disability. It is not. Although, it is well documented that both parents have a loss of income when they have children with a disability and that mothers of children with disabilities often must abandon their planned career (Stancliff, R. and Lakin, C. (2005) *Costs and Outcomes of Community Services for People with Intellectual Disabilities.* Paul H. Brookes, Baltimore, MD). While further discussion and significant changes to social and financial policies around how to best support families with a child with disabilities in Kansas and other states are past due, Self-Directed Services is not an opportunity for families to recover very real extraordinary financial costs.

On the subject of families providing services, it is required that persons providing Medicaid Services be certified, qualified, and/or have the skills necessary to provide beneficial services. Such skills may become evident through education, experience, or meeting agreed upon standards in regulation, certification, and or other qualifications. Such skills may become evident with the person's functional improvement and lessening need for services or supports. Again, it is not necessary for family members to be accredited like a rehabilitation provider agency.

While the new Medicaid Rule published January 16, 2014 seemed to discourage payments to parents; it actually does not discourage relatives from being providers

if warranted. The new Rule only prohibits relatives from providing the evaluation of eligibility and determining access to care. Payments to family members make sense and Kansas should consider approval in some circumstances, such as: remote rural areas where there are no qualified providers available to provide the needed service, and other limited circumstances and situations, considering participant and family trauma history, extensive disease or medical circumstances, life threatening circumstances, and situations where significant financial savings to Medicaid may be realized while providing superior outcomes. In every instance Kansas should consider approving family members to be paid under Self-Directed Services only if the parent is qualified to provide the service.

Kansas should consider policies that encourage families to provide needed services when: 1) there is no access to otherwise skilled or qualified providers, and, 2) very real costs may be attributed to the parent's delivery of the service without financial benefit or gain, and 3) the service ameliorates or lessens current or future costs in an economical manner, and 4) the service is delivered by a qualified or skilled relative as evidenced by beneficial outcomes due to the quality of the service or care provided. What this guidance clearly says is that parents who Self-Direct services should not be authorized to pay themselves, relatives, friends, etc. because they want to or because it is their choice. All expenditures of Self-directed resources should be approved by the State-authorized Independent Conflict Free Case Manager in accordance with State guidelines that closely mirror federal Centers for Medicare and Medicaid (CMS) Technical Guidance.

Missing Tool #8: An (i) State Plan Amendment

An (i) State Plan Amendment has the ability to limit the State's and the managed care corporation's financial exposure. An (i) could specifically target persons with Behavioral Health needs in Kansas and only for Supported/Customized Employment using eight of the twelve necessary services as listed above: 1) Self-Directed Services; 2) Financial Management Services; 3) Community Guide or

Support Broker Services; 4) Supported Employment, including Customized Employment; 5) Community Access Services; 6) Goods and Services; 7) Education and Training Services; 8) Benefits Counseling Services; 9) Non-residential transportation services.

Unnoticed by some States, and potentially Kansas, was a provision in the Affordable Care Act of 2010 that had nothing to do with healthcare. It was this significant change to something called the (i) State Plan Amendment in Medicaid. Previously, the (i) provision allowed States to run pilots of a few hundred or fewer persons with disabilities, and they could be targeted to just one or a few areas of a state. The new (i) provision is substantively different. It requires state wideness, like all Medicaid State Plan Amendments and for this reason some State Medicaid Directors early on thought it was a budget buster; they in error thought it was just an add-on to existing Medicaid State Plans. It is not.

An (i) State Plan Amendment gives a state the ability to target a specific group and within that group use an assessment of need to further target a subgroup for (i) State Plan Amendment Services. And, the (i) State Plan Amendment allows States to target a particular service or group of services. Any service delivered under a state's 1915 (c) Medicaid waiver may become an (i) State Plan Service, but it's up to the State. So this means Kansas could target a limited number of citizens with mental health needs, not every person with mental health needs would be eligible, which significantly controls costs, and only offer a limited menu of services, like supported and customized employment and the other services mentioned above, which significantly controls costs, and be able to place caps on those services that are chosen (hopefully the list presented above), to significantly control costs.

Additionally, as a hypothetical, if a Kansas determines for example that instead of paying $17 million in pure state money for mental health services in the manner that it is today just as an example, it could increase services to $35 million without spending any more state taxpayer funds, it could target a specific group of persons

with mental health needs based on and assessment of needs, for example 3000 Kansans with co-occuring substance use and mental health needs. If it turns out that 3000 was a huge overestimate and only 300 people qualify and want services, then Kansas could, after HHS has approved the (i) plan amendment, ask in a letter after the fact for the Secretary to agree with expanding the criteria in order to make additional persons eligible. Conversely, it also allows State to quickly tighten or shrink the pool of potentially eligible persons if for example 4500 Kansans instead of 3000 become eligible. This does not mean the (i) gives a State the ability to remove beneficial services to people who have already been deemed eligible and are receiving services under previous less restrictive criteria, but it does mean going forward that the number of eligible persons can be more easily expanded or reduced.

Once states figured out the advantages of how the (i) allows both targeting of persons and services and limiting financial risk by States having the ability to tighten or expand eligibility based on an assessment, then many states are today hurrying to implement at least one and some several (i) State plan amendments to both control costs and serve person who were previously unserved due to a state's fear of cost overruns.

Considering the information available on employment services, currently funded by state only or SAMSHA grants for persons with behavioral health needs in Kansas, but 809 people and only 11 of 26 Community Mental Health Centers in Kansas are using the evidence-based Individual Placement Model (IPS) and among those that do, only 44% get jobs in competitive employment, only better than the 15% who try without the IPS model. This despite IPS being one of the most effective psychosocial interventions for persons with mental health needs and one of only six recommended evidenced based practices by SAMSHA.

The (i) State Plan Amendment for Kansas would allow Kansas to more than double the amount of resources available to serve citizens with significant mental health

needs, allow the introduction of the most effective and proven psychosocial intervention—the individual placement model (IPS) of Supported and Competitive employment, at no additional cost, while saving significant costs in the current treatment of these citizens using pharmacological and therapeutic approaches to services, largely without the most effective psychosocial approach known—Supported Employment.

Missing Tool #9: Changes to Kansas Vocational Rehabilitation

If the plan is to save the maximum amount of dollars possible, taxpayer dollars that are typically used to help persons who become injured or disabled, then the plan in Kansas is not working as well as it could. Taxpayer dollars could be saved by implementing Vocational Rehabilitation Services in a manner that gets far more persons employed, making a living wage, working and paying taxes in his or her Kansas community. For this reason, substantive changes to Kansas Vocational Rehabilitation are recommended:

1) Pay new Vocational Rehabilitation Counselors and any Counselors that have been employed for three years or less at least 75% more so that Kansas Rehabilitation Counselors are paid as well as Nebraska Rehabilitation Counselors, $53,000 per year.
2) Cut the Caseloads of Vocational Rehabilitation Counselors in half at minimum, so that no counselor will have more than 70 open cases at any point in time in Kansas.
3) Hire twice as many Vocational Rehabilitation Counselors, to ensure Counselors are available in every region of Kansas.
4) Increase the number of agencies authorized as Vocational Rehabilitation vendors, who deliver more than $150,000 worth of Vocational Rehabilitation Services annually, by ten-fold, while gradually eliminating vendors who do not have the capacity to deliver greater than $25,000 worth of services annually, currently two-thirds of all Vocational Rehabilitation vendors.

5) Eliminate all milestone/benchmark or performance payment systems as they discourage qualified providers of services by paying about half of the actual provider's costs to deliver quality Vocational Rehabilitation Services that deliver a lasting employment outcome.
6) Replace the milestone payment system with a simple to use hourly rate, beginning with an hourly rate of between $42 and $52 per hour for all vendors with the requirement that Employment Specialists and Job Coaches working for providers must be paid on average $21.00 per hour and be a full time Employment Specialist/Job Coach, resulting in at least a 50% increase in annual salaries. This statewide rate formula would be replaced with an individual provider rate based on actual Employment Specialist/Job Coach annual salaries.
7) Ensure that every Employment Specialist/Job Coach is credentialed or certified. This change would increase the number of credentialed or certified Employment Specialist/Job Coaches working in Kansas by three-fold.
8) Increase the Vocational Rehabilitation hourly rate from $34 per hour to between $42-52 per hour and anticipate and budget for average per person Vocational Rehabilitation expenditures of between $8400and $10,400 for approximately 200 billable hours of support services.
9) Do not allow 26 successful VR closure status for anyone who has not faded ongoing support to at least 20%, meaning that 80% of the persons employed hours are without paid support.
10) Only place persons in Supported or Customized Employment who have a matching ongoing follow-along and support rate of funding, $42-$52 per hour.
11) Make certain providers of services understand that Vocational Rehabilitation may not be billed for meetings, paperwork, round trip travel time, and generic job development, can only be billed for person specific time, face to face training and support, and non-face to face, advocacy and person specific meetings with family members, the employer, and phone calls that are person specific.

Summary

Two questions will be answered by two coming Deliverables, how are we going to finance and pay for all this? A new allocation, rate, and payment methodology. And, how are we going to get there? A roadmap. In 1994, when Kansas was at its pinnacle in the number of citizens per capita with disabilities employed, it is likely that the average employment specialist or job coach earned between $18,000 and $26,000 per year, between one-half and one-third of what the average teacher in the United States made then, about $35,000 per year. Only because of inflation, in 2015 those wages for Employment Specialists/Job Coaches should be between $28,980 and $41,600. They are not even close. Today the average teacher in the United States makes $56,383.

Conclusion

Persons with disabilities in Kansas and their families are as good as other persons with disabilities and their families living in other states. They deserve good employment supports and services that help them succeed as much as similar persons in other states. Changing waivers, the state plan, services, supports, funding allocations, and rates can ensure that federal tax dollars that have left Kansas, will be returned to benefit Kansans with disabilities, their families, their employers—the businesses of Kansas.