Report
of the
Community Services Oversight and Planning Council
to the
Arkansas Legislative Council

November 19, 2010

Legislative Members

Sen. Randy Laverty, Chair
Sen. Bill Pritchard
Sen. Cecile Bledsoe
Rep. James Word, Vice Chair
Rep. David "Bubba" Powers
Rep. Debra Hobbs

Non-Legislative Members

Ms. Rita Taunton
Mr. Mike McCreight
Ms. Pam Christie
Mr. Scott Linebaugh
Mr. Tim Herr

Mr. Chairmen:

The Community Services Oversight and Planning Council was created by Act 1670 of the Regular Session of 2005. The Community Services Oversight and Planning Council serves in an advisory capacity to the Legislative Council and the Joint Budget Committee. The purpose is to gather information and data concerning community-based service needs of citizens in regard to:

- Developmental Disabilities Services
- Behavioral Health Services
- Aging and Adult Services
- Youth Services

With this information and data, the Community Services Oversight and Planning Council make recommendations concerning community-based services for the community-based programs to the Legislative Council and Joint Budget Committee.

The Community Services Oversight and Planning Council met on the following dates:

Thursday, September 30, 2010

The Community Services Oversight and Planning Council (CSOPC) met to discuss the following items:

- Intermediate Care Facility for Individuals with Developmental Disabilities Fee
- Community Based Provider Appropriations
- Continuing Level Funding

Thursday, October 21, 2010

The Community Services Oversight and Planning Council (CSOPC) met for a status update on a possible waiver for group homes/apartments and a DDS waiver amendment for Adult Foster Care.

Ms. Pam Christie, Executive Director-Mental Health Council of Arkansas, gave an overview of the Community Mental Health Centers requests for the 2011-13 Biennium. *Overall, the Community Mental Health Centers requested additional General Revenue of $7,701,782 each fiscal year of the 2011-13 Biennium to restore funding from previous funding cuts, fully implement Assertive Community Treatment Teams, and regional evidence-based service initiatives.*

Mr. Scott Linebaugh, President-Arkansas Youth Service Providers Association, gave an overview of the Arkansas Youth Service Providers Association requests for the 2011-13 Biennium. *Overall, the Arkansas Youth Service Providers Association requested additional General Revenue of $3 million each fiscal year of the 2011-13 Biennium.*

Mr. Tim Herr, with the Arkansas Association of Area Agencies on Aging, gave an overview of the Arkansas Association of Area Agencies on Aging requests for the 2011-13 Biennium. *Overall, the Arkansas Association of Area Agencies on Aging requested additional General Revenue of $2,286,983 for FY2012 and $2,736,373 for FY2013 to restore funding from previous funding cuts to the Senior Citizen Centers, provide an increase to the State Older Worker Program, and funding increases due to inflation.*

Mr. Mike McCreight and Ms. Rita Taunton, with the Developmental Disabilities Service Providers, gave an overview of the Developmental Disabilities Service Providers requests for the 2011-13 Biennium. *Overall, the Developmental Disabilities Service Providers requested additional General Revenue of $10,639,332 for FY2012 and $16,184,966 for FY2013 to provide funding for reserve capacities in the Developmental Disabilities Services Alternative Community Services (ACS) Waiver program, a reduction of the DDS ACS Waiver Program wait list, regional cooperatives in the DDS ACS Waiver Program, and additional Intermediate Care Facility beds.*

Motions Adopted

The Community Services Oversight and Planning Council (CSOPC) approved all motions regarding community-based provider requests for the 2011-13 Biennium as shown in the attachments following this report.

- Community Mental Health Centers
- Youth Service Providers Association
- Association of Area Agencies on Aging
- Developmental Disabilities Service Providers

Respectfully submitted,

_____	_____
Randy Laverty	James Word
Senate Chair	House of Representatives Vice Chair

COMMUNITY MENTAL HEALTH CENTERS

Presentation of Budget Requests for
The Community Services Oversight and Planning Council
For Fiscal Years 2012 and 2013
October 21, 2010

Background Information:

Arkansas' 14 community mental health centers were established between 1963 and 1971 under the Federal Community Mental Health Center (CMHC) Construction Grant #AR-MH-01B6 and the Public Health Service Act Section 1913. Community mental health centers are non-profit, citizen governed organizations funded by federal, state, and local funds. They are regulated by the Arkansas Division of Behavioral Health Services through regulation, contracts, and State law. Centers are required to provide a minimum array of services to individuals residing in defined geographic areas. The minimum services are listed as follows:

- Inpatient services.
- Outpatient services, including diagnosis, treatment planning, individual/family/group therapy, collateral intervention, and therapeutic day services.
- 24-hour emergency services.
- Screening for patients being considered for referral to the Arkansas Mental Health System to determine if appropriate alternatives to institutionalization are available.
- Follow-up and aftercare.
- Crisis stabilization and intervention services.
- Rehabilitative services.
- Case management.
- Specialized services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- Consultation and education.

The mental health centers provide comprehensive mental health services within the limits of the capacities of the centers to any individual residing or employed in the service area of the center regardless of ability to pay for such services. Community mental health centers are funded with Federal, State and local funds. In FY10, Community Mental Health Centers had total revenues of $225,126,762. The primary source of funding was Medicaid with $131,803,879 or 59% of the total funding. Other funding sources included Medicare $5,379,617, private insurance $3,016,804 and State, local, and other funding of $84,926,462.

Community Mental Health Centers provide services through its 144 service sites and a staff of 3,062 people. Centers employ 52.2 Psychiatrist, 10.1 physicians, 109.5 Registered Nurses, 53.6 Psychologists, 56.7 Psychological Examiners, 328.5 Social Workers, 188.6 professional counselors, and 1274 mental health paraprofessionals. In FY10, Community Mental Health Centers provided services to 75,278 Arkansans. The following are some of the services provided fiscal year 2010:

- 29,873 adults with serious mental illness (SMI) received treatment
- 17,124 seriously emotionally disturbed (SED) children received comprehensive treatment
- 1,979 adults were treated in jails
- 242 jailed children served, of whom 158 were served in jail. 84 jailed children were served at some site other than the jail, typically being brought to the Center's clinic.
- 5,556 – number of adult acute care hospital admits
- 14,597 – number of emergency screenings
- 1,316 – number of admits to crisis beds

Through the partnership with Federal, State and local governments, Community Mental Health Centers have provided comprehensive public mental health services for the past 40 years. Community Mental Health Centers have provided the opportunity for persons with severe mental illness to live productive lives in their communities and provided safer and healthier communities.

In order to continue the level of services throughout Arkansas to one of the state's most vulnerable populations, the Mental Health Council of Arkansas would like to submit the following funding requests.

PRIORITY REQUESTS

Request #1

The restoration of SFY 2010 State General Revenue funding reductions for community based programs and request sufficient increases during the 2011-13 Biennium DBHS Funded Appropriation to provide continuing level funding for both DBHS community based and institutional delivered services.

Amount Requested: $1,443,754 each fiscal year

Supporting Rationale: The original DBHS decision to reduce a small portion, $662,835 of the general revenues allocated to community based providers was

reached **prior** to the initiation of statewide reductions in Medicaid reimbursement caused by changes in the Medicaid RSPMI Program in late Fall 2009. The second DBHS decision to further reduce community based programs by an additional $780,919 was made following public acknowledgement of a projected $1,000,000 decrease in 2010 SFY Medicaid reimbursement to CMHCs. The SFY 2010 Medicaid reimbursement projected decrease is currently projected to be $3,480,291 based on a recent survey conducted by MHCA.

The cumulative effect of this decrease in Medicaid reimbursement for adults with serious and persistent mental illness coupled with the continued reduction of general revenues into SFY 2011-2012 for CMHCs will significantly impact both access to public mental health services and the availability of public mental health services statewide. In turn, individuals served by the system will be adversely impacted by provision of less early intervention and continuous support with predictable increased utilization of more costly crisis related interventions including 24 hour inpatient care. The continuation of even a portion of this general revenue reduction in the SFY 2011 will further endanger a statewide public mental health system now in crisis by high demand and resource loss.

Community based program infrastructure such as closing outlying program sites, equipment replacement and capital needs will be further delayed or eliminated. Restricted service access will be continued at a time of increased high demand for service due to the cumulative effects of statewide economic conditions. In consideration of a partial restoration, while providing some short term relief, does not adequately address multiple adverse affects of a reduction in general revenue, a reduction in service reimbursement, significant increases in indigent client demand, and recession generated high demand for general mental health services.

Request #2

Establish and fully implement an Assertive Community Treatment Team (ACT) in each CMHC Service during the 2011-2013 biennium to serve an enrolled 1260 adult individuals with severe and persistent psychiatric disorder inclusive of co-occurring disorders.

Amount Requested: $5,278,028 each fiscal year

Supporting Rationale: An Assertive Community Treatment (ACT) as an Evidence Base Practice (EBP) is a widely replicated model of intense service provision and necessary for individuals demonstrating high acuity of need and behavioral dysfunction over a prolonged period as evidenced in recidivism. The model has demonstrated effectiveness in supporting community re-integration and significant reduction of psychiatric crisis and relapse. Its accepted general

purpose is the application of organized and continuous support to assure stability and community reintegration of a high risk defined user population. These target groups varying from high psychiatric inpatient users to other user groups of many types with the common characteristics of high recidivism.

For example, the model is increasingly utilized in both jail diversion and jail/prison community re-entry. Nationally, in the past decade, forensic ACT teams have been demonstrated to be highly effective with psychiatric forensic populations including offenders with severe co-occurring disorder. Similarly, "housing first" models for supported housing and rapid housing in homeless intervention initiatives replicate the model in moving people and families from the street directly into housing. In Arkansas there are currently several operational ACT teams serving different high risk target populations in both urban and less populated areas.

Note: Following the in-depth study and resulting findings of the MHCA Ad Hoc Adult System of Care Workgroup, it was concluded the implementation of a minimum of one (1) ACT team in each DBHS service area would have the greatest systematic impact on improving the functional status and quality of life for adults with serious mental illness and significant history of recidivism.

Request #3

Establish a DBHS administered discretionary fund into support regional service initiatives that employ evidence-based practices/approaches (EBP/A) to introduce new responsive service technologies into the adult public mental health system.

Amount Requested: $980,000 each fiscal year (14 community initiatives statewide)

Supporting Rationale: In further consideration of the Ad Hoc Adult System of Care Workgroup findings, recommends a DBHS discretionary grant process to enable local programs to implement a variety of responsive, recovery focused service initiatives utilizing EBP/A across the state. The use of small, but well conceived and fully accountable service initiatives is a proven means to introduce change in a large systems such as the state public mental health system. This approach to change has been employed in previous periods of reform in this state, and is an accepted strategy to improve service delivery and system reform. Under the oversight of DBHS, community based programs would select from a range of EBP/A for implementation that are applicable to the particular service area considering consumer need, program resources, and other factors. These EBP/A models are identified by national sources including SAMHSA, DOJ and

HUD as accountable service delivery models to address the challenges of adult consumers in achieving recovery.

Note: These EBP/A models are identified by national sources including SAMHSA, DOJ and HUD as accountable service delivery models to address the challenges of adult consumers in achieving recovery. A partial listing of evidence based programs and approaches are as follows:

- **Illness Management and Recovery**

- **Assertive Community Treatment (ACT)**
  ACT Applications
  Crisis Intervention and Stabilization
  Individuals with Serious and Persistent Mental illness and High Recidivism
  Jail Diversions
  Forensic Diversion and Community Re-Integration
  Transitional Population (Adolescent to Adult)
  Other

- **Supported Employment**
  - **Integrated Treatment for Co-Occurring Disorders**
    http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/cooccurring/default.asp
  - **Permanent Supportive Housing**
  - **Housing First with Highly Focused Support**
  - **APIC Model for Community Re-entry from Jails**
  - **Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness**
  - **Suicide Prevention**
  - **Other EBP/A as Approved by DBHS**

PRIORITY REQUESTS

Grand Total Priority Funding Requests from the Community Mental Health Centers for the Division of Behavioral Health Services
FY2011-12 - $7,701,782 (General Revenue)
FY2012-13 - $7,701,782 (General Revenue)

ARKANSAS YOUTH SERVICE PROVIDERS ASSOCIATION

Presentation of Budget Requests for
The Community Services Oversight and Planning Council
For Fiscal Years 2012 and 2013
October 21, 2010

Background Information:

The membership of the Arkansas Youth Service Providers Association (AYSPA) brings over 200 years of combined institutional experience focused on advocating for and providing leadership in the development of a comprehensive, community based system of effective and responsive services to delinquent and at risk youth. Our mission is "To help youth develop a foundation to build on by providing empowering and supportive community based services".

Since its formation in 1979, Arkansas Youth Service Provider Association members have been at the forefront in the advocacy, planning, development, coordination of responsive and effective services and support to at risk youth including delinquent youth and their families. The efforts and activities of the AYSPA have always been guided by a vision of a truly comprehensive and effective community based system that will provide children and youth with the necessary services they need to make a successful transition to adulthood. Our agencies were set up after the Division of Youth Services (DYS) decided to use the community based system to serve its youth. A major consolidation by DYS brought these agencies into the form they are today. To the communities we serve, the AYSPA Providers are the DYS staff in the field.

All twelve non-profit agency members of the association hold contracts with the Division of Youth Services (DYS) to provide comprehensive, community based programs that cover the state. These contracts for services are identified by judicial district, with some providers holding contracts for multiple districts. Contract funding consists primarily of state general revenue.

Services Provided:

Categories of Service and examples:

- Academic/ Social Support Services
  - Tutoring
  - Social and Life Skills Education
- Clinical Treatment: Mental Health & Substance Abuse
  - Diagnosis and Evaluation
  - Individual & Family Counseling/Therapy
- Behavioral Management Intervention
  - Community Service Supervision
  - Compliance Monitoring

- Sanction Services
  - Electronic Monitoring
  - Day Services
- Residential Services
  - Emergency Shelter
  - Residential Treatment
- Educational Services
  - GED Education
  - Special Education Classrooms

PRIORITY REQUESTS JUSTIFICATION

- The Division of Youth Services agency total funding request and Executive Recommendation for FY12 is **unknown at this time.** (SGR + federal/other). DYS in their FY 12 requested budget has increased Community Based funding by $3 million for current services. This additional $3 million will only cover the services currently being provided. (DHS added $3 million onetime stimulus funding to our contracts in July of 2010. This funding will go away in June of 2011.) Even with the increased funding the level for community based services does not get the Provider agencies to where they were in 2000. This level of funding is critically insufficient to insure that each county will receive the needed level of service for troubled youth and their families.

- For the past five (5) legislative sessions, DHS has requested no increase in funding for community based treatment programs. Today, there are fewer services (*not counting services funded by one time stimulus funds going away in June) in the communities as compared to 2000 and even court ordered youth must be placed on waiting lists for community treatment services. There are fewer emergency shelter and residential treatment beds and day services programs have closed. DHS realized that youth services was in a crisis and added $3 million of stimulus funding (one time/one year funding) to our services in 2010 to keep Alexander out of a crisis. This funding however goes away on June 30.

- In the past fourteen (14) years funding for community based services has increased only twelve (12%) percent (not counting one time stimulus funding that goes away June 30). The Consumer Price Index shows that it would take a total of twenty-six (26%) percent of increases or an additional fourteen (14%) percent increase to get the Community Based Providers to where they were ten (10) years ago.

- In addition to only such a small increase over the ten (10) year period, in 2002, the age range of youth served by the Division of Youth Services was increased from a maximum age of eighteen years to the age of twenty one

years. This has amounted to hundreds of youth each year over 18 that are being served by the community based providers. There was no increase in community program funding to help manage this new population. The result is that much less resources are now available to provide services for the below 18 year old population. Prevention programming has all but been eliminated by the provider agencies as resources dwindle and this new population makes increasing demands on a limited number of available programs and services.

- DYS collaborating with the JEHT Foundation developed a report in 2008 titled "Juvenile Justice Reform in Arkansas". This report recommends the need for juvenile justice reform. The report recommends that the initial funding priorities to jump start the reform include "Increased funding for community based programs and interventions..." DYS own Task Forces in the past five (5) years have agreed with this finding. However, no permanent change has been made, only a temporary increase with stimulus funds that goes away June 30.

- In December of 2008, Paul Kelly of Arkansas Advocates for Children and Families prepared a study titled "Juvenile Justice in Arkansas". In that study they recommended that we "Increase reliance on effective community-based services by investing funds and resources..."

The DHS proposed funding increases will help stop the erosion of existing services but will do little to increase services in a woefully under funded system of community based services. If we are to stem the continuing flow of delinquent youth into state custody and local detention centers, it is imperative that we significantly expand the service capability in all counties in the state. The Arkansas Youth Services Provider Association respectfully suggests that the Division of Youth Services reform effort will fail unless more funding is placed in community based services and less in secure confinement.

The Arkansas Youth Service Providers Association makes the following requests:

PRIORITY FUNDING REQUEST

Increase DYS funding ***above the proposed DYS budget*** for community service programs by:

Community Services: (All General Revenue)
State Fiscal Year 2012 - $3,000,000
State Fiscal Year 2013 - $3,000,000

ARKANSAS ASSOCIATION OF AREA AGENCIES ON AGING, INC.

Presentation of Budget Requests for
The Community Services Oversight and Planning Council
For Fiscal Years 2012 and 2013
October 21, 2010

Background Information:

The eight (8) Area Agencies on Aging were organized as private non-profit organizations under the provisions of the Internal Revenue code and the corresponding Arkansas statutes in 1978 and 1979. These organizations are authorized under the Older Americans Act of 1965, as amended, to plan, develop, coordinate and provide services to older adults. Each Area Agency on Aging has a designated planning and service area consisting of six (6) or more counties, and the cumulative coverage is statewide. The Arkansas Area Agencies on Aging receive funding from State and federal sources through agencies such as the Arkansas Department of Human Services, Housing and Urban Development, Medicare, Department of Agriculture and others. Local funding is also provided through participant contributions, private grants, donations and fund-raising activities. The Arkansas Area Agencies on Aging are part of a national network that includes 670 Area Agencies on Aging and Native American tribal organizations throughout the country.

The Arkansas Association of Area Agencies on Aging, Inc. is the separate non-profit organization by which all eight (8) Area Agencies work jointly in an official manner. These agencies have a mission to advocate for and develop a coordinated system of programs and services that improves the quality of life for older persons and that enables them to live independently with dignity in the least restrictive environment. To accomplish this mission, the Area Agencies on Aging provide services and may contract some services such as Senior Center services (i.e. Congregate meals, Meals on Wheels and transportation) to other non-profit providers including community action agencies, single purpose non-profits and in some limited cases, county governments. Each Arkansas Area Agency on Aging is governed by a local, volunteer Board of Directors, which meets quarterly or more often. These Boards of Directors are representative of the counties within the respective planning and service areas.

- The Division of Aging and Adult Services allocated general revenues to the Area Agencies on Aging for senior center meals programs, transportation, and socialization, for state fiscal year 2010 – 2011, not counting State Older Worker Program funding, were **$11,640,023.** In fiscal year 2009 – 2010 the amount was **$12,017,784.** The amount of state funding has steadily eroded since 2006. This decrease comes at a time of sharply escalating costs for fuel, food and

labor. In addition, the senior population is rapidly increasing, and the State's population aged 65 and over is projected to grow to 731,000 by the year 2025. **An increase of $2,286,983 for fiscal year 2012 and $2,736,373 for fiscal year 2013 is requested to restore funding to its previous level.**

PRIORITY REQUESTS

The **Arkansas Area Agencies on Aging** are requesting additional funding for the Division of Aging and Adult Services for the following Services:

Senior Centers' Meals Programs

State Older Worker Program

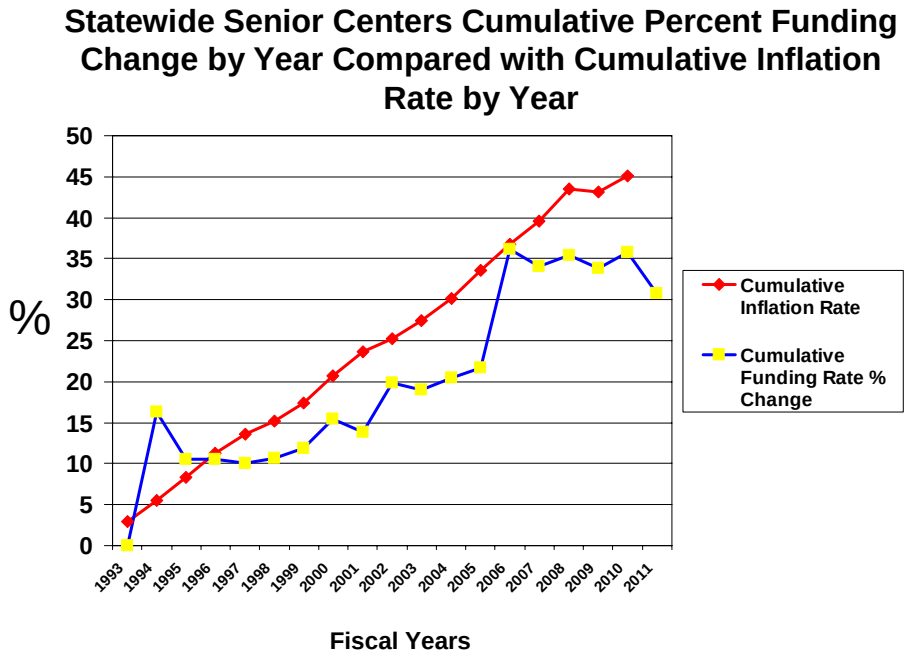
Rebalancing of Home and Community Based Care

Area Agencies on Aging Justification
SENIOR CENTERS' MEALS PROGRAMS

The simple fact is: If a person cannot **eat** at home, they cannot **stay** at home. This is especially true for homebound and disabled seniors. The statewide home delivered meals programs, administered by approximately 205 senior centers, are an essential and critical component of home and community based services in the state. Without this key element of service many seniors are destined for premature institutional care.

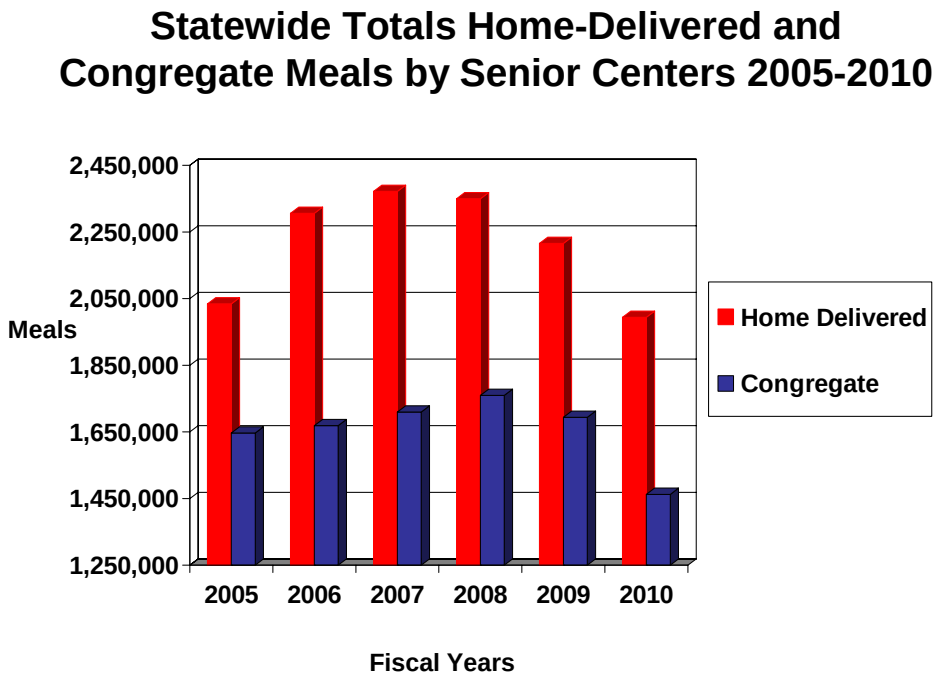
Funding for senior center meals programs has decreased dramatically, particularly since 2006, but has never kept up with the inflationary increase in the cost of doing business. Consequently, the number of meals provided, and the number of seniors served has proportionally decreased.

The following graph (Graph #1) illustrates not only the total decrease in funding going back to 1993, but compares the cumulative effect of inflation with the cumulative percentage change in senior center funding. As can be seen, senior center funding through 2011 has dropped approximately 15% below where it should be just to maintain the level of service.



Graph #1

The second graph (Graph #2) shows the steady and significant decrease in the total number of meals, both home delivered and congregate, provided from FY 2005 through FY 2010. Projections for FY2011 are even lower.



Graph #2

State funding for senior centers for FY 2010-2011 is $11,640,023 when Older Worker funding is taken out. (That will be addressed separately below.) Applying the 15% shortage due to funding cuts and inflation, **an additional $1,746,003 each fiscal year in state general revenue is requested**. This would bring statewide senior center funding to **$13,386,026**, not counting the Older Worker Program request below.

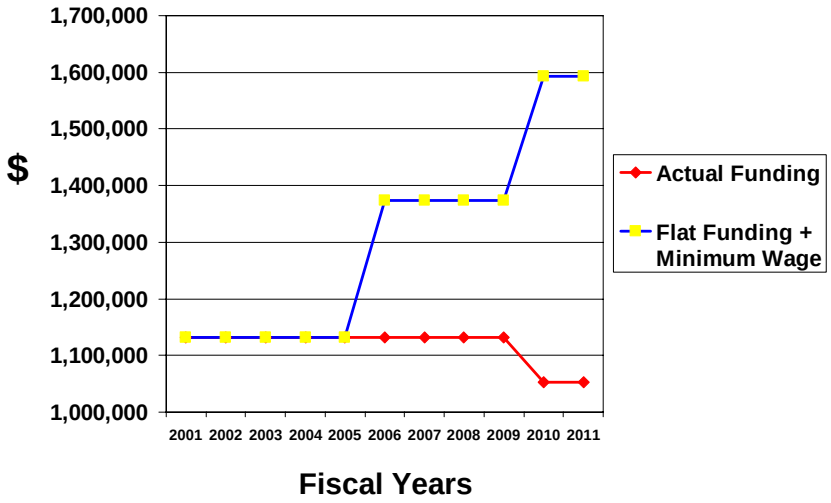
STATE OLDER WORKER PROGRAM

Older Workers perform critical jobs at senior centers across the state. They work an average of 20 hours per week, at minimum wage. They perform such important tasks as meal preparation, meal delivery, transportation, cleaning, clerical, and other duties at the senior centers. Along with the loss of Title V federal Older Workers in 2004, the senior centers have lost a significant number of State Older Workers (or hours) as a result of reduced state funding and having to comply with minimum wage increases.

Further crippling the senior centers' ability to meet the overwhelming need for senior meals is the significant loss of manpower and personnel as a result of long-term deterioration of the State Older Worker Program. This program has never had an increase in its funding since its inception, in spite of two increases in the federal minimum wage.

The following graph (Graph #3) illustrates the large discrepancy between current funding and the funds needed just to maintain the original allocation of State Older Worker hours.

Statewide Older Worker Program Funding Compared to Flat Funding with Increases in Minimum Wage



Graph #3

In order to restore State Older Worker funding to its original level, **an additional request of $540,980 each fiscal year in General Revenue is made**. This would bring total State Older Worker Program funding to a total of **$1,593,644.**

REBALANCING OF HOME AND COMMUNITY BASED CARE

The following request does not include a dollar amount. There are so many permutations and ramifications of rebalancing that it would be presumptuous of us to attempt to assign a dollar value. Nevertheless, it is an issue which needs to be addressed by the state.

The Division of Aging and Adult Services commissioned a study completed in April of 2009 entitled "Recommendations to Balance Arkansas' Long-Term Care System". The following is reported in the Executive Summary of that report: "Arkansas' long-term care system remains heavily invested in expensive institutional care. Arkansas devotes a much greater percentage of its Medicaid long-term care budget to institutional care than most other states; 73% for all Medicaid populations in Arkansas, versus 61% nationally."

The report goes on to say, "Between FY 1999-2008, Arkansas spending in nursing homes increased by 93%, due at least in part to an effort to improve the quality of care. It should be noted that during this same period of time, the number of individuals in nursing homes decreased by 9%, while the budget for the ElderChoices waiver and most other home and community based services remained essentially flat."

As shown above in the two budget requests involving senior meals programs, those needs are part of a larger picture. Both the federal and state governments are promoting the use of home and community based care as a better and less expensive alternative to institutional care. However, without the necessary home and community based infrastructure (home delivered meals, in-home care, etc.) that alternative becomes less and less available to senior Arkansans.

The Arkansas Area Agencies on Aging very much support the Division of Aging and Adult Services in their efforts to rebalance the long-term care system in Arkansas. We ask that the legislature, in its thoughtful deliberations, move rebalancing to the forefront as a method for not only effective, but cost-effective, long-term care.

PRIORITY REQUESTS

Division of Aging and Adult Services
Total Priority Funding Requests: (All General Revenue)

Fiscal Year 2011 - $12,692,687 (Current)
Fiscal Year 2011-2012 - $14,979,670 (**$2,286,983 increase - each year**)
Fiscal Year 2012-2013 - $15,429,060 (**$449,390 increase for 3% inflation**)

Grand Total Priority Funding Requests from the Arkansas Association of Area Agencies on Aging for the Division of Aging and Adult Services
FY2011-2012 - $14,979,670 ($2,286,983 increase) – General Revenue
FY2012-2013 - $15,429,060 ($2,736,373 increase) – General Revenue

DEVELOPMENTAL DISABILITIES SERVICE PROVIDERS

Presentation of Priority Requests for
The Community Services Oversight and Planning Council
For Fiscal Year 2012 and 2013
October 21, 2010

Background Information:
Developmental disability is a term used to describe a long-term disability that begins any time from conception through age twenty-one (21) and is attributable to mental or physical impairments or a combination of physical and mental impairments. Common developmental disabilities include mental retardation, cerebral palsy, Down syndrome, epilepsy, and autism spectrum disorder. Some persons with developmental disabilities receive services in an institutional setting because they require a level of care that can only be provided in an institution or because community-based services are not available. Other persons with developmental disabilities have the opportunity and are able to function successfully in community-based settings with appropriate supports and services.

1. **Institutional Services.**
   Persons with developmental disabilities who receive services in an institutional setting generally reside in either an Intermediate Care Facility for the Mentally Retarded/Developmentally Disabled (ICF-MR/DD) or a state-operated Human Development Center (HDC). There are six (6) HDCs in the state, and they are located in Alexander, Arkadelphia, Booneville, Conway, Jonesboro, and Warren. Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICFs-MR/DD) are classified as large –16 beds and over – or small – under 16 beds. There are four (4) large ICFs-MR/DD in the state: Easter Seals Arkansas in Little Rock, Arkansas Pediatric Facility in North Little Rock, Brownwood Life Care Center in Fort Smith, and Millcreek of Arkansas in Fordyce. These large ICFs-MR/DD serve pediatric patients and range in service capacity from 45 beds to 65 beds. There are 31 small ICFs-MR/DD across the state, all of which are operated by nonprofit community programs. A small ICF-MR/DD usually serves ten (10) to fifteen (15) individuals with developmental disabilities. There are very few private pay patients receiving services in an ICF-MR/DD or an HDC. These services are funded primarily by Medicaid, and each of the three (3) types of ICFs-MR/DD has a different reimbursement methodology.

2. **Community-based Services.**
   A. Developmental Day Treatment Clinic Services. There are approximately 100 nonprofit community programs that are licensed by the Department of Human Services/Division of Developmental Disabilities Services (DHS/DDS) to

provide Developmental Day Treatment Clinic Services (DDTCS) under the Medicaid program to approximately 10,000 children and 6,000 adults with developmental disabilities. Non-profit community programs have been designated by the General Assembly as quasi-governmental instrumentalities for the purpose of providing community-based services to persons with developmental disabilities, who would otherwise require supports and services through state-operated programs and facilities. Non-profit community programs vary significantly in size but all have strong local community support. The goal of DDTCS is to provide opportunities for the participants to maximize their ability to function independently in as normal and integrated a setting as possible. Services must be prescribed by a physician, and an Individual Service Plan is developed by an interdisciplinary team of professionals, direct care staff and parents. Providing these services is very labor intensive. Typically, the majority of staff earn only marginally more than the minimum wage.

B. Alternative Community Services Medicaid Waiver. The Alternative Community Services Medicaid Waiver provides another option for the delivery of services in community settings to individuals with developmental disabilities. The components of this service are:

*Supported Living: A community residential service that provides supervision where necessary and coordinates and/or provides support services that allow the individual with a developmental disability to maintain an independent life style. Room and board costs are paid by the consumer. Services may be provided in a variety of settings, i.e., group home, apartment, own home, etc.

*Integrated Support: A service that includes supportive living, alternative living, day habilitation services, respite care, and non-medical transportation.

*Case Management Services: Services provided by a certified case manager chosen by the consumer whose role is to locate, coordinate, and monitor an appropriate group of services for the consumer.

*Consultation Services: Consultation services provided by professionals in psychology, speech therapy, occupational therapy, physical therapy, behavioral intervention and nursing care to assist with delivery of services under the Individual Service Plan.

*Transportation Services: Transportation to and from eligible services as well as transportation when it is used to carry out objectives and goals under the Individual Service Plan.

*Adaptive Equipment/Physical Adaptations: A cash subsidy program that allows persons with developmental disabilities to purchase equipment and have adaptations made to their environment that enable the person to live more effectively and independently in the community.

*Specialized Medical Supplies: Specialized medical supplies include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and non-durable medical equipment not available under the Medicaid State plan.

*Therapy Services: Physical, speech, or occupational therapy services, as prescribed by a physician.

Again, the majority of staff employed to provide waiver services earn only marginally more than the minimum wage.

Recommendations

The following changes to the DD system would enhance service delivery to individuals with developmental across the entire continuum of available services from institutional settings to integrated community-based placements.

1. **Direct DMS with the cooperation of DDS to add adult foster care component to DDS ACS Waiver.**

   Plans of care under the DDS ACS waiver often use alternative family living arrangements to deliver services to clients. Under this arrangement, the client lives with the caregiver, and the caregiver is paid a daily rate to provide care to the client. A daily rate is allowable under an exemption to federal wage and hour law known as the companionship exemption. The use of that exemption in certain situations has been questioned by the federal Department of Labor and is a target for elimination on the federal level. Unless an alternative means of paying a daily rate is established, costs for service delivery to adults under the ACS waiver will be driven up by the increased use of hourly wages to compensate caregivers. Foster care is already available under the waiver for children. Adding an adult foster care component to the waiver will authorize the use of a daily rate for service delivery in approved host homes under the ACS Waiver. In addition, caregivers will receive the added benefit of tax exempt wages.

2. **Direct DMS with the cooperation of DDS to take action to separate DDS licensed group homes and apartments from existing DDS ACS Waiver.**

In an environment in which housing is a major challenge in terms of availability and affordability, separating waiver services delivered in DDS licensed group homes and apartments will enhance opportunities to increase use of existing housing already partially subsidized by federal funds.

3. Direct DMS to change the reimbursement methodology to allow multi-hour billing for personal care services delivered in DDS licensed group homes and apartments.

The Arkansas DD system is in desperate need of residential services. Opportunities to use empty housing already subsidized by HUD are being wasted because insufficient residential services are available to support the individuals with disabilities who are eligible to live in the subsidized housing. Permitting multi-hour billing for personal care services will be a cost effective method of delivering services for which these individuals are already eligible while taking advantage of available cost effective housing.

Please see attached bill draft for details.

4. Include in appropriation for Division of Medical Services (DMS) appropriation and funding levels necessary to satisfy federal matching requirements for reserve capacity in DDS ACS Waiver for individuals who are in the custody of DAAS and prepare a cooperative agreement between appropriate divisions of DHS to maximize resources to support DDS ACS Waiver.

SECTION 4. APPROPRIATION – GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account, as determined by the Chief Fiscal Officer of the State, for grant payments of the Department of Human Services-Division of Medical Services- Grants for the Biennium ending June 30, 2013, the following:

ITEM	*FISCAL YEARS*	
NO.	*2011-2012*	*2012-2013*
(5) HOSPITAL AND MEDICAL SERVICES	$400,000	$425,000
(GENERAL REVENUE PORTION)	**$114,480**	**$121,635**

5. Include in appropriation for Division of Medical Services (DMS) appropriation necessary to satisfy federal matching requirements for reserve capacity in DDS ACS Waiver for individuals who are in the custody of the Division of Children and Family Services (DCFS) and prepare cooperative agreement between DCFS and DMS of DHS to maximize resources to support DDS ACS Waiver. Under the

recommendation, existing DCFS general revenue currently designated for 100% SGR wrap-around services for individuals with developmental disabilities in the custody of DCFS will be more effectively used as leverage to draw down federal matching funds for Medicaid-funded DDS ACS Waiver Services.

SECTION 4. APPROPRIATION – GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account, as determined by the Chief Fiscal Officer of the State, for grant payments of the Department of Human Services-Division of Medical Services- Grants for the Biennium ending June 30, 2013, the following:

ITEM	*FISCAL YEARS*	
NO.	*2011-2012*	*2012-2013*
(5) HOSPITAL AND MEDICAL SERVICES	$4,000,000	$4,250,000
(GENERAL REVENUE PORTION)	**$0**	**$0**

6. Reduce the DDS ACS Waiver wait list.

It is critical that the DDS ACS Waiver be expanded to reduce the existing wait list. The following request would fund the first two (2) years of a four-year plan to reduce the DDS ACS Waiver wait list to two (2) years. Currently, there is an approximate waiting period of over six (6) years for persons who are not on the priority list to receive services through the waiver. These funds would enable an additional 960 persons to receive waiver services in each of the next two (2) years. There are approximately 1,700 people on the current wait list. Funds to support waiver slots would be appropriated through DHS-Division of Medical Services. Administrative costs would be appropriated through DHS-Division of Developmental Disabilities Services:

SECTION 4. APPROPRIATION – GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account, as determined by the Chief Fiscal Officer of the State, for grant payments of the Department of Human Services-Division of Medical Services- Grants for the Biennium ending June 30, 2013, the following:

ITEM	*FISCAL YEARS*	
NO.	*2011-2012*	*2012-2013*
(5) HOSPITAL AND MEDICAL SERVICES	$18,014,287	$33,257,142
(GENERAL REVENUE PORTION)	**$5,155,689**	**$9,518,194**

SECTION 3. APPROPRIATION – OPERATIONS. There is hereby appropriated, to the Department of Human Services - Division of Developmental Disabilities Services, to be payable from the paying account as determined by the Chief Fiscal Officer of the State, for personal services and operating expenses of the Department of Human Services-Division of Developmental Disabilities Services for the Biennium ending June 30, 2013, the following:

ITEM	*FISCAL YEARS*	
NO.	*2011-2012*	*2012-2013*
(12) PURCHASE OF SERVICES	$557,142	$1,028,572
(GENERAL REVENUE PORTION)	**$278,571**	**$514,286**

7. Provide funding for regional cooperatives to provide specialized supports for clients receiving DDS ACS Waiver services.

The regional cooperative concept involves the establishment of a provider driven infrastructure to support the delivery of waiver services through the formation of nonprofit organizations governed by certified waiver providers in designated regions of the state. The cooperatives would be a mechanism for members to arrange for centralized access to specialized supports for individuals with developmental disabilities who receive services under the ACS Waiver. The figures below assume the start-up of two (2) regional cooperatives in FY12 and three (3) regional cooperatives in FY13.

SECTION 6. APPROPRIATION – GRANTS-IN-AID. There is hereby appropriated, to the Department of Human Services - Division of Developmental Disabilities Services, to be payable from the Division of Developmental Disabilities Services Fund Account, for grants-in-aid to the community providers of services to the developmentally disabled by the Department of Human Services-Division of Developmental Disabilities Services for the Biennium ending June 30, 2013, the following:

ITEM	*FISCAL YEARS*	
NO.	*2011-2012*	*2012-2013*
(5) GRANTS TO COMMUNITY PROVIDERS	$1,079,200	$2,698,000
(GENERAL REVENUE PORTION)	**$539,600**	**$1,349,000**

8. Amend state law to authorize a provider fee on waiver services.

Federal law permits the establishment of healthcare-related provider fees that satisfy certain criteria. Broadly, these criteria require that the fee be broad-based, uniform, and offer no guarantee that any provider in the class being assessed will receive additional reimbursement equal to or exceeding the amount of its fee. The provider fee is typically established in a state law that

authorizes the collection of revenue from a specified category of healthcare provider. The fee is then used as a mechanism to generate "new" in-state funds and match them with federal funds so that the state gets additional federal Medicaid dollars. Because provider fee revenue grows with medical spending, it is more stable and less susceptible to changes in the business cycle than other traditional revenue sources. Amending state law to authorize the imposition of a provider fee on waiver services would allow the state to leverage additional federal funds to support community-based services for individuals with developmental disabilities.

9. Fund an additional 140 small ICFs-MR/DD beds to provide community-based supports and services to individuals with developmental disabilities needing an intermediate level of long-term care and supports.

In 1989, 300 ICFs-MR/DD beds were authorized and developed in 30 communities around the state which provided a community-based option for individuals with developmental disabilities needing long-term intermediate care. The additional 140 beds requested would provide a community-based option for the more intense level of long-term care required for individuals with complex medical needs who desire and are able to live in the community.

SECTION 4. APPROPRIATION – GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account as determined by the Chief Fiscal Officer of the State, for grant payments of the Department of Human Services-Division of Medical Services - Grants for the Biennium ending June 30, 2013, the following:

ITEM NO.	*FISCAL YEARS 2011-2012*	*2012-2013*
(1) PRIVATE NURSING HOME CARE	$12,876,586	$13,134,119
(GENERAL REVENUE PORTION)	**$3,685,279**	**$3,758,985**

10. Base Level Funding Adjustment

Current economic conditions, including substantially increased costs over time related to fuel and health and liability insurance rates, mandated increases in minimum wage, difficulties in recruitment and retention of qualified staff, and other 'unfunded mandates' combine to dramatically impact the cost of service delivery to persons with developmental disabilities. There is currently not a mechanism in place to address these constant and open-ended increases in the personnel and operating costs of providing Developmental Day Treatment

Clinic Services (DDTCS). Further, the nonprofit community programs delivering these services frequently wait several years between rate adjustments despite the fact that these programs have been designated by the General Assembly as quasi-governmental instrumentalities that provide services to persons with developmental disabilities that would otherwise be provided through state-operated programs and facilities. The specific programs involved are DDTCS Children's Development, DDTCS Adult Development, and DDTCS Transportation.

In the event that a cost-of-living-adjustment is authorized for state employees during either or both FY12 or FY13, a rate equivalent to eighty-five percent (85%) of the cost-of-living-adjustment for state employees would be applied to the base level funding of the DDTCS programs over and above the 2011 fiscal amounts.

SECTION 4. APPROPRIATION – GRANTS. There is hereby appropriated, to the Department of Human Services - Division of Medical Services, to be payable from the paying account as determined by the Chief Fiscal Officer of the State, for grant payments of the Department of Human Services-Division of Medical Services - Grants for the Biennium ending June 30, 2013, the following:

ITEM	*FISCAL YEARS*	
NO.	*2011-2012*	*2012-2013*
(5) HOSPITAL AND MEDICAL SERVICES	$3,024,352	$3,224,548
(GENERAL REVENUE PORTION)	**$865,713**	**$922,866**

PRIORITY REQUESTS

Grand Total Priority Funding Requests from Developmental Disabilities Service Providers for the Division of Developmental Disabilities Services and the Division of Medical Services
FY2011-12 - $10,639,332 (General Revenue)
FY2012-13 - $16,184,966 (General Revenue)