HCBS FMAP Portfolio Compendium

July 9, 2021

In order to determine how to use the funding, KDADS leveraged several guiding principles

Maximize benefit to Kansas citizens

Ensure equity. Support full spectrum of eligible HCBS populations. Target underserved & minority populations.

Balance direct and indirect investments. Mix member services support with foundational enablers.

Invest in lasting impact and change

Balance near- and long-term benefits. Mix one-time benefits with systemic changes.

Measure, track & report impact. Compare future metrics to baseline to prove impact and streamline future budget enhancements.

Prioritize sustainable initiatives. Invest in continuity after funding is exhausted (e.g., initiatives with cost savings).

Ensure flexibility to meet evolving needs

Incorporate ability to scale pilot programs up or down. Align on decision milestone & leverage impact metrics.

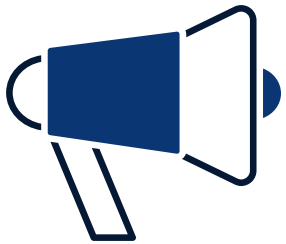
Leverage flexibility of initial spending plan to re-evaluate needs during implementation process.

Fully utilize *all* Federal funding

Use all one-time funding. Slightly frontload expenditures and ensure exhaust funding by 2024.

Comply with requirements. Ensure compliance with Federal requirements where they exist.

KDADS gathered ideas from several key stakeholders across Kansas



Advocacy groups

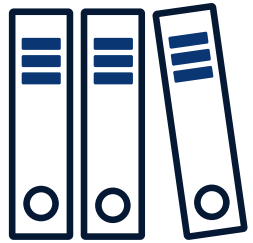
e.g., Interhab, Big Tent Coalition

Service providers

e.g., Aging and Disability Resource Centers, Managed Care Organizations

Government agencies

e.g., KDADS



Educational institutions

e.g., University of Kansas Lifespan Institute

The long list of ideas was narrowed down into three priority investment areas based on size of need and alignment to principles

Workforce

Improve DSW **retention and training** leading to enhanced capacity, quality of care, and career opportunities

Employment

Support disabled workers to **find integrated jobs** at employers who pay fair minimum wage

Access to care

Expand accessibility to HCBS through **transition management**, & increased **capacity**

The final investment portfolio has funding allocated across twelve initiatives

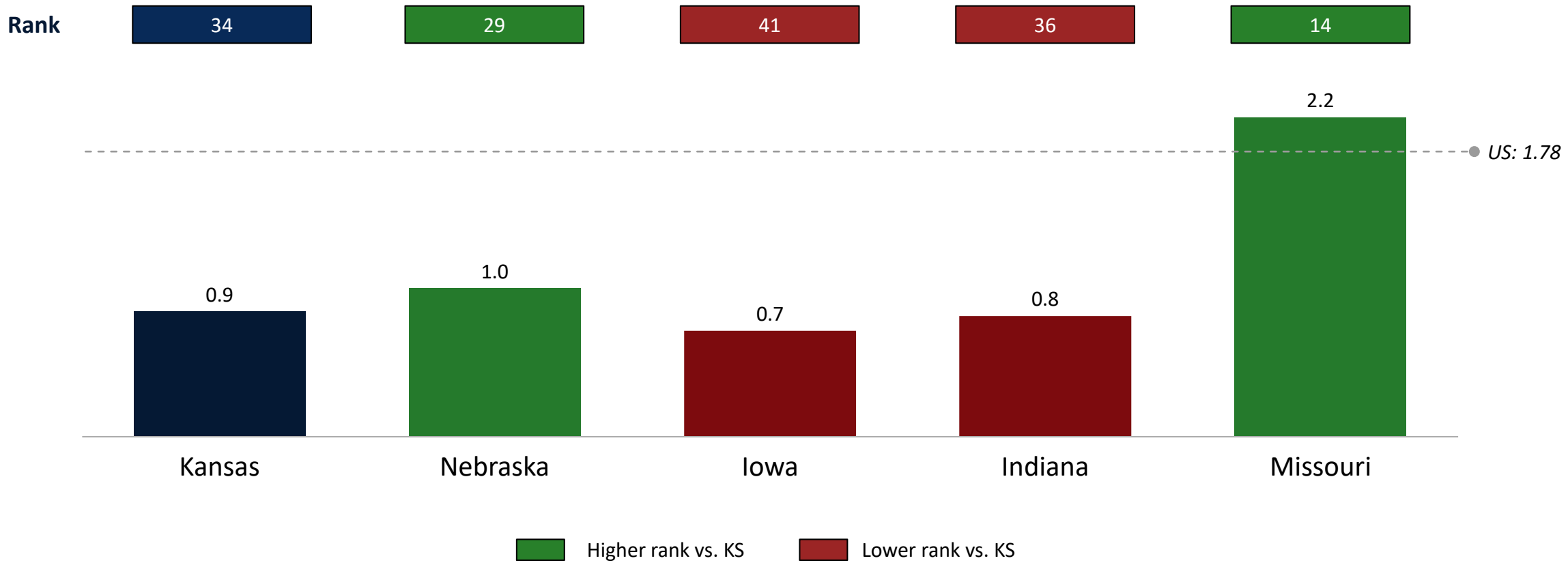
Investment area		Initiative	Investment
Workforce (~$57.1M)	1	One time retention bonus	**(~$51M)** Provides $2,000 bonus per worker
	2	Training grants	**(~5.1M)** Provides $200 training grant per worker
	3	Study and design career ladder	**(~$1M)** Investigates opportunity to create a career track
Employment (~$2.0M)	4	Study – Employment First	**(~$2M)** Lump sum contractor rate
Access to Care (~$20.7M)	5	Short term internal staff	**(~$6.8M)** 16 HCBS FTEs (Final Settings & Admin); 5 Financial FTEs; 1 FTE Agency Project Manager
	6	Study – Waiting List	**(~$1M)** Lump sum contractor rate
	7	Extend ACL Going Home Transition Services	**(~$1.5M)** Extend existing grant processes
	8	Study – TCM Models	**(~$1M)** Lump sum contractor rate
	9	Mobile Crisis for I/DD	**(~$3.5M)** Provide I/DD response training to ~400 respondents
	10	SIM Consultant	**(~$30k)** Lump sum contractor rate
	11	Behavioral management training pilot	**(~$2M)** Train 10% of I/DD families (~1k)
	12	Remodeling grants – HCBS providers	**(~$5.4M)** Provide $50k to $100k grants for 50 to 100 providers
	Total		**~$80.3M**

Workforce

Needs Assessment

Workforce| Kansas has half the US average of home health and personal care workers per HCBS participant compared to US average

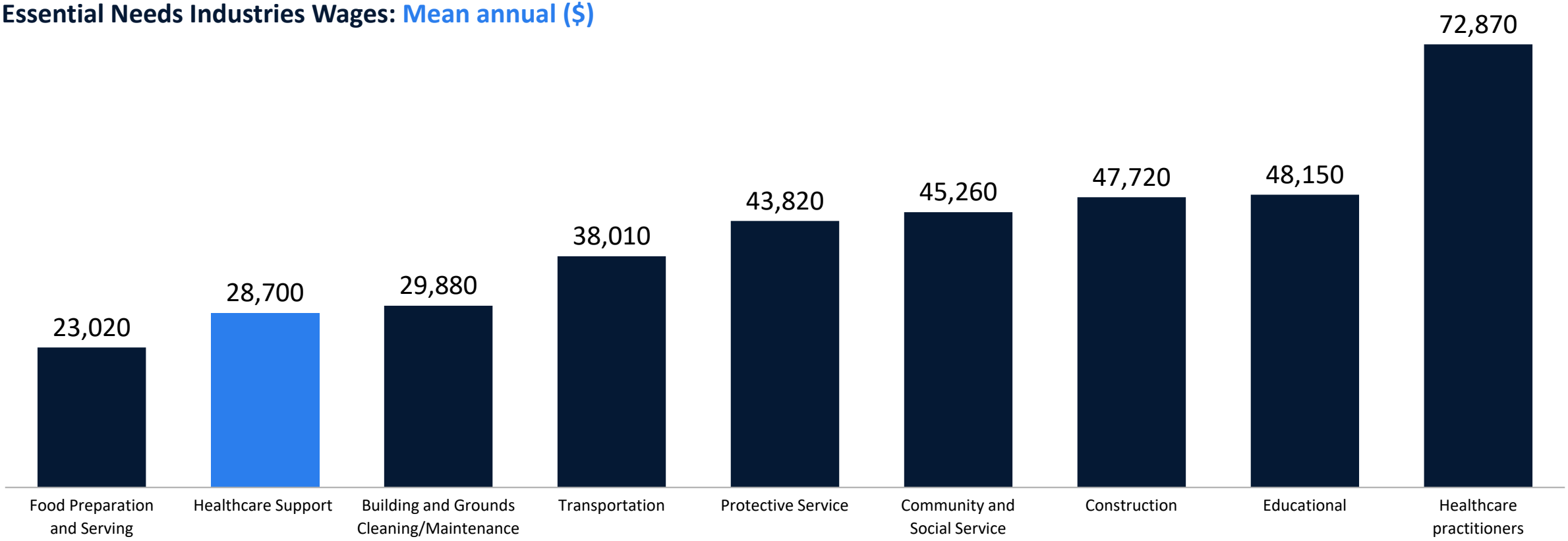
Home health and personal care workers per HCBS waiver participants: Workers per participant



Source: https://www.bls.gov/oes/current/oes311120.htm#(9); https://www.kff.org/medicaid/state-indicator/medicaid-section-1915c-home-and-community-based-services-waivers-participants/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Workforce| Kansas' wages for the healthcare support industry lower than other essential needs industries in Kansas

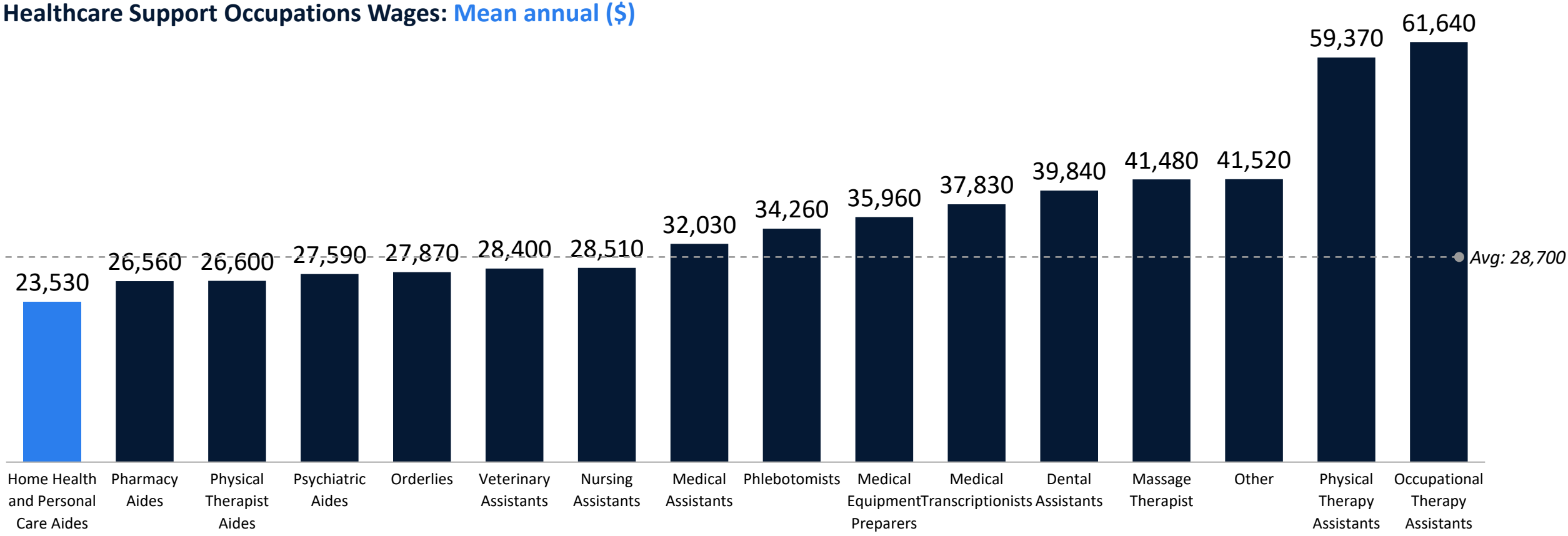
Essential Needs Industries Wages: Mean annual ($)



Source: https://www.bls.gov/oes/current/oes311120.htm#(9)

Workforce| Kansas' wages for direct service workers lower than other healthcare support occupations in Kansas

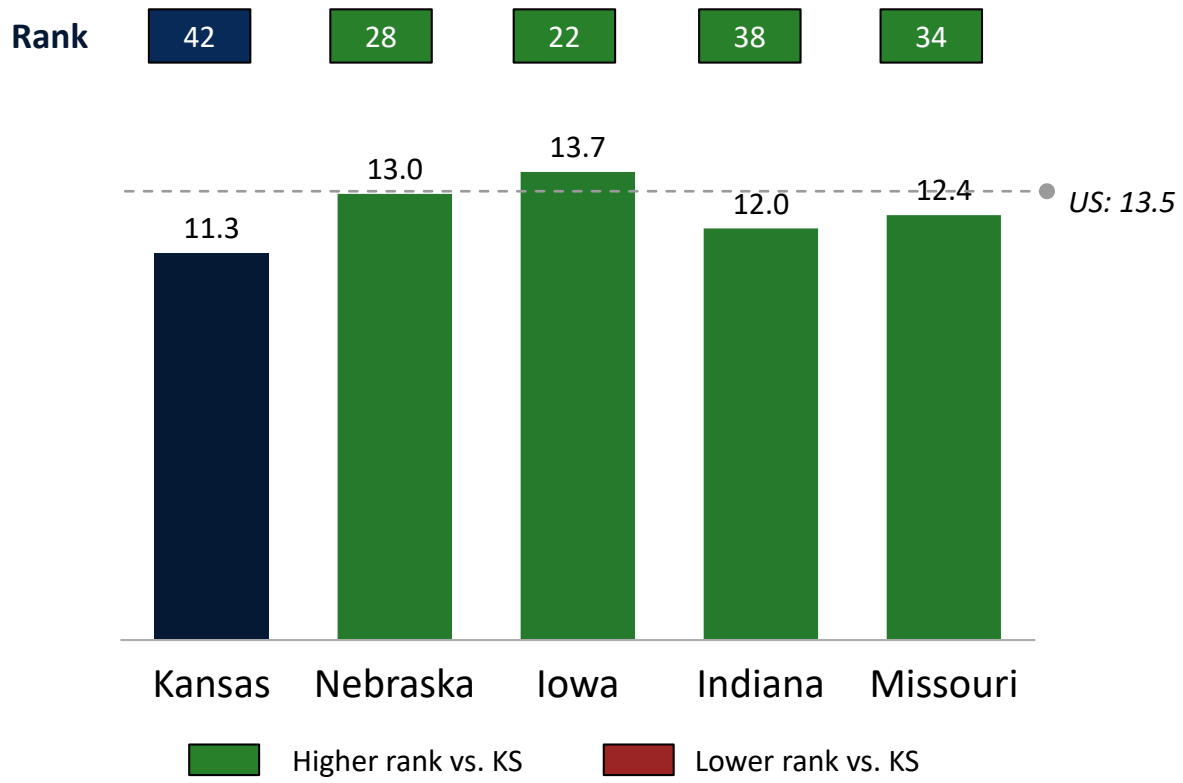
Healthcare Support Occupations Wages: Mean annual ($)



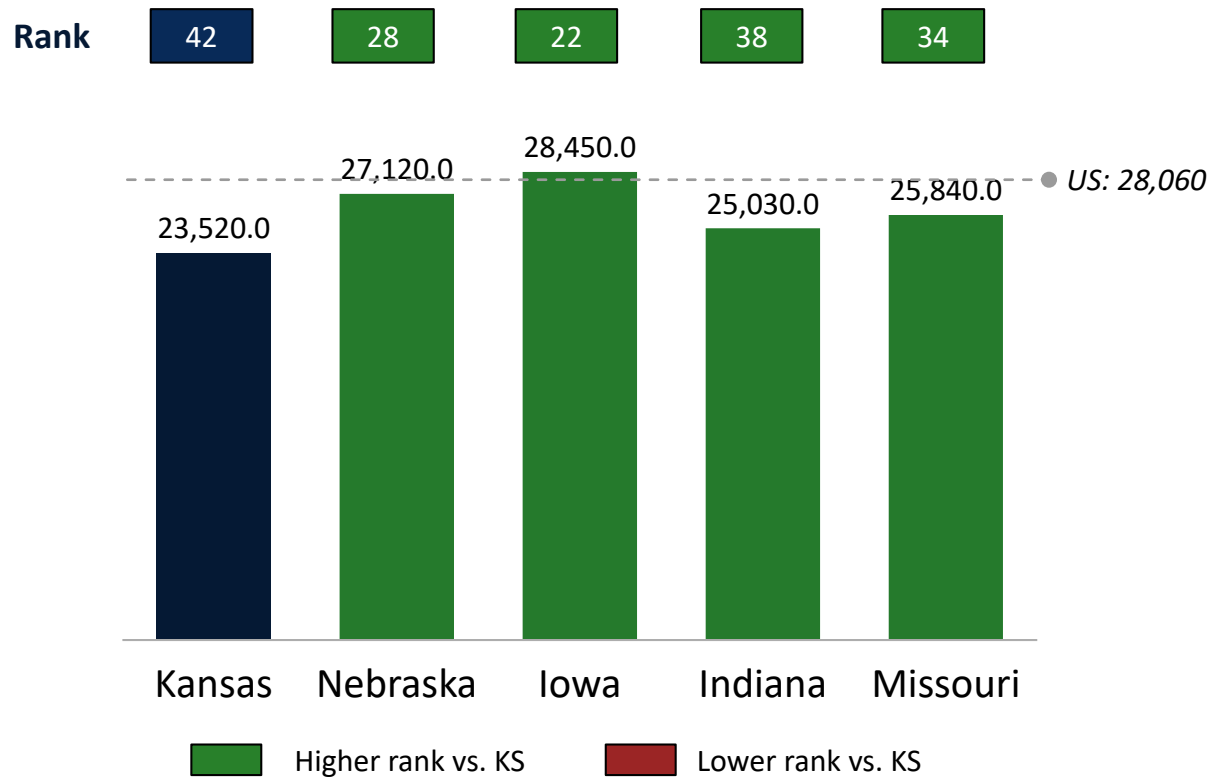
Source: https://www.bls.gov/oes/current/oes311120.htm#(9)

Workforce| Kansas' wages for direct service workers lower than US average and peers

Direct service workers' wages: Mean hourly ($)



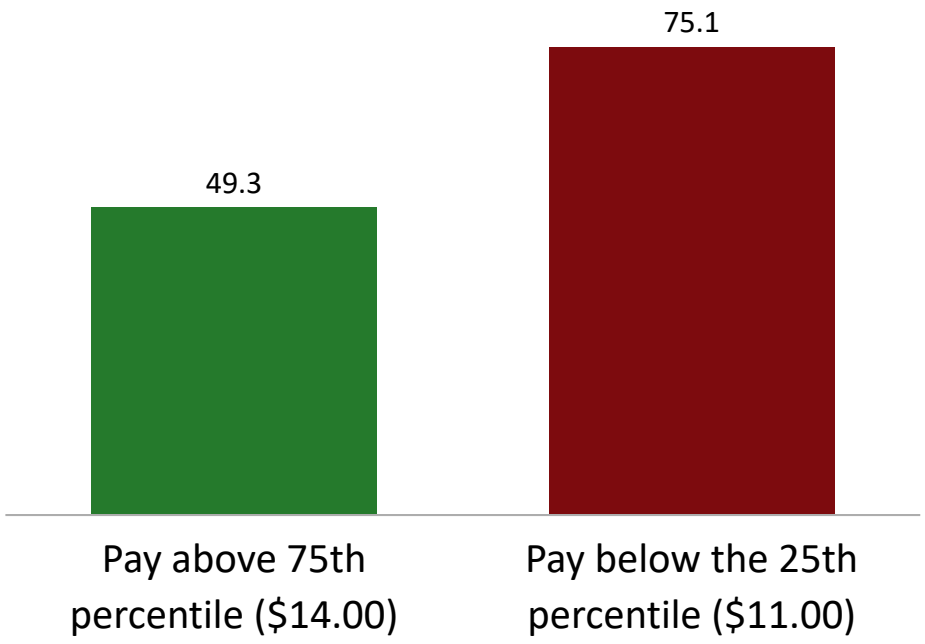
Direct service workers' wages: Mean annual ($)



Source: https://www.bls.gov/oes/current/oes311120.htm#(9)

Workforce| Wages not only impact the ability to attract caregivers, but also to retain caregivers

Home health and personal care workers' turnover: Turnover rate(%)



On average, for every $1 per hour more a caregiver is paid, annual caregiver turnover decreases by 3%

Source: Home Care Benchmarking Study 2021

Deep Dives

1 Workforce Retention Bonus Program

Workforce bonuses| Retention bonuses for Direct Service Workers improve retention rates leading to increased capacity for Kansans to receive care in their homes/community

Current state

- Kansas ranks 34th in Direct Service Workers (DSW) per HCBS waiver participant
- Kansas ranks 42nd in DSW wages
- DSW retention rate[1] is 15.8%
- On average, for every $1 per hour more a caregiver is paid, annual caregiver turnover decreases by 3%

Investment opportunity

- Provides bonuses to all DSW (~24k workers) to increase retention

Required financial investment

- Total initiative investment of $51M
  - $2,000 retention bonus per worker ($48.5M)
  - 5% administrative contractor fee ($2.5M)

Potential impact

- Increase DSW retention rates which…
  - Increases capacity for Kansans to receive care in their homes/communities
  - Reduces agency's recruiting and onboarding cost

- While this solves the short-term need, there is additional investment needed to create systematic change

Remaining gap

1. Number of caregivers who did not quit or get terminated in the year divided by the avg number of caregivers employed in the same period
Source: US Bureau of Labor Statistics; Kaiser Family Foundation

Workforce bonuses| Retention bonuses temporarily address direct service workers' low wages

Description
Agencies will provide all their direct service workers with bonuses totaling $2,000.

Objectives
Address high turnover amongst direct service workers

Increase capacity for Kansans to receive care in their homes/communities

Beneficiaries
Benefits 100% of Kansas DSW (~24k workers)

Needs
- Kansas ranks **34th in number of DSW per HCBS waiver participant**
  - Kansas has half the US average of DSW per HCBS waiver participant compared to US average
    - Kansas: 0.9 DSW/HCBS waiver participant
    - US avg: 1.8 DSW/HCBS waiver participant
- Kansas' DSW **wages of $23,530…**
  - **rank 42nd in the US** with the average US DSW wage being $28,060
  - **lower than wages for other healthcare support occupations in Kansas** ($28,700)

Portfolio fit
- Appendix C eligibility: Workforce recruitment
- Sustainability: Potential state investment based on ROI; Potential AJP funding to create systematic change
- Equity: A majority of DSW are women and ethnic minorities
- Impact tracking: Administrative contractor to track retention rates before and after bonuses

Source: US Bureau of Labor Statistics; Kaiser Family Foundation

Workforce bonuses| Each direct service worker could receive up to a $2,000 bonus, which is equivalent of $1 per hour wage increase for a year

$51M total investment with 95% going directly to DSW

Direct cost

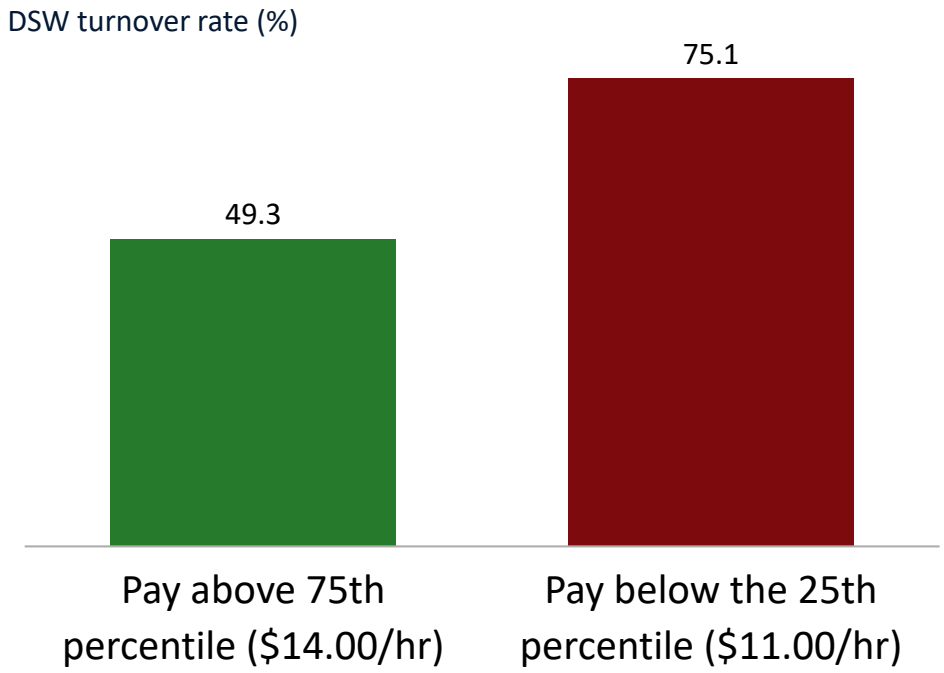
# of workers	~24,250
×	
Bonus/worker	$2,000[1]
=	
Direct bonus cost	$48.5M

Admin cost

Direct bonus cost	$48.5M
×	
Admin % of cost	5%
=	
+ Admin cost	$2.5

Total initiative cost **$51M**

On average, for every $1 per hour more a caregiver is paid, annual caregiver turnover decreases by 3%

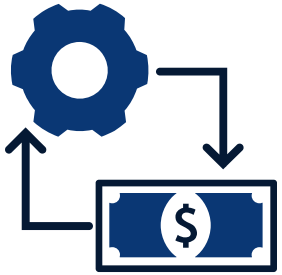


1. $2,000 bonus is equivalent of $1/hr increase in wages for a year assuming 40hours/week, 50weeks/year
Source: US Bureau of Labor Statistics

Workforce bonuses | KDADS working with provider groups to decide how to execute

Who delivers bonuses?

- Can the state deliver bonuses?[1]
- If agencies deliver bonuses…
  - How to determine which agency will deliver given workers working at multiple agencies?
  - Do agencies need to deliver bonuses in the same way? (e.g., All delivery quarterly)
  - What guidance, if any, do we want to give agencies on bonus structure? (e.g., restrictions)



How do they deliver bonuses?

- What is the total amount of money to provide to each person? (e.g., $1500)
- What frequency do we provide the funding? (e.g., annually for 3yrs, quarterly for 1yr)
- What restrictions do we want to allow? (e.g., remain at job for 3 months)

What defines success?

- What KPIs are we going to track to show impact? (e.g., health outcomes)
- How do we work with the agencies to get visibility into outcomes?
- How often will we measure KPIs?

1. KDADS will not execute, will leverage a contractor

2 Training grants

Workforce training grants| Workforce training ensures that direct service workers have the knowledge, skills, and abilities they need to provide quality support

Current state

- Minimum qualifications required to become a direct service worker
- Most DSW are trained through their provider/agency
  - 5 hours avg. onboarding training
  - 8 hours avg. ongoing training
- Large gaps in training available for specific needs (e.g., Autism)

Investment opportunity

- Training providers apply for funding to develop and train workers

Required financial investment

- Total initiative investment of $5.1M
  - $4.9M available for training
  - Grant amounts vary based on need; providers to apply for grants
  - 5% administrative contractor fee ($0.2M)

Potential impact

- Improves quality of care by ensuring DSWs have the knowledge, skills, and abilities to provide support
- Improves retention rate
- Provides DSW with skills needed to grow professionally and earn higher wages

- While this solves the short-term need, there is additional investment needed to fund on-going cost

Remaining gap

Source: Home Care Pulse

3 Study and design career ladder

Workforce career ladder study| Designing a career ladder improves DSW retention rate while reducing workforce shortages in other health care occupations

Current state

- No defined DSW career ladder
- DSW retention rate is 15.8%
- Kansas' DSW wages of $23,530 lower than wages for other healthcare support occupations in Kansas ($28,700)

Investment opportunity

- Study and design a career ladder which allows Direct Service Workers to get promoted to other healthcare occupations with higher wages and a workforce need

Required financial investment

- $1M in one-time funding to hire contractors to study and design DSW career ladder

Potential impact

- Reduces turnover rate by incentivizing DSW to stay in job longer and get promoted
- Reduces workforce shortage in other health care occupations
- Increases direct service workers' career earning potential

Source: US Bureau of Labor Statistics; Home Care Pulse

Workforce career ladder study | DSWs have no defined career ladder which is a key factor in increasing employee retention

Description

Study and design a career ladder which allows Direct Service Workers to get promoted to other healthcare occupations with higher wages and a workforce need

Objectives

Reduce turnover rates

Reduce workforce shortage in other health care occupations by establishing DSW as a stepping stone into other HC professions

Increase DSW's career earning potential

Beneficiaries

Benefits 100% of Kansas DSW (~24k workers)

Needs

- No defined career ladder
  - "One of the key factors in increasing employee retention is providing a viable career path"- Glassdoor chief economist, Andrew Chamberlain Ph.D.
- DSW **retention rate is 15.8%**
- Kansas' DSW **wages of $23,530 lower than wages for other healthcare support occupations in Kansas** ($28,700)
- Workforce shortages across other health care support occupations in Kansas (e.g., behavioral health)

Portfolio fit

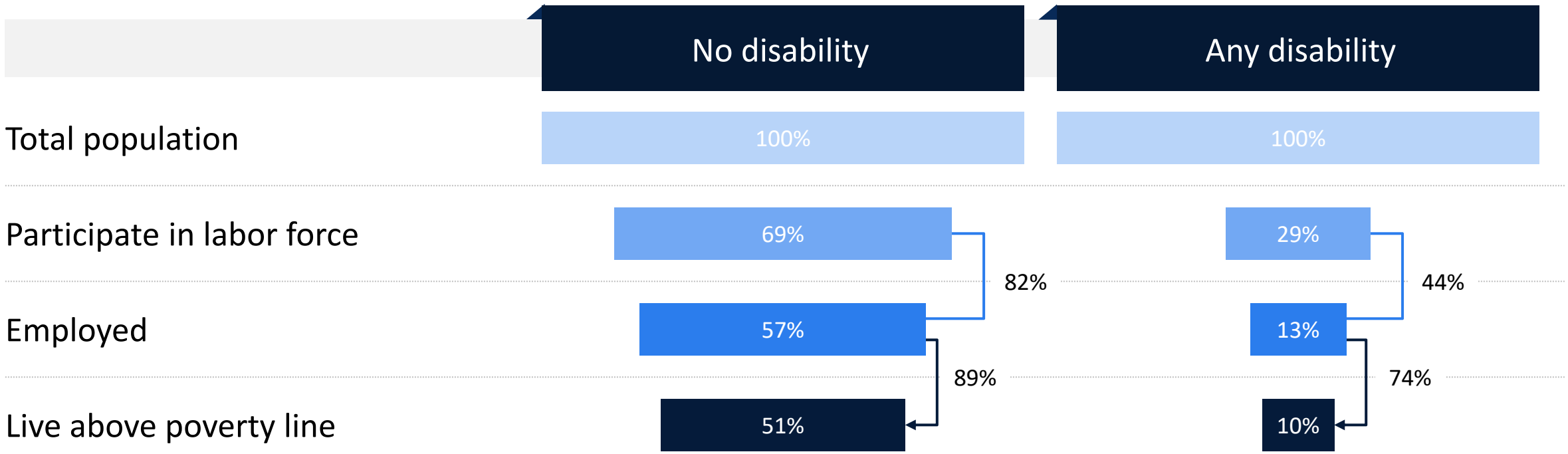
- Appendix C eligibility: Workforce recruitment
- Sustainability: Initiative only requires a one-time investment
- Equity: A majority of DSW are women and ethnic minorities
- Impact tracking: Administrative contractor to track metrics before and after bonuses

Source: US Bureau of Labor Statistics; Home Care Pulse

Employment

Needs Assessment

Employment | Disabled individuals in Kansas are less likely to look for work, get employed if they are, and make above the poverty line when employed



There is a need to understand how these needs are addressed by proposed initiatives

Employment | Employment First project addresses full spectrum of needs

			
Need	Participate in labor force	Employed if looking for work	Live above poverty line if employed
Initiative to address need	Increase Protected Income Level to 300% of SSI ***(Done)***	Employment First	Employment First
How does initiative address need	Increases the amount of monthly income protected from medical expenses and can be used for other needs	Helps those with disabilities find jobs along side those without	Ensures those with disabilities are paid at least federal minimum wage

Deep Dives

4 Employment First

Employment First | Studying how to make Employment First a reality enables Kansas to address employment gaps between those with and without disabilities

Current state

- Legally an Employment First state
- Employment disparity between those with and without disabilities
  - Labor force participation rate
    - Disability: 29%
    - No disability: 69%
  - Employment rate
    - Disability: 44%
    - No disability: 82%
  - Live above poverty line rate
    - Disability: 74%
    - No disability: 89%

Investment opportunity

- Hire a contractor to study how to make Employment First a reality (e.g., supported and integrated employment)

Required financial investment

- One-time investment of $2M

Potential impact

- Supports 9,100 individuals on the I/DD waiver find integrated and supported employment
- Long-term impact includes stimulating the economy, improving health and decreasing homelessness within I/DD community

- Additional ongoing funding needed to operationalize recommendations from study

Remaining gap

Source: US Census: CPS Annual Social and Economic Report; 2020 Annual Disability Statistics Compendium

Access to care

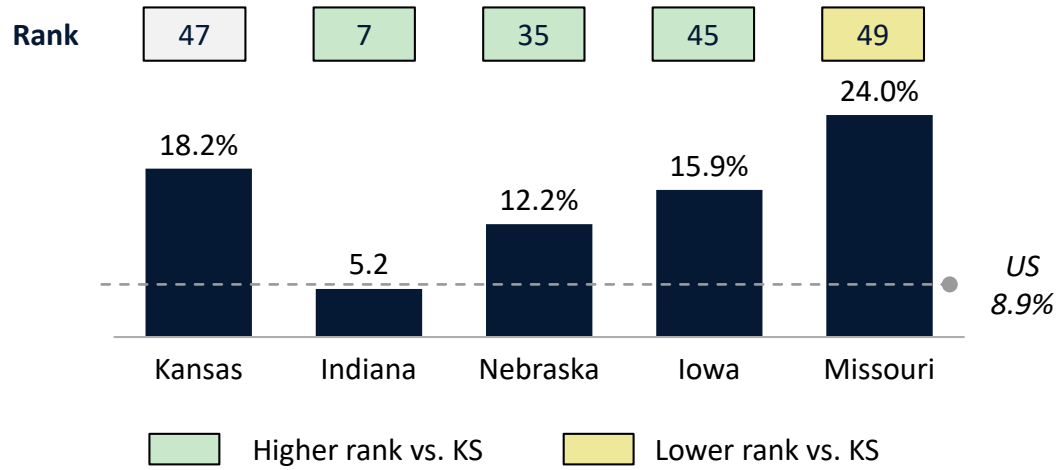
Needs Assessment

Ineffective intake & transition | Lack of individualized case management restricts diversion & discharge of patients to home & community-based care settings

Overuse of facility-based care results in missed opportunities for community-discharge

> The COVID-19 crisis has shone a harsh light on the human costs of a **long-term care system that relies too heavily on institutional services** like nursing homes. Too often, they are seen as the default option, even for those who **may not require** round-the-clock care[1]
>
> *CMS Administrator Verma*

Percent of nursing home residents with low care needs[2]
i.e., discharge to HCBS is feasible



Kansas is falling behind on discharge & diversion processes, which limits patient choice of care setting

41st Ranking in **avoidable hospitalization** of home health patients (~16%)[2]

31st Ranking in **successful discharge** of short-stay residents (~54%)[2]

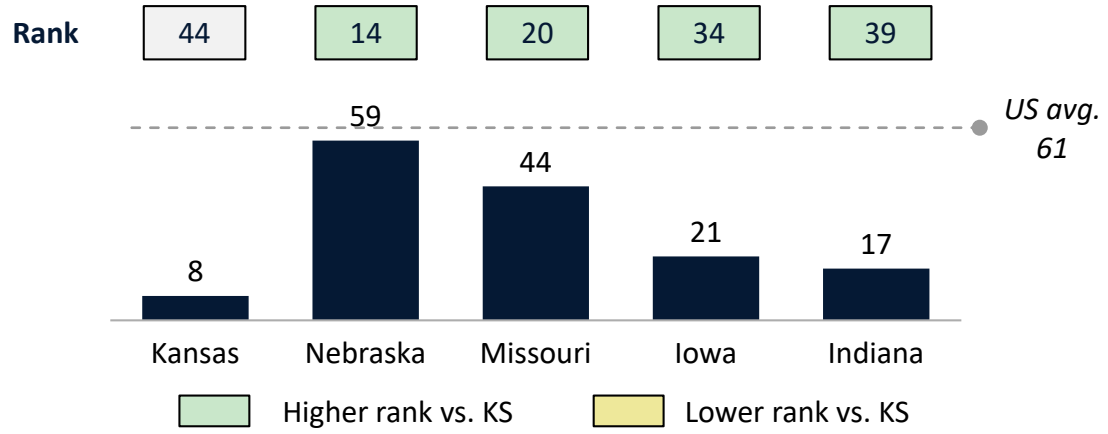
29th Ranking in **Aging & Disability Resource Center (ADRC) functionality[2]**

1. CMS 2. 2020 AARP Scorecard

Limited capacity | Supply is inadequate to meet existing, let alone growing demand for HCBS care settings, which drives intensifying unmet needs

Kansas has a more pervasive lack of HCBS supply versus peer states, & worsening due to workforce shortage

Adult day services total licensed capacity per capita[1,2]
# of providers



30th Ranking in **capacity of home health & personal care aides** *(19 aides per 100 pop w/ ADL disabilities)[1]*

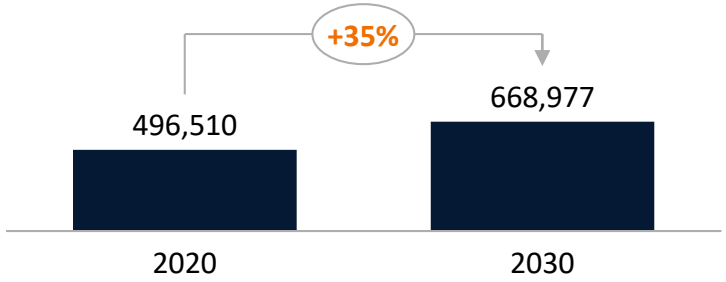
Limited supply is largely driven by **worsening workforce shortage**, to be addressed separately

Shifts away from institutional care & aging demographics suggest increased demand for HCBS

42% of total **COVID-19 deaths** in Kansas are attributed to **nursing home clusters[3]**

Demand for **transition out of facility-based LTSS[4]** & into HCBS increased during the pandemic

Projected growth of Kansas population over 65 years old[4]



Aging population trends also suggest expected **surge in LTSS[4] demand**

~6k **Individuals on waiting lists** (I/DD & Physical Disability waivers)[6]

Waiting lists illustrate **unmet HCBS demand**

1. 2020 AARP Scorecard 2. Per 10,000 population 65+ (demographic comprises two-thirds of adult day services recipients) 3. Wichita Eagle 4. Long term services & supports 5. Kansas Association of Area Agencies on Aging & Disabilities 6. KFF

Deep Dives

5 Short term internal staff – Final Settings Rule

Final Settings staff | Ongoing & intensive compliance oversight of Final Settings Rule necessitates additional KDADS staffing to prevent worsened HCBS capacity strains

Current state

- Historical underfunding leaves HCBS commission **understaffed**
  - Limits ability to deliver on HCBS expansions through FMAP
- ~15%[2] of HCBS providers are **at risk of failing Final Settings compliance**
  - Managing compliance oversight of approx. 2.5k providers necessitates additional FTEs

Investment opportunity

- Onboard **8 KDADS FTEs** to manage Final Settings compliance oversight

Required financial investment

- **~$2.5M** to cover FTEs for 3 years at $100k avg. annual salary[1]
- KDADS to seek **budget enhancement** to cover new FTEs once FMAP funding exhausts

Potential impact

- **Increase number of compliant providers** regarding Final Settings requirements to prevent worsened capacity crisis
  - Ensure **thorough & streamlined** compliance oversight processes
  - Expand internal bandwidth to **recruit HCBS providers**

1. Includes benefits, potential recruitment costs, and OEE

6 Study – Waiting list

Waiting list study | Conducting a study on the HCBS waiver waiting list population assists KDADS in ultimately eliminating unmet treatment needs

Current state

- Lack of clarity in **level of need** amongst HCBS waitlist patients
  - **~6k individuals** on I/DD & Physical Disability waiting lists[1]
  - Portion of 6k likely **don't require full selection** of waiver services

Investment opportunity

- Contract a **detailed assessment** of the individual, varying needs of HCBS waiver waiting list patients to **optimize level of service provided** (i.e., resolve patient needs at lowest level of care required)

Required financial investment

- Minimal financial investment (**~$1M** lump-sum contractor cost)

Potential impact

- Enable KDADS to develop an **informed action plan** to **decrease waiver waiting lists**
  - E.g., seek alternative service approach for lower-need population
- Reserves limited HCBS waiver slots for **individuals with outsized needs**

1. KFF

7 Extend ACL Going Home Transition Services

ACL Transition| Extending the ACL transition pilot can further expedite departure from institutional care by supporting patients on an individualized basis

Current state

- LTSS[1] system relies too heavily on institutional services like NFs[2]
  - ~3k NF residents have **low care needs[3]**
- KS ranks 47th in effective transitions[3]
  - E.g., high frequency of **avoidable hospitalization**[3,4]

Investment opportunity

- Extend Administration for Community Living (ACL) COVID Going Home Transition Services
  - Assist patient transition out of facilities
  - Extend scope beyond individuals at risk of contracting COVID-19

Required financial investment

- **~$1 to $2M** in grants to cover services & assistive technologies not offered through MCO's transition policy
  - E.g., housing (rent), electronic devices

Potential impact

- Enable transition to HCBS for **~90 individuals**
  - Based on ~16k facilitation cost per individual
- Optimize **cost-effectiveness** by pivoting from institutional to HCBS
  - Adult day care is **2.5x less expensive** vs. NF care[5]

1. Long term services & supports 2. CMS 3. 2020 AARP Scorecard Report, 18.2% of total residents (~16k) 4. KS ranks 41st, ~16% of home health patients are hospitalized 5. Utilizes NFMH annual cost of care as proxy for NF cost ($47k – Kansas Disabilities Rights Center), ~$20k annual cost of adult day health care (Genworth)

8 Study – TCM Models

TCM Study| Contracting a study of the TCM model will illuminate avenues to improve participant intake & referral processes while upholding strict quality assurance

Current state

- Long-term **shortcomings of TCM[1] model,** including:
  - Case manager conflict of interest (~**60%** of providers[2] employed by direct services agencies)
  - Tedious billing processes

Investment opportunity

- Contract a study to identify **avenues to rectify TCM** and explore **alternative models** (incl. health homes)

Required financial investment

- **~$1M** lump-sum rate to finance a contracted study

Potential impact

- Uphold **quality assurance** for ~1,800[3] participants using TCM annually
  - Eliminate conflicts of interest
- Leverage study to inform KDADS' potential next steps in actioning structural change, e.g.,
  - Explore revamped intake & **referral process detached from direct services**
- Streamline billing process to **minimize administrative burden** on case managers

1. Targeted case management 2. ~45 providers 3. Assumes 1:40 case manager/participant ratio

9 Mobile crisis response – I/DD

Mobile Crisis | Crisis respondent training fosters inclusion of I/DD participants in statewide mobile crisis efforts to prevent avoidable hospitalizations

Current state

- I/DD participant hospitalization poses **avoidable burdens to participants & the healthcare system** *(e.g., long stays, high readmissions, high cost of care)*
- Behavioral health mobile crisis teams are **not trained to address nuanced needs of individuals with I/DD**

Investment opportunity

- Build upon mobile crisis infrastructure investments underway *(e.g., $5M from KDADS behavioral health commission)*
- Ensure respondents are **equipped to manage I/DD participant crises**

Required financial investment

- **~$3.5M** investment covers statewide I/DD response training of mobile crisis teams 3 years[1] (before leveraging cost savings)

Potential impact

- **~$7M[2] in direct cost savings** by avoiding hospitalizations of individuals with I/DD (~1k individuals)[3,4]
- Ensure **effective** mobile crisis services are **accessible** to individuals with I/DD
  - Fill existing service gap in Kansas' care offering

1. Assumes $5k cost of training, 4 respondents per mobile crisis team, 30% annual turnover of respondents 2. Assumes ~$8k cost of care per I/DD hospitalization (Healthcare Cost & Utilization Project – HCUP) 3. Approx. 1k I/DD individuals referral to OSH & LSH annually (KDADS) 4. Assumes 15% utilization of mobile crisis amongst I/DD waiver population; 70% success of community resolution (SAMHSA)

Mobile Crisis | Inexperienced workforce must be trained in I/DD response in order to successfully resolve crises in the community

Description

Leverage mobile crisis infrastructure to triage, assess & de-escalate crises through 24/7, on-site support services from clinical professionals & peer support specialists. Mobile crisis participants include those with I/DD & behavioral health diagnoses.

Objectives

Ensure respondents are **equipped to manage I/DD patient crises**

- Uphold **quality assurance** of mobile crisis response for I/DD population specifically

Reduce avoidable hospitalization of participants by resolving crises in the community

Beneficiaries

- Individuals with I/DD:
  - **~10k individuals** enrolled on I/DD waiver
  - Additional non-waiver individuals (incl. waitlist & unmeasured prevalence)

Needs

- I/DD participant hospitalization continues, though participants' needs can be addressed effectively in less intrusive settings
  - Individuals w/ autism spectrum disorder (ASD) are hospitalized **2x more frequently** vs. general population (when experiencing similar crises[1])[2]
  - National increase in hospitalization of individuals with I/DD due to COVID-19[3]
  - I/DD participants have **higher hospital readmission** rates & **longer length of stays**[2] vs. general population[4]
- High cost of care at hospitals (~**6x higher** vs. mobile crisis)
  - ~8.5k[5] hospital stay vs. ~1.5k[6] mobile crisis case
- Mobile crisis workforce is inexperienced in responding to I/DD participants' crises
  - Clinical professionals, peer support specialists & on-call psychiatrists specialize in behavioral health needs

Portfolio fit

- Appendix D eligibility: New and/or Additional HCBS
- Sustainability: Cost savings (approx. ~$15M per year) cover ongoing training costs beyond initial investment

1. E.g., self-injurious behavior & ideation 2. Shileds et al. 3. New England Journal of Medicine 4. Axmon et al. 5. Healthcare Cost & Utilization Project (HCUP) 6. SAMHSA

Mobile Crisis| ~$7M in cost savings from decreasing hospitalization of individuals with I/DD covers initial ~$3.5M investment & expected ongoing costs

~$3.5M allocation of FMAP dollars covers initial investment & 3 years of ongoing training costs

One-time training costs

Cost of training	~$5k[1,2]
×	
# of respondents per mobile crisis team	4[3]
×	
# of counties in KS	105
×	
Statewide crisis workforce to train	~400[4]
=	
Total upfront cost (yr 1)	~$2M

Ongoing training costs

Expected annual workforce turnover	30%
×	
# additional individuals to train per year	~130
×	
Ongoing cost per year[5]	~$600k
=	
Total ongoing cost to cover (2 yrs)	~1.5M

Opportunity to scale down cost of investment given lower cost of training or less workforce to train

Costs avoided by decreasing I/DD hospitalizations cover twice the cost of I/DD training investment

Reduce avoidable hospitalizations of I/DD participants

- ~$7M[6] in annual cost savings by avoiding hospitalizations for ~1k individuals[7,8]

Solidify mobile crisis response as a **viable treatment avenue** for I/DD participants

- Fill existing service gap in KS care offerings
- Interrupt default to institutionalization

> Going to a hospital while in crisis can be scary, but in the [crisis] apartment, I felt relaxed
>
> *Recipient of mobile crisis services (New Hampshire)*

1. Assumes multi-day in-person training, lower-touch online trainings available from NADD 2. Includes trainer fees, travel, supplies, etc. 3. SAMHSA 4. Doesn't account for workforce shortage 5. Assumes $5k cost of training 6. Assumes ~$8k cost of care per I/DD hospitalization (Healthcare Cost & Utilization Project – HCUP) 7. Approx. 1k I/DD individuals referral to OSH & LSH annually (KDADS) 8. Assumes 15% utilization of mobile crisis amongst I/DD waiver population; 70% success of community resolution (SAMHSA)

10 Sequential Intercept Model (SIM)

SIM Consultant | Sequential Intercept Model (SIM) assessment will enable KDADS to mitigate disproportionate incarceration of individuals with I/DD

Current state

- Individuals with **I/DD are disproportionately enmeshed in the criminal justice system**
  - Account for ~10% of prison population vs. ~3% of general population[1]

> People with developmental disabilities can **engender [undue] suspicion** because they lack the necessary social cues…resulting in inappropriate responses[2]
>
> *Former sheriff & current employee at Lexipol*

Investment opportunity

- Hire one SIM expert to **identify gaps in Kansas' criminal justice system** & propose solutions to address said gaps

Required financial investment

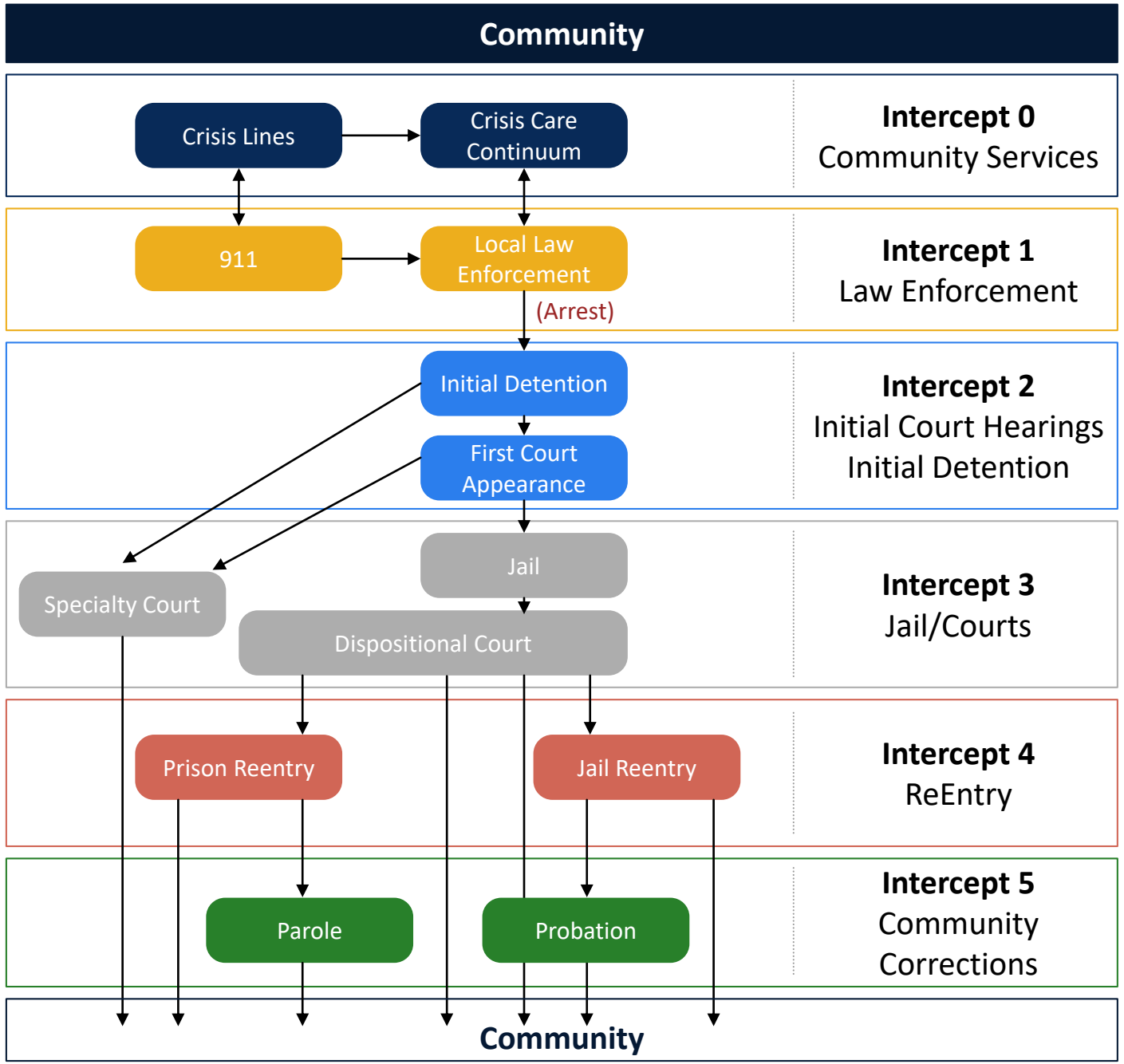
- **~$30k** lump-sum contractor rate

Potential impact

- Leverage SIM mapping & assessment to illuminate actionable methods to,
  - **Prevent wrongful arrest & incarceration,**
  - **Shorten length of stay** in correctional facilities,
  - **Increase connectivity** to support services, and
  - **Reduce recidivism** rates for the I/DD community
- Reduce economic burden of providing support services in correctional facilities

1. Refers to US prison & general population, Petersilia: Doing Justice? Criminal Offenders with Developmental Disabilities 2. Lexipol (public safety policy & training solutions company)

> The SIM helps communities identify resources and **gaps in services** at each intercept and develop **local strategic action plans**…to divert people with [I/DD and behavioral health] disorders away from the justice system into treatment.
>
> *SAMHSA*



Source: SAMHSA

11 Behavioral management training pilot

Behavioral management training | Training family caregivers of children with disabilities prevents foster care & PRTF admissions in order to keep children in their home

Current state

- Medical & behavioral care of children with disabilities is **burdensome psychologically & financially**
- Parents of children with disabilities have **higher levels of psychological distress**

Investment opportunity

- Train **~850 family caregivers** (incl. biological parents, foster parents & other guardians) in behavioral management practices
  - 15% of target population[2]

Required financial investment

- **~$2M** to cover approx. $2.5k training per family *(includes trainer fees, supplies, etc.)*

Potential impact

- **~15% of target population[2]** (850 families) trained in behavioral management training
- Approx. **120 children** kept out of foster care & PRTFs[3]
  - **~$5M in costs avoided** by keeping children in their homes[3]

- ~85% of target population (~4,800 families) still unequipped

Remaining gap

1. Assumes 20% of children in pilot are at risk of entering foster care or PRTFs, 70% success of rate of behavioral management training
2. Children enrolled on HCBS waivers in KS 3. Assumes ~$65k annual cost of PRTF care & ~$20k annual cost of foster care per child, Saint Francis PRTF, KVC PRTF, Foster care news letter

Behavioral management training | Equip families with the tools to properly care for their children in the home & prevent admissions to institutions

Description

Providing care for a child with disabilities (e.g., non-congenital brain injuries, autism spectrum disorder) is **burdensome for families**, parents & other caregivers. Training family caregivers (incl. foster parents) in behavioral management **equips them with the proper tools to effectively care** for their child.

Objectives

- **Prevent institutionalization** of children with disabilities (e.g., decrease PRTF admissions)
- **Decrease foster care placements** arising from neglectful family environments
  - **Increase stability in foster care placements** for children already in system

Beneficiaries

- **~5.5k** HCBS patients (across all waivers[1]) in Kansas are under 18[2]
  - Pilot seeks to address ~850 families (~15% of target population)

Needs

- Parents of children with I/DD tend to report higher-than-average rates of stress, anxiety and depression[3]
  - Effectively addressing behaviors exhibited by children with I/DD may close the family well-being gap[3]
- Family caregivers bear a large financial burden to support their children with disabilities
  - E.g., lifetime cost for a person with autism is between $1.4 to $2.4M[4]

> **Caring for kids with I/DD can be really intense** behaviorally or it can be really intense medically, or both. It's just far **too complicated for a foster family to take on** in most cases[5]
>
> *Young Adult Institute: Seeing Beyond Disabilities*

Portfolio fit

- Appendix C eligibility: Training and Respite
- Equity: Serves foster parents that are frequently overlooked
- Sustainability: Seek ongoing funding from budget enhancements once prove positive impact of pilot program
- Impact tracking: Ensure rigorous measuring & reporting of data
  - E.g., # of KS children in foster care, # of net new PRTF admissions/waitlist enrollees

1. Except Frail Elderly 2. Assumes same proportion of youth in general population vs. HCBS enrollment, incorporates eligible age ranges of all 7 waivers, Census Bureau, Statista 3. McConnell & Savage
4. Autism Speaks 5. YAI

Behavioral management training | Pilot investment improves quality of life for ~850 children & families; ~$2M investment covered by ~$5M cost savings

Training ~15% of families with children with disabilities across Kansas requires ~$2M investment

Pilot program: one-time training

Size of target population (# of children)	~5.5k
×	
Percent of population to address	~15%
+	
Cost of behavioral management training[2]	~$2,500[3]
=	
Total costs	~$2M

~850 families

Training offered by contractor

***Track impact** & **consider expanding pilot** to address remaining gap (~85% of population)*

Pilot improves quality of life for ~850 children & families; data tracking enables scalability of program

Improves **quality of life of ~850 children & families**

- Improve quality of child's medical care by prioritizing HCBS approach
- Combat families' psychological stressors

Prevent foster care or **PRTF admission** of ~120 children[4]

- **~$5M in costs avoided** by keeping children in their homes[5]

Gather detailed data on successes & limitations of pilot program to **inform program improvement & expansion**

- Enables a larger-scale training program to ultimately address 100% of families of children with disabilities in KS

1. Families of children enrolled on HCBS waivers 2. Including cost of trainer, supplies, amenities, etc. 3. Final training cost may vary pending contractor rates 4. Assumes 20% of children at risk of entering foster care or PRTFs, 70% success of rate of behavioral management training 5. Assumes ~$65k annual cost of PRTF care & ~$20k annual cost of foster care per child, Saint Francis PRTF, KVC PRTF, Foster care newsletter

12 Remodeling grants – HCBS providers

Remodeling grants | Provider grants cover the financial burden of remodeling required to fulfill HCBS setting standards

Current state

- Patient **choice of care setting is restricted** by lack of HCBS capacity (KS ranks 44th in adult day service capacity[1])
- ~15%[2] of HCBS providers are **at risk of failing Final Settings compliance**

Investment opportunity

- Provide **direct grants to providers** to cover costs to reach compliance
  - E.g., renovation to provide community care setting

Required financial investment

- **~$5M** in one-time grants to 50 to 100 providers in underserved communities (e.g., based on SVI[3] score)
  - ~25k to 50k to cover application review administrative process

Potential impact

- Prevent worsened capacity strains
  - Ensure **continuity of care** at 50 to 100 target facilities
  - Mitigate **inequitable access** to care
- Improve **quality** of care & maximize **choice of setting** for up to ~5,000 patients[4]

- ~75% of target population (~300 of 400 total providers) may require additional support in fulfilling Final Settings requirements

Remaining gap

1. 2020 AARP LTSS Scorecard Report 2. ~400 of ~2,500 total settings 3. Social Vulnerability Index (SVI) 4. Assumes ~50 distinct individuals served at each facility

Remodeling grants | Offering grants to HCBS providers prevents worsened capacity strains & expedites departure from institutional approaches to care

Description

Direct provider grants can cover and/or share the financial burden of renovation to satisfy Final Settings Rule compliance. ~15%[1] of HCBS providers are at risk of failing to reach compliance, which would limit already strained HCBS capacity.

Objectives

Prevent worsened capacity shortage by ensuring continuity of care from existing HCBS providers

Maximize patient choice in long-term services & supports (LTSS) care setting by financially supporting the shift away from institutional approaches to care

Beneficiaries

- 50 to 100 HCBS providers (e.g., adult care homes)
  - Target providers in underserved KS counties (e.g., based on SVI[2] score) to maximize impact & equity

Needs

- Kansas ranks 44th nationally in capacity of adult day services[3]
  - KS has 8 providers per 10k pop. 65yo+ (vs. US avg. of 61)
  - Lack of capacity **limits patient choice of provider & setting**

  Interdependence with workforce shortage
- Lack of HCBS capacity precludes ability to meet existing demand
  - **~5k individuals** sit on HCBS waitlist (I/DD ~70% of waitlist; Physical Disabilities ~30%)[4]
  - **~120% growth in HCBS waitlist** since 2014[5]
- Demand for HCBS is expected to grow, further pressuring Kansas' limited capacity
  - **Aging** demographic trends (e.g., Kansas' population over 65 years expected to grow by ~35% by 2030[6])
  - **Skepticism of institutional approach** to LTSS skyrocketed since the pandemic (e.g., 42% of COVID-19 deaths in Kansas occurred in NFs[7])

Portfolio fit

- Appendix D eligibility: Expanding Provider Capacity
- Sustainability: One-time grants for capital improvement (sustainability not necessary)
- Equity: Providers in underserved communities (e.g., high SVI)
- Impact tracking: Providers required to submit detailed reports on use of grants

1. ~400 of ~2,500 total settings, KDADS 2. CDC Social Vulnerability Index 3. 2020 AARP LTSS Scorecard Report 4. KFF 5. Case for inclusion (~2400 individuals in 2014) 6. Kansas Association of Area Agencies on Aging & Disabilities (~500k in 2020 to ~700k in 2030) 7. Wichita Eagle

Remodeling grants | One-time investment in remodeling grants unlock long-term value for both patients & providers

KDADS can enable Final Settings compliance & incentivize further investment at 10 target facilities

One-time grants

# of providers	50 to 100	*KDADS to determine target providers in underserved counties*
×		
One-time renovation grant	~$50k to $100k	*Providers must cover all remaining costs (incl. upkeep)*
+		
One part-time FTE (grant application review)	~$25 to 50k	
=		
Total costs	~$5M	

> Oregon offered two grant funding opportunities to adult care homes to **finance improvements to meet HCBS requirements**. Applicants were required to **contribute at least 10%** of the renovation costs
>
> *Oregon Health Systems Division*

One-time grants drive lasting impact for patients by expanding accessibility of HCBS settings across KS

Improve quality of care for up to ~5,000 individuals[1] by expanding accessibility of community-based care

- Nationally, ~80% of adults above 50 years old prefer to receive care in their communities & homes[2]

Address inequities across Kansas by supporting providers in underserved counties

- E.g., expand optionality for rural patients which is currently limited to quasi-institutional settings

*Investments to cover capital expenditures (e.g., remodeling) will be **durable** & drive **long-lasting** impact*

1. Assumes ~50 distinct individuals served at each facility 2. 2018 AARP home and community preferences survey

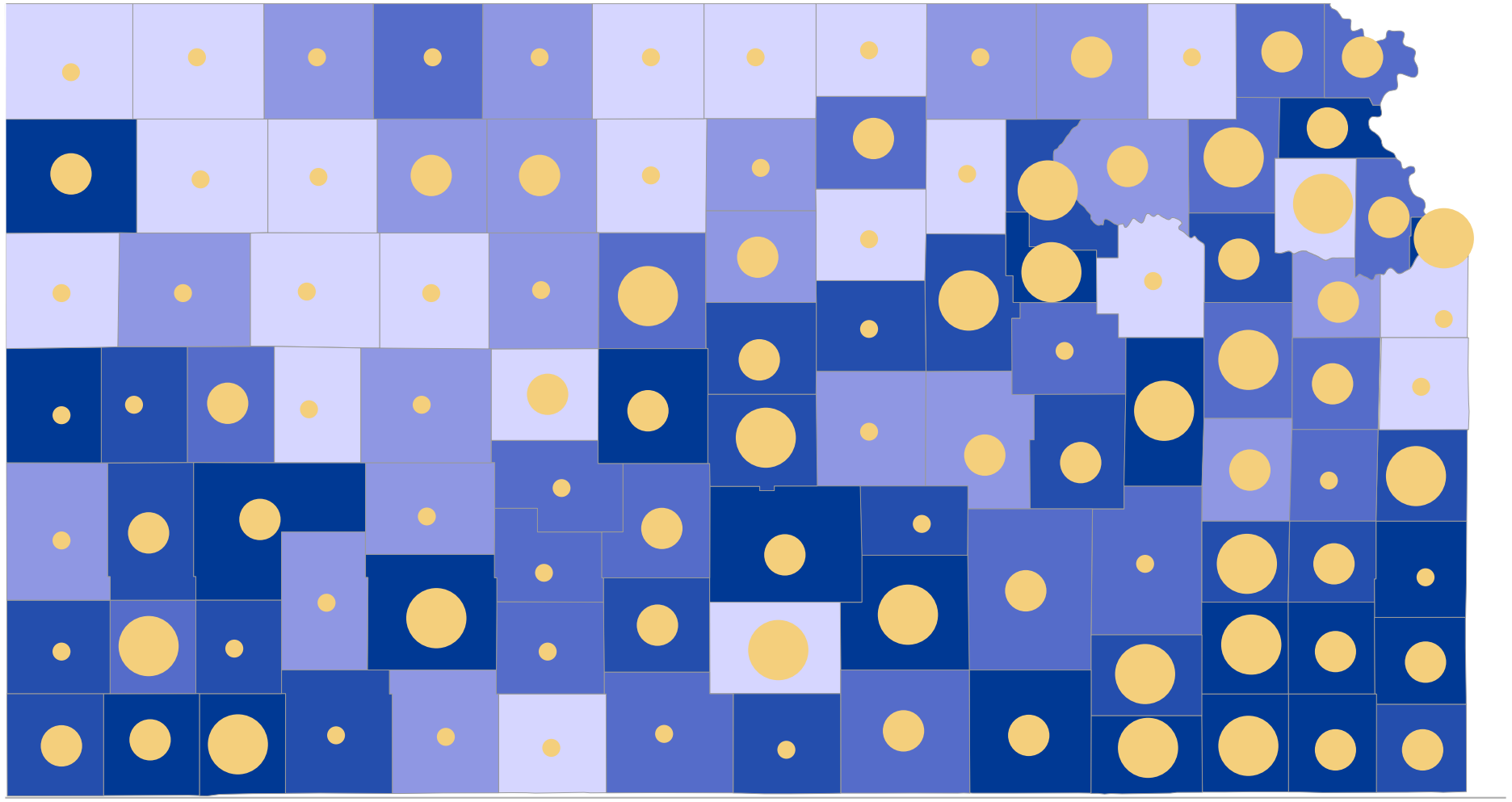
Remodeling grants | Social vulnerability index portrays Southern Kansas counties as most vulnerable

Kansas 2018 unemployment rates

- 5%-8.6%
- 3.3%-4.9%
- 0.9%-0.19%

Kansas 2018
Social Vulnerability Index

- 0.81-1.00 *(most vulnerable)*
- 0.61-0.80
- 0.40-0.60
- 0.20-0.39
- 0.00-0.19 *(least vulnerable)*



Source: CDC

Implementation

Supporting implementation details to ensure accountability & measure impact

Investment area		Initiative	Investment	Owner	KPIs
Workforce	1	One time retention bonus	**(~$51M)** Provides $2,000 bonus per worker	Amy P.	• Retention rate
	2	Training grants	**(~5.1M)** Provides $200 training grant per worker	Amy P.	• HCBS waiver participant satisfaction
	3	Study and design career ladder	**(~$1M)** Investigates opportunity to create a career track	Amy P.	• Retention rate
Employment	4	Study – Employment First	**(~$2M)** Lump sum contractor rate	Amy P.	• NA; study findings
Access to Care	5	Short term internal staff	**(~$6.8M)** 16 HCBS FTEs (Final Settings & Admin); 5 Financial FTEs, 1 Project FTE	Amy P.; Brad R.	• # of HCBS providers recruited
	6	Study – Waiting List	**(~$1M)** Lump sum contractor rate	Amy P.	• NA; study findings
	7	Extend ACL Going Home Transition Services	**(~$1.5M)** Extend existing grant processes	Amy P.	• # of individuals transitioned out of facilities
	8	Study – TCM Models	**(~$1M)** Lump sum contractor rate	Amy P.	• NA; study findings
	9	Mobile Crisis for I/DD	**(~$3.5M)** Provide I/DD response training to ~400 respondents	Andy B.; Amy P.	• % utilization (patients); % of workforce trained; # of I/DD hospitalizations
	10	SIM Consultant	**(~$30k)** Lump sum contractor rate	Amy P.	• NA; study findings
	11	Behavioral management training pilot	**(~$2M)** Train 10% of I/DD families (~1k)	Amy P.	• # of families trained; # of PRTF & foster care admissions
	12	Remodeling grants – HCBS providers	**(~$5.4M)** Provide $50k to $100k grants for 50 to 100 providers	Amy P.	• Trend in # of patients served at each provider
		Total	**~$80.3M**		

FMAP portfolio enhances Medicaid HCBS by addressing workforce, employment & accessibility needs via three distinct mechanisms

Direct support

Provide support (e.g., additional services, financial relief) directly to **HCBS patients** and/or **providers**

Administrative

Enhance KDADS' **internal capabilities** at the foundation to **enable comprehensive delivery** on all HCBS processes

Studies

Invest in **contracted assessments** of Kansas' HCBS system to identify gaps & **develop an action plan** to address shortcomings

Investment portfolio prioritizes direct support mechanism, but leverages studies & administrative processes to further reinforce HCBS

Direct support

~83% of portfolio, ~$66M total

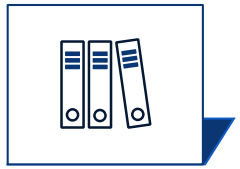
Investment	CMS eligibility	Allocation
Retention bonuses	Workforce recruitment	$48.5M
DSW training grants	Training & Respite	$4.9M
HCBS provider remodeling grants	Expanding Provider Capacity	~$5M
ACL Transition Services	Community Transition	$1 to $2M
Mobile crisis for I/DD	New and/or Additional HCBS	~$3.5M
Behavioral management training pilot	Training and Respite	~$2M

Administrative

~12% of portfolio, ~$9M total

Investment	CMS eligibility	Allocation
Retention bonuses (admin. portion)	Workforce recruitment	$2.5M
DSW training grants (admin. portion)	Training & Respite	$0.2M
HCBS provider remodeling grants (admin. portion)	Expanding Provider Capacity	$0.25 to $0.5M
Final Settings Rule (8 staff)	Eligibility Systems (provider eligibility)	$2.5M
***HCBS admin.** (9 staff)	*TBD*	$2.8M
***Financial and Information Services** (5 staff)	*TBD*	$1.5M

**No deep dive available, allocation covers FTEs for 3 yrs ($100k/yr salary)*



Studies

~5% of portfolio, $5M total

Investment	CMS eligibility	Allocation
DSW career ladder	Workforce recruitment	$1M
Employment First	SDOH Disparities	$2M
Waiting lists	Reducing or Eliminating HCBS Waiting Lists	~$1M
Targeted case management	Quality Improvement Activities	~$1M
Sequential Intercept Model	New and/or Additional HCBS	$.03M

Total investment: ~$80.3M


GREAT SEAL OF THE STATE OF KANSAS
AD ASTRA PER ASPERA
JANUARY 29, 1861