



PERFORMANCE AUDIT REPORT

Kansas Neurological Institute: Evaluating the Efficiency of the Institute's Operations and the Cost and Safety Implications of Moving Its Residents into Local Communities

**A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
December 2011**

Legislative Post Audit Committee

Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about \$14 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

We conduct our audit work in accordance with applicable government auditing standards set forth by the U.S. Government Accountability Office. These standards pertain to the auditor's professional qualifications, the quality of the audit work, and the characteristics of professional and meaningful reports. The standards also have been endorsed by the American Institute of Certified Public Accountants and adopted by the Legislative Post Audit Committee.

The Legislative Post Audit Committee is a bipartisan committee comprising five senators and five representatives. Of the Senate members, three are appointed by the President of the Senate and two are appointed by the Senate Minority Leader. Of the Representatives, three are appointed by the Speaker of the House and two are appointed by the Minority Leader.

Audits are performed at the direction of the Legislative Post Audit Committee. Legislators

or committees should make their requests for performance audits through the Chairman or any other member of the Committee. Copies of all completed performance audits are available from the Division's office.

LEGISLATIVE POST AUDIT COMMITTEE

Representative John Grange, Chair
Representative Tom Burroughs
Representative Ann Mah
Representative Peggy Mast
Representative Virgil Peck Jr.

Senator Mary Pilcher-Cook, Vice-Chair
Senator Terry Bruce
Senator Anthony Hensley
Senator Laura Kelly
Senator Dwayne Umbarger

LEGISLATIVE DIVISION OF POST AUDIT

800 SW Jackson
Suite 1200
Topeka, Kansas 66612-2212
Telephone (785) 296-3792
FAX (785) 296-4482
E-mail: LPA@lpa.ks.gov
Website: <http://www.kansas.gov/postaudit>
Scott Frank, Legislative Post Auditor

HOW DO I GET AN AUDIT APPROVED?

By law, individual legislators, legislative committees, or the Governor may request an audit, but any audit work conducted by the Division must be directed by the Legislative Post Audit Committee, the 10-member joint committee that oversees the Division's work. Any legislator who would like to request an audit should contact the Division directly at (785) 296-3792.

The Legislative Division of Post Audit supports full access to the services of State government for all citizens. Upon request, Legislative Post Audit can provide its audit reports in large print, audio, or other appropriate alternative format to accommodate persons with visual impairments. Persons with hearing or speech disabilities may reach us through the Kansas Relay Center at 1-800-766-3777. Our office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.



LEGISLATURE OF KANSAS
LEGISLATIVE DIVISION OF POST AUDIT

800 SOUTHWEST JACKSON STREET, SUITE 1200
TOPEKA, KANSAS 66612-2212
TELEPHONE (785) 296-3792
FAX (785) 296-4482
WWW.KSLEGISLATURE.ORG/POSTAUDIT

December 8, 2011

To: Members, Legislative Post Audit Committee

| | |
|-----------------------------------|---------------------------------------|
| Representative John Grange, Chair | Senator Mary Pilcher-Cook, Vice-Chair |
| Representative Tom Burroughs | Senator Terry Bruce, |
| Representative Ann Mah | Senator Anthony Hensley |
| Representative Peggy Mast | Senator Laura Kelly |
| Representative Virgil Peck Jr. | Senator Dwayne Umbarger |

This report contains the findings, conclusions, and recommendations from our completed performance audit, *Kansas Neurological Institute: Evaluating the Efficiency of the Institute's Operations and the Cost and Safety Implications of Moving Its Residents into Local Communities*.

The report also contains appendices showing how certain individuals with developmental disabilities living in a community setting are distributed across Kansas, and the methodology, assumptions, and limitations related to our cost-savings estimates. Additional appendices include three CDDO region's average cost estimates to serve five KNI residents we reviewed in detail, as well as a selection of survey comments from parents and guardians, medical professionals, community service providers, and KNI direct care staff related to the possibility of relocating KNI residents into the community.

The report includes several recommendations for the Kansas Neurological Institute, the Department of Social and Rehabilitation Services, and the Legislature. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials. These findings are supported by a wealth of data, not all of which could be included in this report because of space considerations. These data may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

Scott Frank
Legislative Post Auditor

This audit was conducted by Katrin Osterhaus, Joseph Cullen, Matt Etzel, Brad Hoff, and Heidi Zimmerman. Justin Stowe was the audit manager. If you need any additional information about the audit's findings, please contact Katrin Osterhaus at the Division's offices.

Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612

(785) 296-3792
Website: <http://www.kansas.gov/postaudit>

Table of Contents

Question 1: What Opportunities Exist for the Kansas Neurological Institute To Decrease Costs or Increase Revenues Through Improved Use of Its Resources and Restructuring Non-Essential Services?

| | |
|--|----------------|
| <i>We Thoroughly Reviewed KNI's Operations To Identify Ways It Could Reduce Costs or Increase Revenues.....</i> | page 13 |
| <i>KNI Could Save \$266,000 in State Funds Annually and Generate \$546,000 in One-Time Revenues With Little Or No Effect on KNI Residents or Services.....</i> | page 15 |
| <i>KNI Could Save \$388,000 in State Funds Annually by Reducing Several Staff Positions, Potentially Affecting Residents But Not Eliminating Any Essential Services.....</i> | page 20 |
| <i>KNI Could Save \$539,000 State Funds Annually By Changing How it Delivers Two Core Services, Likely Affecting Most Residents.....</i> | page 23 |
| <i>Few Opportunities Exist For KNI To Generate Significant Ongoing Revenues By Charging for Certain Services.....</i> | page 26 |
| Conclusion..... | page 27 |
| Recommendations..... | page 28 |

Question 2: What Are the Cost and Safety Implications of Moving Current Kansas Neurological Institute Residents to Local Communities?

| | |
|--|---------|
| <i>A Network of Providers Deliver Services in the Community That Are Funded by Federal, State, And Local Moneys.....</i> | page 30 |
| <i>In General, Individuals With Severe Developmental Disabilities Can Be Served In the Community, But There May Be Exceptions.....</i> | page 32 |
| <i>KNI and Local Communities Provide Similar Core Services, But Provide Medical Services Differently.....</i> | page 34 |
| <i>Serving KNI Residents In The Community Could Save the State About \$5 Million a Year, Once All The Residents Are Relocated.....</i> | page 36 |
| <i>The State Would Realize Savings by Cutting Some Costs and Shifting Other Costs to Service Providers.....</i> | page 38 |
| <i>Community Service Providers Would Need To Use a Number of Cost-Containment and Revenue Producing Strategies to Avoid Losses.....</i> | page 41 |
| <i>The State Doesn't Track Certain Safety Outcomes for Developmentally Disabled Adults to Allow for Good Comparisons Between KNI and the Community.....</i> | page 43 |
| <i>Many Stakeholders Expressed Concerns About Addressing KNI Residents' Medical Needs in the Community.....</i> | page 44 |
| <i>Fewer Stakeholders Expressed Concerns about Addressing Residents' Behavioral Needs, but Some Residents May Have Trouble Adapting to Community-Based Services.....</i> | page 45 |

| | |
|---|----------------|
| <i>Community Providers May Struggle to Offer the Same Continuity of Care That Residents Receive at KNI.....</i> | <i>page 48</i> |
| <i>Stakeholders Strongly Disagree on Whether KNI Residents' Quality of Life Would Improve or Worsen in a Community Setting.....</i> | <i>page 49</i> |
| <i>Transitioning Residents From KNI to the Community Would Take Time and Money.....</i> | <i>page 52</i> |
| Conclusion..... | page 53 |
| Recommendations | page 53 |

List of Figures

| | |
|---|---------|
| Figure OV-1: KNI Resident, Expenditure, and Staff Trends Since 2000..... | page 8 |
| Figure OV-2: KNI's Funding and Operating Expenditures, Fiscal Year 2010..... | page 9 |
| Figure 1-1: Summary of Cost Saving and Revenue Enhancement Actions with Little to No Impact on KNI Residents..... | page 16 |
| Figure 1-2: KNI Campus Land and Building Map..... | page 20 |
| Figure 1-3: Summary of Cost Saving Actions That Reduce Staffing Levels But Don't Eliminate Essential Services..... | page 22 |
| Figure 1-4: Summary of Cost Saving Actions That Will Likely Affect Residents Through Comprehensive Service Delivery Changes..... | page 24 |
| Figure 2-1: Glossary of Important Terms and Concepts..... | page 31 |
| Figure 2-2: Comparison of KNI Residents and Individuals Living in the Community..... | page 33 |
| Figure 2-3: Sources of Savings by Cost Category Based on KNI Expenditures and Community Setting Reimbursements..... | page 38 |
| Figure 2-4: Summary of Survey Responses to Questions Related to Medical Services by Respondent Group..... | page 46 |
| Figure 2-5: Residential Bedrooms and Bathrooms at KNI and in the Community..... | page 51 |

List of Appendices

| | |
|---|---------|
| Appendix A: Scope Statement..... | page 55 |
| Appendix B: Information on Cost Savings and Revenue Enhancement Ideas We Found That Were Not Feasible or We Didn't Pursue..... | page 57 |
| Appendix C: Distribution of Adults with Developmental Disabilities Served in Community Settings Throughout Kansas..... | page 58 |
| Appendix D: Methodology for Estimating Costs and Savings to Move KNI Residents to a Community Setting..... | page 61 |
| Appendix E: Summary of Five KNI Resident Reviewed | page 64 |
| Appendix F: Summary of KNI Stakeholders Survey Information..... | page 66 |
| Appendix G: Agency Response..... | page 69 |

Kansas Neurological Institute: Evaluating the Efficiency of The Institute's Operations and the Cost and Safety Implications of Moving Its Residents Into Local Communities

The Kansas Neurological Institute (KNI) in Topeka is an intermediate-care facility for individuals with developmental disabilities. Since the early 1990s, KNI has treated residents using a “person-centered” approach that focuses on allowing residents to experience as independent and normal a lifestyle as possible. This approach moves away from scheduled routines and focuses on having residents participate with staff in activities such as grocery shopping, laundry, and attend community events like movies and basketball games. To accomplish this, KNI administers several programs including:

- Support Living Services—support teams develop, implement, and monitor each resident's treatment and support plan.
- Community Services—staff coordinate resident community outreach services in areas such as dental care, behavioral support, assistive technology, and medical evaluations.
- Ancillary Services—staff provide clinical and therapeutic services for residents.
- Medical and Surgical Services—staff evaluate, monitor, and treat illnesses and injuries, and help prevent infectious disease.

The number of staff and residents at KNI has steadily declined over time. Since 1995, KNI staff levels have decreased from 815 to 491 as of August 2011, or 40%; while the number of residents has declined from 254 to 153, or 40%, during that timeframe. In fiscal year 2010, KNI spent a total of \$28.6 million (including \$8.1 million in State appropriations and \$19 million in Medicaid). Most of those costs, about \$24 million, were for salaries and wages; remaining expenditures covered such things as contractual services and commodities.

Legislators have expressed interest in knowing whether KNI provides services to community members that it doesn't charge for, whether some KNI services could be made available to others in the community, and whether KNI is using its building and land resources efficiently. Additionally, legislators would like to know how much it could cost to move KNI residents into local communities and how such a move might affect the overall safety and well-being of the current residents.

This performance audit addresses the following questions:

- 1. What opportunities exist for the Kansas Neurological Institute to decrease costs or increase revenues through improved use of its resources and restructuring non-essential services?**
- 2. What are the cost and safety implications of moving current Kansas Neurological Institute residents to local communities?**

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in *Appendix A*. For reporting purposes, we've collapsed the first two questions into one.

To answer the first question, we reviewed a number of publications and interviewed officials from KNI, SRS, and several community organizations that serve Kansas' developmentally disabled population to learn about KNI operations, and to identify possible cost saving or revenue enhancement opportunities. For the ideas we decided to pursue, we analyzed KNI expenditure and personnel data, and compared those data to similar data from Parsons State Hospital and Training Center (Parsons State Hospital)—the State's only other institution for individuals with developmental disabilities.

We also analyzed KNI's vehicle fleet information, toured KNI grounds and facilities, and analyzed building usage based on several resident and staffing scenarios. Further, we interviewed officials from the Division of Health Care Finance within KDHE, the Department of Administration, and the federal Centers for Medicare and Medicaid Services (CMS) regarding certain Medicaid-related issues. Lastly, we reviewed relevant policies and contracts to estimate potential savings or revenue enhancements.

To answer the second question, we reviewed national and Kansas trends on deinstitutionalization of developmentally disabled individuals. We also surveyed parents and guardians of KNI residents, KNI staff, community service providers, and medical professionals about their opinions on moving KNI residents into the community. We further evaluated the inspection requirements and reporting process for abuse, neglect and exploitation within both systems, and looked for studies or data to evaluate potential safety implications.

To determine how much the State spends to serve KNI residents, we analyzed KNI expenditures as well as relevant Medicaid and Medicare costs. Based on expenditures for a comparison population in the community, we estimated what the total and State portion of costs would be if KNI residents were served in the community, and calculated estimated total and State savings.

We also selected five KNI residents and worked with three Community Developmental Disability Organization regions to determine whether service providers could provide applicable services to those individuals, and what the estimated total cost would be. In addition, we toured several group homes and service sites in the community to gain an understanding of the differences and similarities between the two systems, and to evaluate the potential safety implications of moving KNI residents into the community.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. As part of the standards, the U.S. Government Accountability Office requires us to assess the sufficiency and appropriateness of computer-processed data. To comply with this standard, we performed data reliability work on the following datasets:

- Personnel data (SHARP) for KNI and Parsons State Hospital
- Financial data (STARS) for KNI
- KNI vehicle data
- Basic Assessment and Services Information System (BASIS) – SRS database providing demographic, service, assessment and other information on developmentally disabled individuals across Kansas
- Medicaid and Medicare data

Among other things, we performed analytic test work for accuracy and completeness for each of these datasets and determined the data to be sufficiently reliable. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our findings begin on page 13, following an overview of KNI's operations and national and State trends in serving individuals with developmental disabilities.

KNI is One of Two State Institutions That Serve Individuals with Developmental Disabilities

Individuals with developmental disabilities include people who have a low intellectual functioning and require special protection and services, as well as individuals with disabilities such as epilepsy, cerebral palsy, and autism. The box below provides Kansas' statutory definition of an individual with developmental disabilities.

Statutory Definition of Developmental Disability

Based on K.S.A. 39-1803(f), a person is developmentally disabled if he or she is diagnosed as such or has a severe chronic disability which:

- is attributable to a mental or physical impairment, a combination of mental and physical impairments or a condition which has received a dual diagnosis of mental retardation and mental illness;
- is manifest before 22 years of age;
- is likely to continue indefinitely;
- results, in the case of a person five years of age or older, in a substantial limitation in three or more of the following areas of major life functioning: Self-care, receptive and expressive language development and use, learning and adapting, mobility, self-direction, capacity for independent living and economic self-sufficiency;
- reflects a need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are lifelong, or extended in duration and are individually planned and coordinated
- and doesn't include individuals who are solely and severely emotionally disturbed or seriously or persistently mentally ill or have disabilities solely as a result of the infirmities of aging.

Kansas provides supported living and medical services to individuals with developmental disabilities in both institutional and community settings. We discuss services provided in a community setting in more detail in Question 2.

Since 1998, Kansas has had only two public institutions for individuals with developmental disabilities. Between 1968 and 1988, Kansas had four public institutions for individuals with developmental disabilities. Norton State Hospital closed in 1988 and Winfield State Hospital closed in 1998. Upon closing, residents in those two hospitals either moved into local communities or into one of the State's remaining institutions—KNI and Parsons State Hospital and Training Center.

Both KNI and Parsons State Hospital are intermediate care facilities for individuals with developmental disabilities (ICFMR), and operate under SRS. Both of the institutions provide ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or habilitation services for people with developmental disabilities. The ICFMR designation also means that Medicaid pays for almost all of the facilities' operations.

As of August 2011, KNI provided direct care, medical, and therapeutic services to 153 residents. Currently, KNI serves only developmentally disabled adults. Many KNI residents have lived at the facility since their childhood, and more than 90% of the current residents have lived at KNI for 10 years or more. Residency at KNI is voluntary, and KNI residents currently have a guardian who makes decisions on their behalf.

Services provided to the 153 residents are based on a “person-centered” approach. Under this approach, direct-care staff help residents participate in activities such as cooking, laundry, grocery shopping, and attend community activities such as movies or basketball games. As part of that approach, KNI created “self-directed work teams” to better tailor activities to meet individuals’ needs and wants.

KNI staff also provide services for developmentally disabled individuals living in the community. KNI’s goal is to care for residents’ health, provide opportunities of choice to residents, promote personal relationships among the residents, and encourage participation in the community. During the 1990s—around the same time as the facility adopted its new person-centered planning approach—KNI became a regional resource center for northeast Kansas. Here’s a summary of services provided to the community:

- **KNI provides a number of free medical and wrap-around services.** These include dental services, posture seating for individuals in wheelchairs, behavioral support services (to help keep people in their home communities), and assistive technology (such as tailored computer keyboards, speech devices or other information technologies).
- **KNI offers research and education services to community members intended to benefit the developmentally disabled community at large.** Part of KNI’s mission is to train personnel and research the causes, prevention, and proper methods of treatment and training of individuals with developmental disabilities. KNI provides online training courses for its employees, which are also available to others who work with individuals with developmental disabilities.

In recent years, stakeholders have sought to close or reduce the size of KNI and Parsons State Hospital. Here’s a summary of those efforts:

- **In March 2004, the Developmental Disabilities Services Task Force recommended that the Legislature should consider closing one of the two State hospitals.** SRS convened the task force in response to a request from the Special Committee on

Appropriations/Ways and Means. The task force reviewed several options for the State's developmental disability hospitals.

- **In January 2010, Governor Parkinson rejected a recommendation to close KNI but called for a gradual reduction in its residents.** Former Governor Sebelius created the Closure and Realignment Commission in 2009 to evaluate State-owned and operated facilities for potential closure, realignment, or alternative uses. KNI and Parsons State Hospital were among the facilities reviewed. Among other things, the report recommended closing KNI and having SRS review KNI residents for placement in the community or transfer to Parsons State Hospital.
- **In January 2011, Governor Brownback proposed a plan to close KNI over a period of 23 months, beginning in July 2011.** During the 2011 legislative session, the Senate Ways and Means committee voted not to close KNI, while the House Appropriations committee endorsed the Governor's proposal. In April, the Topeka legislative delegation requested Legislative Division of Post Audit to evaluate the financial and safety consequences of closing KNI. Partly due to the lack of legislative support, the Governor announced in September 2011 he was not going to seek KNI closure during the 2012 legislative session.

Although KNI's Resident Population Has Steadily Declined Over the Last Decade, Its Expenditures Per Resident Increased by Almost 40%

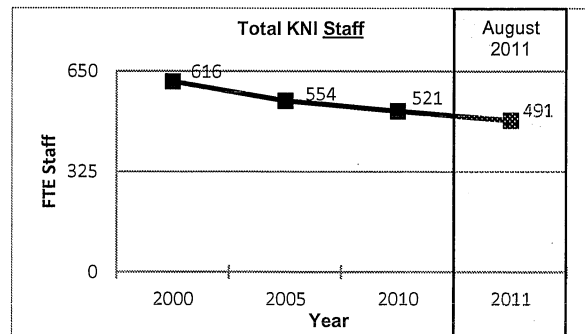
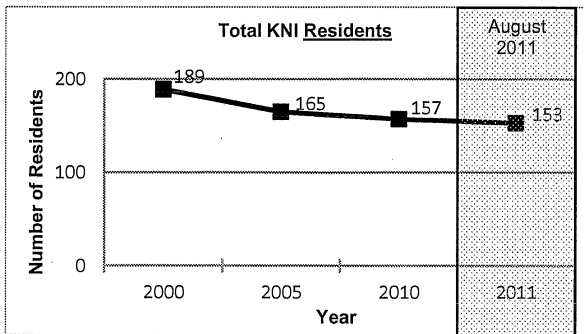
Since its peak resident population of 450 in 1971, KNI's population has steadily declined. We reviewed KNI's resident population and its expenditures over time to see how they compared.

Since fiscal year 2000, the number of residents served by KNI has decreased by an average of three residents a year. KNI receives few residents because individuals must be served in the "least restrictive environment" (discussed in the section below), and because aging residents continue to pass away. As *Figure OV-1* on the next page shows, the KNI resident population further dropped from 189 in fiscal year 2000 to 157 in 2010, a decrease of 17%. Just two months into fiscal year 2012, KNI's population had declined to 153 residents. At this rate of decline, KNI will eventually reach a point at which operating the facility won't be feasible.

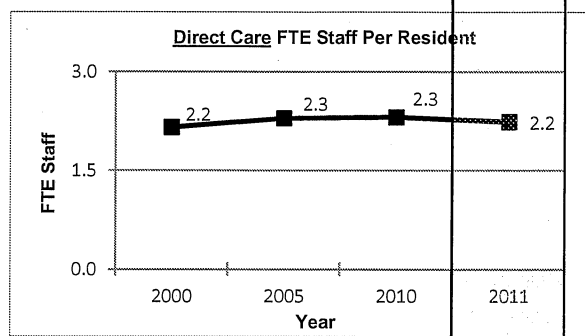
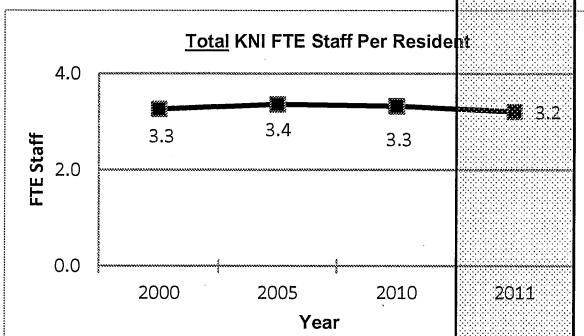
KNI's expenditures per resident have increased by almost \$50,000 since fiscal year 2000. *Figure OV-1* shows annual expenditures per KNI resident have increased from almost \$133,000 to \$182,000 in fiscal year 2010, an increase of 37%. However, when inflation is taken into account, the 10-year increase is a more modest 7%.

Figure OV-1
KNI Resident, Expenditure, and Staff Trends Since 2000

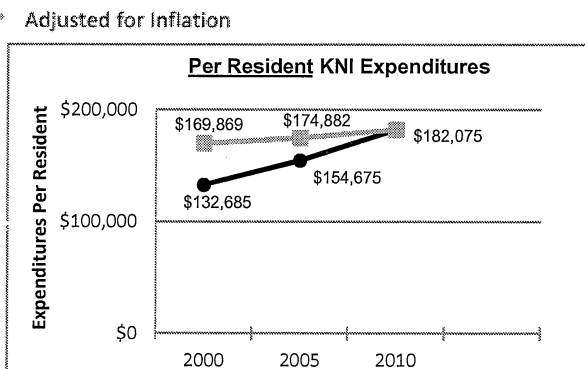
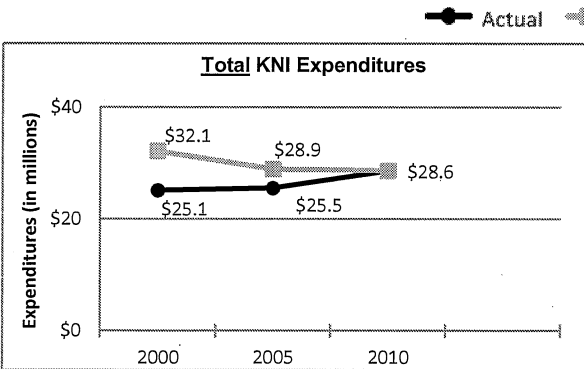
Resident and Staff Trends



Per Resident Staff Trends



Expenditure Trends



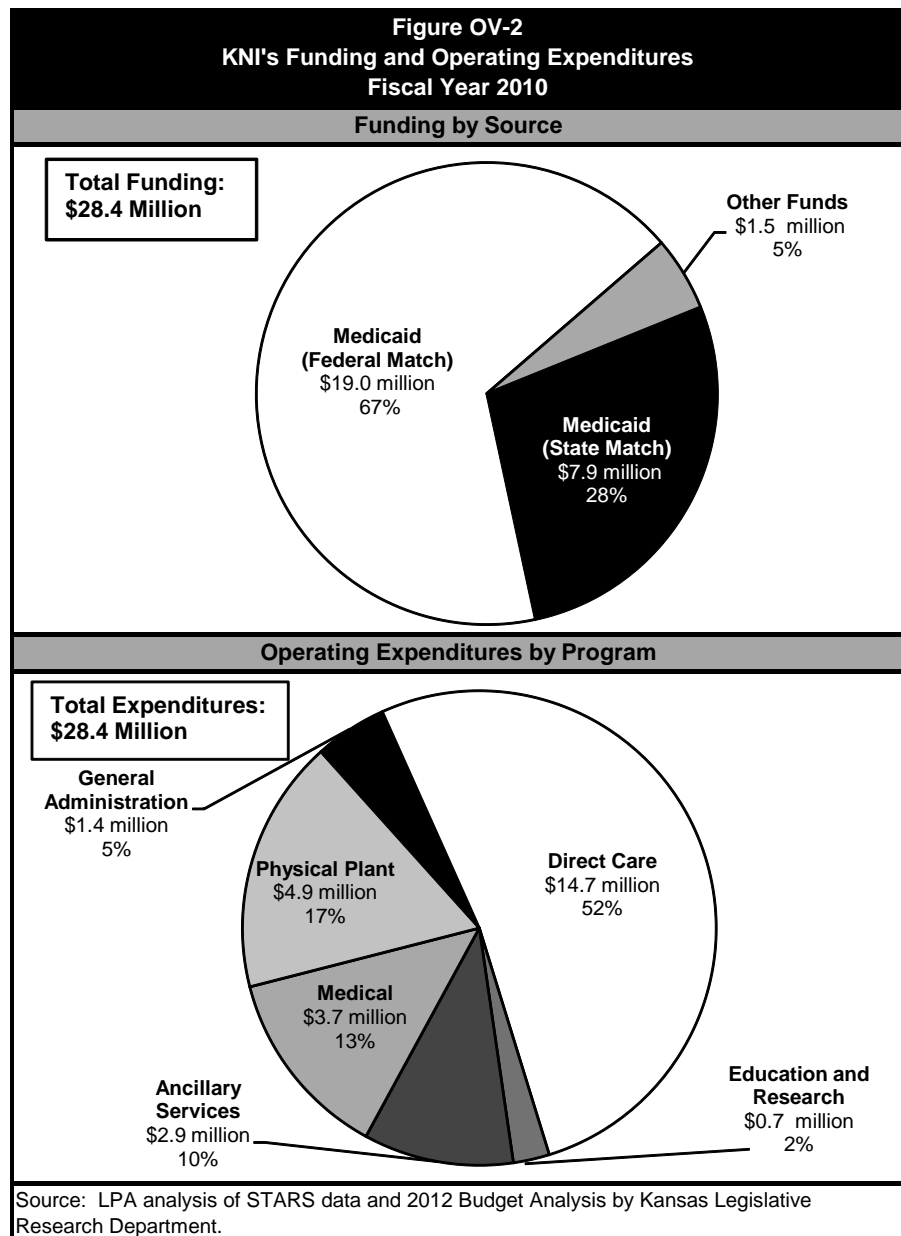
Source: LPA analysis of STARS data; Fiscal Year 2002, 2007, and 2012 Governor's Budget Report; and Fiscal Year 2000, 2005, and 2010 Budget Analysis by Kansas Legislative Research Department.

We analyzed detailed expenditure data for KNI dating back to fiscal year 2003. The per-resident cost increase from 2003 to 2010 is driven by two primary factors:

- **Salaries and wages have increased by 19% since 2003.** Almost 60% of that increase is due to benefits, the largest of which is KPERS and health benefits. The remainder is for salary adjustments made over time. For example, a large portion of direct care staff were reclassified in 2006, which increased salaries for that group.

- **Overhead costs have increased by 25% since 2003.** Operating a campus as large as KNI requires certain “fixed” costs, such as those associated with the KNI power plant, building maintenance, custodial services, and grounds keeping. Because these costs aren’t dependent on the number of KNI residents, per-resident overhead expenditures will increase as the KNI population decreases.

Conversely, staffing levels have not contributed to the rise in per resident costs. Overall staff ratios remained constant from fiscal year 2000 to 2010, at around 3.3 staff per resident. As of August 2011, KNI’s total staff ratio dropped to 3.2. The Governor’s voluntary retirement plan in the current fiscal year is likely to somewhat lower that ratio again.



KNI's expenditures for fiscal year 2010 were \$28.6 million, almost all of which were paid for through Medicaid. As mentioned earlier, KNI's status as an ICFMR means most of the facility's funding comes from Medicaid, a program that is jointly funded by the State and federal government to provide basic medical care to the needy. Historically, the federal government has paid about 60% of the cost, and Kansas paid the remaining 40%.

In order to get Medicaid funding, KNI calculates a per diem cost for each resident based on its annual reimbursable expenditures. **Figure OV-2** on the previous page shows KNI's current funding and expenditure levels. As the figure shows:

- **Half of KNI's expenditures were for direct care services.** Other expenditures included medical and surgical services, and physical plant and central services.
- **95% of KNI's operations were funded through Medicaid.** Although the State/federal split is normally around 40%/60%, additional federal funding through the American Recovery and Reinvestment Act (ARRA) resulted in an unusual 30%/70% split in fiscal year 2010.

Kansas Has Followed the National Trend of Moving Individuals with Developmental Disabilities From Institutions into the Community

Historically, individuals with developmental disabilities were admitted to institutional settings to provide the necessary medical and behavioral services because few community options existed. However, over the past 20 years there has been a national movement to place individuals with developmental disabilities in the community, near their families.

Nationwide, the number of individuals with developmental disabilities who are served in public institutions has decreased significantly. The number of individuals with developmental disabilities living in large, public institutions has decreased from just under 85,000 in 1990 to approximately 33,000 in 2010; a decrease of 60%. In addition, about 150 large public institutions (those that serve at least 16 residents) have closed nationwide since 1969.

Several factors account for this trend, including the rising costs of services, and families not wanting their relatives to live in an institutional setting. Additionally, the 1999 United States Supreme Court case "*Olmstead v. L.C.*, 527 U.S. 581 (1999)" contributed to that trend. The Supreme Court found that "unjustified institutional isolation of people with disabilities is a violation of the Americans with Disabilities Act of 1990."

As part of its decision, the Court required states to provide community-based services for persons with disabilities when possible.

Ten states and the District of Columbia currently don't serve any individuals with developmental disabilities in public institutions. The states closed these facilities between 1972 and 2009. Officials in some of these states told us that the individuals who left institutions generally live with family members, in adult foster homes, or in group homes. In some cases, individuals with developmental disabilities were transferred to ICFMR facilities in other states.

Similar to other states, Kansas has significantly reduced the number of individuals with developmental disabilities living in public institutions. Since the 1980's, Kansas has placed an increasing emphasis on serving individuals with developmental disabilities in the community. In 1983, Kansas became one of the first four states to implement a Home and Community Based Services (HCBS) waiver for developmentally disabled individuals. The HCBS waiver is a joint State and federal program designed to provide services to qualifying individuals with developmental disabilities in a community setting, rather than in an institution.

Further, Kansas' Developmental Disabilities Reform Act of 1996 encouraged community organizations to help individuals with developmental disabilities in an effort to move more people from institutions to the community. Under the Act, a network of Community Developmental Disability Organizations are required to evaluate individuals' service needs and to provide them in the least restrictive environment. Because providers have become more capable of meeting the needs of individuals in the community, few individuals are referred to KNI anymore.

In Question 1, we identified ways that KNI could save money or enhance its revenues. In Question 2, we evaluated the cost and safety implications of closing KNI and moving its residents into the community.

Question 1: What Opportunities Exist for the Kansas Neurological Institute To Decrease Costs or Increase Revenues Through Improved Use of Its Resources and Restructuring Non-Essential Services?

Answer in Brief:

We identified a number of opportunities for the Kansas Neurological Institute (KNI) to reduce costs or increase revenues. We organized these opportunities into three groups, based on how they would affect residents.

First, KNI could save about \$266,000 in State funds annually and realize about \$550,000 in one-time revenue enhancements by billing Medicare for durable medical equipment, and selling unused land tracts. These actions would have little or no effect on KNI residents or services. Second, KNI could save about \$388,000 in State funds annually by reducing staff in a number of areas, such as direct care, medical services and staff education. These changes could affect residents but would not eliminate any essential services. Lastly, we found the largest savings in two areas which would change some aspects of how KNI provides certain services, would likely affect most residents, and could have negative consequences. These actions included consolidating KNI's population from four into three residential buildings, and closing the KNI medical unit. Savings in this area could total to \$540,000 in State funds annually. We also found that KNI has few opportunities to generate significant ongoing revenues by charging for services it currently offers, and potential service options stakeholders have suggested.

These and related findings are discussed in more detail in the sections that follow.

We Thoroughly Reviewed KNI's Operations To Identify Ways It Could Reduce Costs Or Increase Revenues

We examined the Kansas Neurological Institute's (KNI) operations to identify potential areas where it could reduce costs or generate revenues. To accomplish this, we:

- interviewed officials from SRS and various stakeholders about their ideas
- studied KNI's expenditure and staffing trends to identify cost drivers and outliers
- compared KNI expenditure and staffing data with similar data from Parsons State Hospital
- toured buildings and observed operations at the KNI campus

Based on this work, we identified a number of potential areas to improve efficiency that we analyzed further. In addition, there were other areas that we initially identified but did not pursue. These ideas are summarized in *Appendix B*. In general, we didn't pursue options that would fundamentally reduce or eliminate essential services at KNI.

We categorized actions that yielded cost savings or revenue enhancements into the following three groups, based on their potential impact on KNI residents and services:

- **Actions that would have little to no effect on KNI residents and should be implemented.** While some of these options may affect certain aspects of residents' daily routines or change how KNI operates the campus, they will have little effect on KNI residents' safety or quality of life, for example, selling the superintendent's house.
- **Actions that could affect KNI residents by reducing staffing, but should be considered because they don't eliminate essential services.** Options in this category would affect KNI residents by reducing a handful of staff persons, which could lead to some services being provided less frequently or being provided off campus. Reducing the number of dental staff and providing dental cleanings more efficiently is an example of this type of action.
- **Actions that change some aspects of how KNI provides certain services and likely affect most residents.** Not surprisingly, these ideas yielded the largest possible cost savings, but could also affect residents' quality of life or safety. For example, eliminating KNI's medical unit likely would increase hospital admissions for some residents. Although these actions are the most aggressive we evaluated, they should be considered because KNI has been taking similar actions as a result of its decreasing resident population, and because they are a more cost-efficient service delivery model.

Cost savings in each of the last two categories cannot be added together because some of them have overlapping components.

Although we worked with staff information as current as August 2011, it should be noted that staffing levels change frequently in a large agency such as KNI and create a moving target. For example, as of October 2011, KNI officials lost 27.5 FTE staff as a result of the Governor's retirement incentive program. SRS officials indicated that KNI needs to leave 16 of these positions unfilled. Because we don't know which positions will remain vacant in the future, we couldn't adjust our savings estimates, but were told KNI may address some of the staff cuts we suggested as part of this process.

Secondly, officials can reallocate staff through position reclassifications, and have recently done so for 1.5 custodial positions. Once those positions are filled, it can change the number of staff within and across programs. Our staffing analyses are based on filled positions at specific points in time.

Finally, KNI officials raised a number of concerns about the effect many of the cost savings actions we identified could have on KNI residents. We can't fully assess the legitimacy of some of these intangible concerns, but have summarized and assessed them as best we can.

The following sections detail our findings in each of these three areas.

KNI Could Save \$266,000 in State Funds Annually and Generate \$546,000 in One-Time Revenues With Little Or No Effect on KNI Residents Or Services

The cost savings actions presented in this section require few changes to KNI's operations and should have little to no effect on KNI residents or services. These six actions focus on assets or staffing levels that seemed excessive given KNI's current resident population, and aren't necessary to provide essential services.

Figure 1-1 on pages 16 and 17 provides a summary of cost savings and revenue enhancements in this category. The figure also lists concerns KNI officials had with each item, as well as our assessment of those concerns.

KNI could bill Medicare for most of its durable medical equipment, saving up to \$166,000 in State funds annually.

Durable medical equipment includes such things as wheelchairs, feeding equipment, and oxygen tanks. KNI purchases durable medical equipment through Medicaid, of which the State pays 40% of the costs. However, because more than 80% of KNI residents are also Medicare eligible (so-called dual-eligible individuals), most of these costs could be billed to Medicare—with the federal government covering 100% of costs. Based on KNI's fiscal year 2011 expenditures for durable medical equipment, we estimate the State could save \$166,000 a year by billing Medicare.

KNI officials explored the possibility of billing Medicare for durable medical equipment in 2009, but were told by the Kansas Health Policy Authority (at that time, the State's Medicaid agency) that this was not allowed. However, during the course of this audit, we interviewed officials from KDHE's Division of Health Care Finance (the State's current Medicaid agency) who agreed that it is permissible to bill Medicare. As a

result of our findings and the new guidance from the Division of Health Care Finance, KNI officials began a pilot program in October 2011. Officials anticipate broadening this effort after the logistical and administrative issues are worked out.

KNI could eliminate four staff and hire a part-time physical therapist, saving \$79,000 in State funds annually (\$198,000 in total funds). We reviewed KNI staffing over time, evaluated a number of staff ratios, and compared KNI data to similar data we compiled for Parsons State Hospital. We also reviewed KNI staff's role in various community services it provides. Lastly, we reviewed contractual agreements to determine whether KNI could operate more efficiently.

Figure 1-1
Summary of Cost Saving and Revenue Enhancement Actions
With Little to No Impact on KNI Residents

| # | Description | One-Time Revenue Generated | Maximum Annual Cost Savings | KNI Officials' Concerns | LPA Assessment |
|--|---|----------------------------|---|--|---|
| SAVINGS ACHIEVED BY SHIFTING COSTS | | | | | |
| 1a | Bill Medicare for most of KNI's durable medical equipment | \$0 | \$166,000 State Savings <i>no other savings</i> | Purchasing this equipment monthly rather than annually may lead to shortages if items get used up earlier. In addition, KNI will need to separately bill, track, store, and use the equipment based on the individuals it was purchased for, which could take additional staff time. | In order to work through these issues, KNI started a pilot program to bill durable medical equipment to Medicare for about 15 residents in the Honeybee building in October 2011. |
| SAVINGS ACHIEVED THROUGH PERSONNEL AND COMPENSATION CHANGES | | | | | |
| 1b | Reduce 3 FTE custodial positions | \$0 | \$46,000 State Savings <i>\$116,000 All Funds</i> | Although this staff reduction wouldn't affect residents' safety, work may not get done because of staff absences due to illness, injury or scheduled leave. Officials prefer to reduce these positions through attrition. | We analyzed the possible staff reductions based on the number of square feet custodial staff at KNI are responsible for. Because KNI closed one of the residential buildings, keeping all 21 custodial staff results in less work per person at the same cost. |
| 1c | Eliminate 1 qualified developmental disability professional | \$0 | \$24,000 State Savings <i>\$59,000 All Funds</i> | The behavioral support position allows some individuals with developmental disabilities to remain in the community by helping providers cope with special behavior problems. KNI officials think that eliminating this position may result in an increase in State hospital admittances. | This position's primary function <u>does not</u> serve KNI residents, but rather serves individuals with developmental disabilities in the community, and therefore isn't mission critical to KNI. Specific client behavior problems are supposed to be resolved at the local community provider level. |
| 1d | Hire a physical therapist on staff and discontinue the contract | \$0 | \$9,000 State Savings <i>\$23,000 All Funds</i> | KNI is unable to hire the current PT therapist who is experienced and familiar with KNI's residents due to the non-compete clause in her contract. Additionally, officials told us it's difficult to hire a licensed professional on a part-time basis. | Although it would be advantageous to hire someone already experienced with KNI's population, it shouldn't prevent management from evaluating other staffing options. Officials acknowledged they haven't tried to hire a part-time licensed physical therapist. |

**Figure 1-1
Summary of Cost Saving and Revenue Enhancement Actions
With Little to No Impact on KNI Residents**

| Idea | Description | One-Time Revenue Generated | Maximum Annual Cost Savings | KNI Officials' Concerns | LPA Assessment |
|---|-------------------------------------|----------------------------|--|--|--|
| REVENUES AND SAVINGS ACHIEVED BY <u>SELLING VARIOUS ASSETS</u> | | | | | |
| 1e | Sell excess KNI land | \$416,000 | \$18,000 State Savings \$46,000 All Funds | KNI residents would have to travel additional distance from their residential buildings to the vehicles because a parking lot would be eliminated. Additionally, selling the land would reduce the amount of open space and could increase traffic directly around KNI's residential space, causing potential safety risks. Finally, drainage issues, a number of utility lines, and debris from razed buildings would lower the land value estimates to the point of making the idea impractical. | This building has another adjacent parking lot, and vehicles could be brought around to pick up residents. According to the appraiser, potential drainage problems, building debris, and periphery utility lines will not affect the value of this land considerably and are commonly dealt with when developing land. Although utility lines that run directly across the land could reduce the value, selling the land will help reduce KNI's operating size. |
| 1f | Sell the Superintendent's house (a) | \$117,000 | \$0 | This would reduce the number of family visits to KNI residents, which have increased over the last eight months, and average about 16 bedroom days a month during that timeframe. | Until April, the house wasn't available for family stays. While allowing families to stay for free may have increased family visits, the State is under no obligation to cover these costs. In addition, the usage increased mainly as a result of two KNI families utilizing the house for extended stays. KNI officials could allow visitors to stay in residential buildings (a practice that existed previously). |
| 1g | Sell underused vehicles | \$13,000 | \$3,000 State Savings \$7,500 All Funds | This will limit the number of residents' trips into the community; especially impromptu outings. Also, reducing the number of maintenance vehicles could affect maintenance response times, which also could affect residents negatively. Finally, revenue generated through this action likely don't outweigh the negative effect to residents. | We determined KNI needed to keep 42 residential vehicles (buses, cars, and vans), and 12 maintenance vehicles. Some KNI staff told us that some of the vehicles we think KNI should sell are either unnecessary or underused. Given Parsons' vehicle data, we think KNI could improve the way in which it manages its fleet without negatively affecting residents. Although we acknowledge this is a small savings area, we think these cuts reflect good asset management. |
| Total One-Time Revenues | | \$546,000 | n/a | | |
| Annual <u>State</u> Savings | | n/a | \$266,000 | | |
| Annual <u>Total</u> Savings | | n/a | \$418,000 | | |

(a) We didn't estimate savings related to the maintenance of the Superintendent's house, but noted that it will require capital improvements in the future, such as a new roof and an exterior paint job.
Source: LPA analysis of KNI operations and expenditures, and interviews with KNI officials and the Shawnee County appraiser.

Based on this work, we found the following cost-efficient options:

- **KNI could reduce its custodial staff to 18 FTE (eliminating three positions) and save the State about \$46,000 annually (\$116,000 total funds).** In 2000, KNI had about 375,500 square feet of building space to clean. In Spring 2011, KNI closed one of its five residential buildings, which eliminated the need to clean 47,000 square feet. However, as of August 2011, KNI hadn't reduced its custodial staff to account for the reduction in square footage. We estimated, and KNI officials confirmed, that three custodial staff could be eliminated. KNI officials also acknowledged this wouldn't negatively affect residents, but told us they prefer to reduce these positions through attrition.
- **KNI could eliminate one qualified developmental disability professional to save the State about \$24,000 annually (\$59,000 total savings).** We questioned a number of services KNI provides for the community. For the most part, these services are provided with a fraction of a staff person's time, which makes staff cuts impossible. However, KNI has a qualified developmental disability professional who provides behavioral support services to the community. According to KNI officials' estimates, that staff spent less than 10% of her total work hours on activities that directly benefit KNI residents or staff. Because providing services to the community isn't mission-critical and funding for this person's salary should benefit the ICFMR facility and not the community, it appears this position could be eliminated.
- **Hiring a part-time physical therapist to replace an existing contract could save \$9,000 in State funds annually (\$23,000 total funds).** KNI has two staff who provide physical therapy services. In addition, KNI contracts with a local company for a part-time physical therapist to provide oversight and services. In fiscal year 2011 that contract cost KNI \$80,000. Hiring a part-time physical therapist would cost far less. KNI officials told us they would be interested in hiring the current physical therapist they contract with, but can't because she has a 'non-compete' clause in her employment contract. Officials also expressed concerns about the feasibility of finding a part-time therapist, but acknowledged they haven't tried to do so.

KNI could sell various assets to generate up to \$546,000 in one-time revenues and save the State an estimated \$21,000 (\$54,000 total funds) annually in maintenance costs. As part of operating its campus, KNI maintains about 180 acres of land, 13 buildings and shops with about 330,000 square feet, and 75 vehicles. We reviewed those assets to determine whether some of them could be sold or used more efficiently to reduce KNI's annual costs. We found:

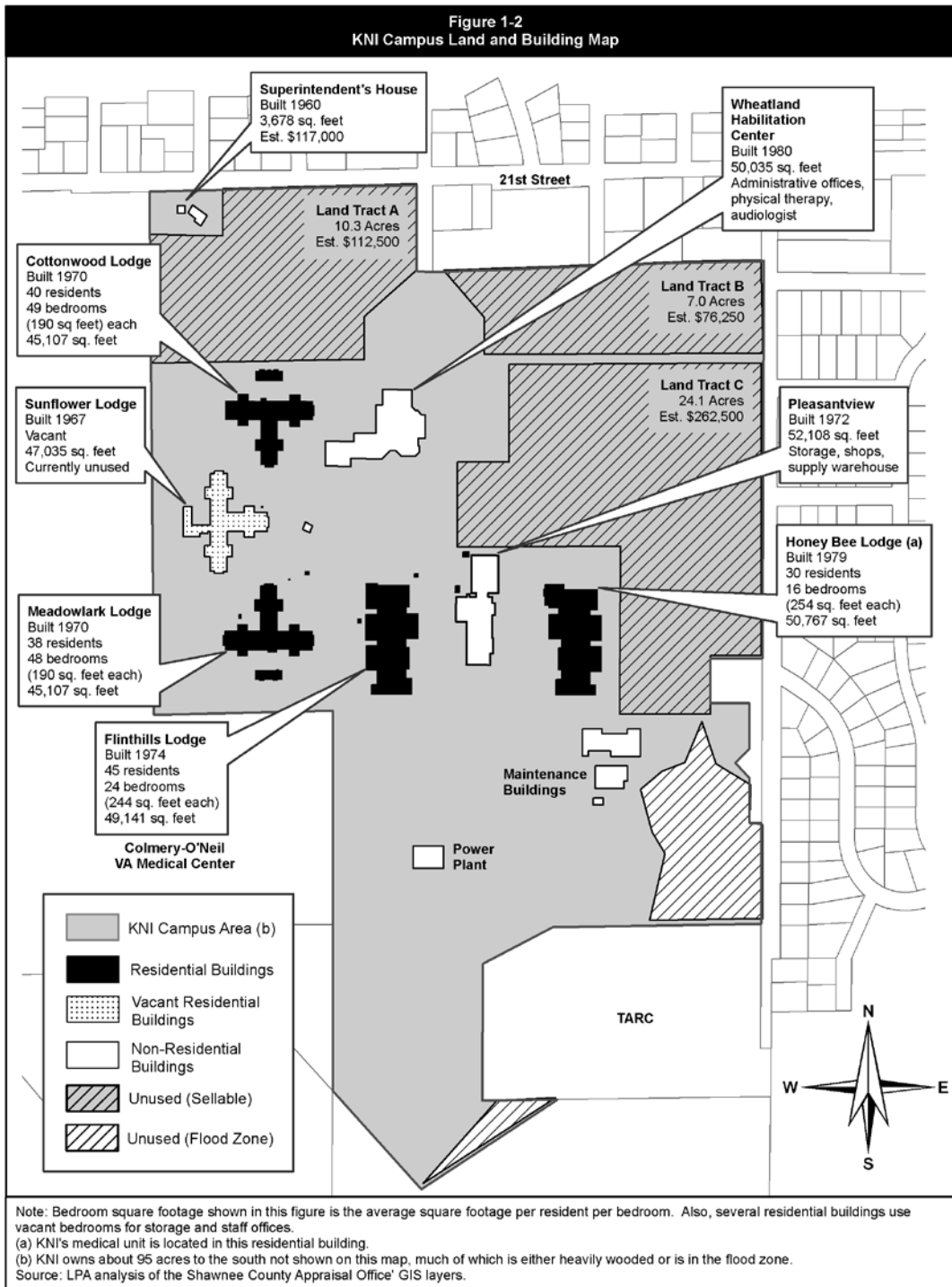
- **The State could sell three tracts of land to generate an estimated \$416,000 in one-time revenues, and could save the State an estimated \$18,000 in maintenance costs (\$46,000 total funds) annually.** After receiving land from the

federal government in 1959, KNI officials developed the current layout of its buildings to provide ample green space. While such space may have been ideal for a population of 450 residents in 1971, the unused land is more difficult to justify today with a population closer to 150 residents.

Figure 1-2 on the next page shows a map of the KNI campus. As shown in the figure, we identified three tracts of unused land totaling approximately 41 acres that are adjacent to residential neighborhoods and could be sold. We also identified some unused land that is not attractive enough to sell because it is located close to a flood zone. We worked with the Shawnee County appraiser's office to estimate the value of the 41 acres of sellable land. While the appraiser confirmed that drainage issues, concrete debris from razed buildings, and utility lines in that area may reduce the actual sale price of the land, he also stated these issues are common and developers deal with those problems regularly. We worked with KNI staff to estimate the potential annual savings from reduced maintenance costs.

- **The State could sell the superintendent's house which is estimated to be worth \$117,000 and avoid future maintenance costs.** The KNI campus includes a 3,700 square foot superintendent's house, which is located at the northwest edge of campus, near other residences, and close to Washburn University. The house has not been used as a full-time residence since 2007, but was repurposed in April 2011 as a place for family members and guardians of KNI residents to stay while visiting KNI residents. However, because of its relatively infrequent use (15 stays in the first two months) and upcoming maintenance needs, the State should consider selling the house to generate one-time revenues and avoid future costs.
- **KNI could sell 16 underused vehicles to generate up to \$13,000 in one-time revenues, and reduce related annual expenditures by \$3,000 (\$7,500 total funds).** KNI has 75 vehicles, of which 43 were driven less than 4,000 miles from April 2010 to April 2011. Most of these vehicles are used to transport residents; others are used for campus maintenance.

We compared KNI's vehicle inventory to that of Parsons State Hospital and found KNI has more vehicles per resident (1 car for every 2 residents at KNI compared to 1 car for about every 3 residents at Parsons). After evaluating usage surveys from KNI staff, and considering additional feedback from officials, it appears that KNI could sell 16 vehicles, including seven that are used to transport residents and seven that are used for maintenance work. Although these vehicles are convenient, they aren't necessary. Reducing the fleet to 59 vehicles also ensures that KNI reduces its costs (e.g. repairs and insurance) in line with continuing resident declines.



KNI Could Save \$388,000 in State Funds Annually by Reducing Several Staff Positions, Potentially Affecting Residents But Not Eliminating Any Essential Services

The cost savings ideas presented in this section require a number of staffing reductions, but do not eliminate any essential services. These staffing cuts could have an effect on residents, which is why we only recommend considering them at this point. However, by presenting these ideas, we hope to provide some cost-efficient alternatives to how KNI currently operates.

Figure 1-3 on the next page summarizes the cost savings options in this section. As before, the figure also lists any concerns KNI officials expressed about the options, along with our assessment of their concerns. It should be noted that potential cost savings in this section overlap potential savings presented in the next section.

KNI could reduce 13 direct care and medical staff for an estimated annual savings of \$250,000 in State funds (\$627,000 total funds). In January 2000, KNI served 189 residents with 477 direct care and medical staff, for a staff-to-resident ratio of 2.5. By August 2011, both the number of residents and the number of direct care and medical staff had decreased significantly (to 153 residents and 399 staff), for a staffing ratio of 2.6.

Because direct care and medical services are part of the core activities, KNI has generally tried to avoid staff cuts in these areas. However, recent staff cuts in this area, prompted by the Governor's fiscal year 2012 budget proposal to reduce KNI staffing, demonstrate that cuts in this area are possible. KNI could eliminate 13 additional staff (bringing the total to 386) in this area to reduce its current staff-to-resident ratio back to its 2000 level of 2.5.

KNI could reduce its full-time dental staff or contract for dental services, to save between \$40,000 and \$70,000 in State funds each year (\$101,000 to \$176,000 total funds). Those three staff provide between 2-4 dental cleanings to each of KNI's residents annually. For especially complex dental services, KNI staff take residents to oral surgeons in the community. Annual salaries and benefits for these three dental staff are about \$216,000. In January 2000, KNI also had the same three FTE dental staff but served 189 residents.

By comparison, Parsons State Hospital contracts with a local dentist and two additional staff to serve its residents for about 12 hours a week. Officials told us they provide about two cleanings per resident annually, and dental staff also handle oral surgeries and necessary follow-up. KNI's salary expenditures in this area were five times higher than Parsons' costs in fiscal year 2010, even though KNI has about 40 fewer residents.

KNI could reduce staffing across several program areas by a total of three FTE, for a combined savings of \$68,000 in State funds annually (\$170,000 total funds). We identified several positions that aren't essential to KNI's operations, detailed in *Figure 2-3* on the next page.

**Figure 1-3
Summary of Cost Saving Actions
That Reduce Staffing Levels But Don't Eliminate Essential Services**

| # | Description | Maximum Annual Cost Savings | KNI Officials' Concerns | LPA Assessment |
|---|--|--|---|---|
| 2a | Reduce 13 FTE habilitation or medical positions to bring KNI in line with 2000 staffing ratios | \$250,000 State Savings \$627,000 All Funds | Reducing medical or direct care staff would decrease the level of care residents receive, and be detrimental to their medical safety. Also, KNI's population is aging and becoming more medically fragile, and their increased medical needs necessitate a higher staffing ratio. | KNI's population has aged from an average of 38.3 in 2000 to an average of 48.8 as of August 2011. Although age likely increases some medical needs, it may also lead to more sedentary behavior which could reduce the number of staff needed. Also, KNI residents' severity scores didn't rise, and the proportion of profoundly disabled residents actually declined during this period. |
| 2b | Reduce 3 FTE dental staff to part-time, or contract for dental services | \$70,000 State Savings \$176,000 All Funds | A reduction in dental staff would reduce the number of cleanings KNI residents would be able to receive, and could result in KNI residents developing oral health issues. Additionally, dental services would no longer be provided to non-residents. | Parsons State Hospital has about 40 more residents than KNI but still provides dental cleanings to each resident twice a year for much less than KNI (KNI's dental costs were five times as much as Parsons in FY 2010), it appears that KNI can reduce these dental staff to part time. This reduction would eliminate dental services to non-residents, but those services aren't KNI's responsibility. |
| 2c | Reduce 3 FTE non-essential or miscellaneous positions | \$68,000 State Savings \$170,000 All Funds | <p>Reducing the <u>volunteer coordinator</u> position would reduce KNI's effectiveness in recruiting volunteers, and would reduce community interactions. This position also allows KNI to collect a number of donations, the loss of which will outweigh the savings. Furthermore, KNI staff may not be able to do community outreach and other activities if the position were reduced to part time.</p> <p>Eliminating two <u>training & development staff</u> might make it more difficult to hire staff and could reduce training opportunities for KNI staff.</p> <p>Eliminating the part-time <u>radiologist</u> position might result in X-rays not being performed in a timely manner because the resident would need to be transported to a medical facility to take an x-ray. Additional transportation costs and staff time would be necessary.</p> | <p>Reduction of the volunteer position wouldn't affect residents' health or safety. In August 2011, KNI had about 20% fewer residents and staff than they did in 2000, yet its volunteer coordinator has remained a full-time position. While this position is beneficial to KNI and the community, it is an auxiliary position and not necessary for the residents' well-being. Lastly, KNI has a foster grandparent program position that also manages volunteer staff.</p> <p>Given Parsons' ability to provide training with less staff, eliminating these two training and development staff may not significantly reduce KNI's staff training opportunities.</p> <p>The radiologist elected to participate in the Governor's retirement option. SRS allowed this to be one of several positions that could be re-filled. KNI staff indicated they wouldn't refill this position, which indicates their concerns don't present a barrier to this action.</p> |
| Annual <u>State</u> Savings | | \$388,000 | | |
| Annual <u>Total</u> Savings | | \$973,000 | | |
| Source: LPA analysis of KNI operations and expenditures, and interviews with KNI officials. | | | | |

- **Reduce the volunteer service coordinator’s position to half-time to save the State between \$8,000 and \$12,000 annually (\$21,000 to \$30,000 total savings).** KNI’s volunteer service coordinator is responsible for screening and supervising over 100 volunteers, obtaining donations, sponsorships and tickets for community events, and increasing awareness of KNI in the community. Although the position enhances KNI’s operations, reducing this position to part time is feasible for several reasons. First, KNI has kept this position full-time for at least the past 11 years even though residents have decreased by almost 20%. This means fewer volunteers, donated items, and tickets to community events are necessary. Second, some of this employee’s work benefits the community, and not KNI residents. Lastly, we think that some of what this employee does is beneficial, but isn’t mission critical, or could be done by other staff or volunteers. In addition, KNI has a separate, federally funded volunteer program—the foster grandparent program. This program funds one full-time coordinator and allows about 50 volunteers to spend time with residents.
- **Eliminate two staff education positions to save the State about \$46,000 annually (\$115,000 total savings).** As of August 2011, KNI’s 491 FTE staff included 6 FTE staff responsible for developing and providing training for KNI staff. Some of these staff also provide academic support to newly hired staff to achieve their nurse aide or medication aide certification.

By comparison, Parsons State Hospital officials told us 4.5 of their 465 FTE staff are dedicated to similar staff education activities. Parsons also has a partnership with a nearby community college. That arrangement has several direct care training staff teach certain courses in exchange for college credit hours. Given Parsons’ ability to train their staff with less resources, and given that KNI isn’t required to provide remedial training to direct care staff, staff cuts in this area appear to be possible.

- **Eliminate a half-time radiologist position to save the State about \$10,000 annually (\$25,000 total savings).** KNI employs a radiologist to perform X-rays on the campus weekday mornings. Residents who need X-rays at other times are taken to a local clinic. KNI officials estimate the radiologist takes about 15 X-rays a month. Given this limited workload, and the fact that residents already go off-campus when this staff person isn’t available, it appears this position could be eliminated.

KNI Could Save \$539,000 in State Funds Annually By Changing How it Delivers Two Core Services, Likely Affecting Most Residents

The following section summarizes the most aggressive cost savings ideas we developed. These ideas would fundamentally change how KNI delivers these services, which would likely affect all residents and may have negative consequences. As mentioned before, we present these ideas because they are extensions of what KNI has done in the past, and represent cost-efficient alternatives to providing these services. In light

of the continuing decline in KNI's residents, these more aggressive actions would reduce per-resident costs, and may become more feasible over time.

Figure 1-4 summarizes these ideas. As mentioned earlier, some of the cost savings in this section overlap savings ideas presented previously.

| Figure 1-4 Summary of Cost Saving Actions That Will Likely Affect Residents Through Comprehensive Service Delivery Changes | | | | |
|---|---|--|--|---|
| # | Description | Maximum Annual Cost Savings | KNI Officials' Concerns | LPA Assessment |
| 3a | Close one of KNI's residential buildings (Cottonwood) | \$301,000 State Savings \$753,000 All Funds | <p>Closing this building would likely lead to overcrowding in the remaining residential buildings, especially with increased storage needs for durable medical equipment. This could lead to safety issues and decreased quality of life for all residents. That's because closer proximity of residents can increase the chance of spreading illnesses, risk of injuries, and decreased privacy and less opportunity for choice (e.g. coordinating bathroom routines across more individuals).</p> <p>Consolidating buildings could cause residents to use only twin beds, even when larger beds may be necessary, and could lead to difficulties in meeting space requirements set forth by the Centers for Medicare and Medicaid Services (CMS) to maintain certification and compliance as an ICFMR. Lastly, closing a residential building takes four to five years of planning, and as a result, potential savings from closing Cottonwood wouldn't be realized for several years.</p> | <p>Although closing the Cottonwood building would reduce the amount of space for each KNI resident, KNI would still be able to meet CMS <u>minimum</u> space requirements per resident.</p> <p>CMS also requires that ICFMR facilities provide residents with "adequate space", which isn't defined. Consequently, we can't determine precisely how much space is actually necessary.</p> <p>Additionally, even after making necessary capital improvements, once Cottonwood is closed, the State would see a return on investment in less than one year. As the KNI resident population decreases, consolidating residents into fewer buildings will become increasingly important from a cost-efficiency perspective.</p> |
| 3b | Close KNI's medical unit | \$238,000 State Savings \$595,000 All Funds | <p>Closing the KNI medical unit will likely lead to increased emergency room visits, and hospital admissions. Without the medical unit, KNI residents may not be able to return to KNI. That could result in longer hospital stays or nursing home admissions following discharge from the local hospital.</p> <p>Closing the medical unit will increase the need for staff to transport residents for necessary medical services, thus creating offsetting costs.</p> <p>Frequent trips would be disruptive to residents and could increase additional medical or behavior issues.</p> | <p>While closing the medical unit may increase the amount of trips to the hospital for KNI residents, they would also be admitted to the hospital as soon as they are experiencing health issues, which could potentially benefit residents. Because 83% of KNI residents are eligible for both Medicaid and Medicare, closing the medical unit and admitting residents directly to the hospital is a more cost-efficient model of care for the State.</p> <p>Although closing the medical unit would be a major change in KNI operations, this service model is more in line with how individuals with developmental disabilities currently receive medical care in the community.</p> |
| Annual State Savings | | \$539,000 | | |
| Annual Total Savings | | \$1,348,000 | | |
| Source: LPA analysis of KNI operations and expenditures, and interviews with KNI officials. | | | | |

KNI could close the Cottonwood residential building and move its residents into three remaining residential buildings, saving the State about \$301,000 annually (\$753,000 total funds). As shown in *Figure 1-2* on page 20, KNI's 153 residents currently reside in four residential buildings. Each of the four buildings is divided into four to six smaller housing units. On average, between six to eight residents live in each of the 22 homes. Each home has its own kitchen, dining room, living room, bathrooms and bedrooms.

As described on page 18, KNI recently closed one of its five residential buildings in response to its decreasing population. Because a number of stakeholders raised the possibility of closing other buildings, we reviewed the possibility of closing another residential building. This work consisted of touring the four buildings, studying floor plans, calculating resident space ratios, reviewing CMS guidelines, talking to KNI officials, and identifying possible remodeling needs and costs.

Based on our work, it would be possible to close the Cottonwood building and transfer its 40 residents to the remaining three buildings. This would reduce the amount of space for each resident, but would still meet minimum federal guidelines. This level of space is not unprecedented for KNI, although it would put more KNI residents in each of the remaining buildings than have been housed in those buildings since 1998.

Closing the Cottonwood building would save money by eliminating a number of associated direct care and custodial staff and by reducing utility costs. This option would require some one-time remodeling costs of about \$33,500. Similar to the closure of the Sunflower building, taking this action would require some time to address various logistical issues and to ensure the safe relocation of current residents.

KNI could eliminate its medical unit and rely on local hospitals, saving the State an estimated \$238,000 annually (\$595,000 total funds) with some offsetting costs. KNI's campus includes a five-bed medical unit, located in one section of the Honeybee building. The medical unit has existed since the 1970s and has had as many as 20 beds, but has been downsized gradually over time. Specialized medical staff and equipment and supplies associated with the medical unit cost KNI \$600,000 in fiscal year 2011.

As noted earlier, most KNI residents are dual-eligible under Medicare and Medicaid. This means most off-campus hospital

services could be billed to Medicare, with the federal government covering 100% of the cost. From the State's financial perspective, this would be more cost efficient than serving residents through the medical unit.

Officials from both KNI and Stormont-Vail Hospital (in Topeka) agreed that closing the medical unit significantly changes how residents' medical needs would be met. Although this would save the State a significant amount of money, there would be at least two significant negative consequences. First, emergency room visits, along with the associated disruptions and transportation issues would increase. Second, it would likely result in longer hospital or nursing home stays if residents aren't ready to return to KNI's residential buildings.

As the local hospital most likely affected by this action, Stormont-Vail officials raised concerns that their emergency room and intensive care unit may not be able to handle an influx of KNI residents and still serve the community at large.

A less drastic step would be to reduce the medical unit from five to three beds, which could save the State an estimated \$63,000 annually. Based on KNI's records between January 2007 and June 2011, residents occupied, on average, only three of the five available beds. During that time, medical bed usage varied significantly. For example, the medical unit served more than three residents almost half of the year in 2009. However, in the last 18 months, it served more than three residents for only 2.5 months out of the year. Because two beds were underutilized, we think it's feasible to consider eliminating them and reducing nursing staff from six to four positions.

Stormont-Vail officials told us that smaller bed-capacity on campus may allow KNI staff to better evaluate which residents could benefit from a more intensive off-campus hospital stay. Officials also told us that, in some cases, earlier admissions could be beneficial because earlier intensive services may speed the recovery of an individual.

Few Opportunities Exist For KNI To Generate Significant Ongoing Revenues By Charging for Certain Services

KNI provides a number of services to the northeast Kansas community. Some services, such as allowing the use of KNI's facilities, involve only insignificant staff resources, and therefore are inexpensive for KNI to provide. KNI also makes offers a number of professional services to individuals with developmental disabilities in the community. Services such as dental care, behavioral support, assistive technology services,

and posture seating services are offered free of charge. We looked into the possibility that KNI could raise additional revenues by charging for a number of professional services it offers to non-residents. As an ICFMR facility, KNI would have to track expenses and administrative time for these services separately. That's because KNI's Medicaid funding is supposed to be used for services to residents, not the community. The additional administrative burden likely outweighs the potential benefits. Additionally, KNI would have to become a separate Medicaid provider to provide and bill the Home and Community Based Medicaid waiver for services such as respite care. If KNI were to provide respite care to non-residents, the State would still have to pay 40% of those costs.

Finally, we evaluated whether KNI could rent out the recently closed Sunflower building to generate additional revenues. Based on our own observations, discussions with KNI and Department of Administration facilities management staff, and a review of capital improvement documentation, this doesn't appear to be feasible. That's because the building needs significant renovations before anyone might be interested in it as a rental space.

Conclusion

Over time, KNI has gradually reduced the size of its operations as the number of residents it serves has declined. Although KNI has taken steps to reduce costs and become more efficient, the State's recent budget issues have put an even greater premium on finding opportunities for savings. Our analysis of KNI's operations identified about \$550,000 in one-time revenues and about \$1 million in unduplicated potential cost savings annually. While some of the options we identified would have little or no effect on KNI residents, others would change aspects of KNI's service model and could affect the quality of life or safety of KNI residents. Not surprisingly, while the options with little impact on residents would yield some savings, the more aggressive options have more savings potential. KNI officials are understandably reluctant to pursue the aggressive options because of the potentially negative impact on residents. While it may not be necessary or desirable to implement all of the cost savings ideas at this time, all of the options should be given serious consideration, especially in light of the State's budget issues, and given KNI's continuing decline in residents.

***Recommendations for
Executive Action***

1. To improve its operational efficiencies, the Kansas Neurological Institute should implement the following cost saving and revenue enhancements ideas:
 - a. Bill Medicare for all eligible durable medical equipment.
 - b. Reduce three FTE custodial positions.
 - c. Hire a part-time physical therapist instead of contracting for physical therapy services.
 - d. Sell unused tracts of land on the KNI campus upon receiving approval from the Legislature.
 - e. Sell the superintendent's house located on the KNI campus upon receiving approval from the Legislature.
 - f. Sell 16 vehicles that don't appear to be used efficiently, and improve the assignment and use of its remaining vehicles to ensure residents' activities and campus maintenance aren't compromised.
2. To improve its operational efficiencies, the Kansas Neurological Institute should consider each of the cost saving ideas presented in ***Figure 1-3*** and ***Figure 1-4*** and report back to the Post Audit Committee on its intended course of action in each area by April 1, 2012.

***Recommendations for
Legislative Consideration***

1. To help the Kansas Neurological Institute increase one-time revenues by selling certain land tracts and the superintendent's residence, the Legislative Post Audit Committee should consider introducing legislation that gives KNI the authority to:
 - a. sell the three parcels of unused land shown in ***Figure 1-2***.
 - b. sell the superintendent's house located on the KNI campus.

Question 2: What Are the Cost and Safety Implications of Moving Current Kansas Neurological Institute Residents to Local Communities?

Answer in Brief:

A network of community providers deliver services to the developmentally disabled across Kansas. In general, it is possible to serve individuals with severe disabilities in the community, but there may be exceptions. Although KNI and local communities provide similar core services, medical services are provided differently. For example, the community typically has fewer nurses on staff and may have difficulty providing specialized medical care.

Serving KNI residents in the community could save the State an estimated \$5 million annually, once all the residents are relocated into a community setting. The State would save money by cutting some costs and shifting others to service providers. Because costs for KNI residents in the community are likely to exceed reimbursement rates, community providers would need to use a number of cost-containment and revenue-producing strategies to avoid losses. These include hiring fewer certified staff, providing only medically necessary treatments, or requiring individuals to pay for transportation costs.

The State doesn't track certain safety outcomes for developmentally disabled adults to allow for good comparisons between KNI and community settings. However, many stakeholders expressed concerns that KNI residents' medical needs would not be adequately met in community settings. Although fewer stakeholders expressed concerns about addressing residents' behavioral needs in the community, it is possible some KNI residents will have trouble adapting to a new environment. In addition, community providers may struggle to offer the same continuity of care that residents receive at KNI. Stakeholders also have varying opinions on whether the quality of life of KNI residents will improve or worsen if KNI residents are moved into the community.

Finally, relocating residents from KNI to the community would take time and money, and federal funding may help cover some, but not all, of the transition costs.

These and other findings are discussed in more detail in the following sections.

GENERAL FINDINGS RELATED TO SERVING KNI RESIDENTS IN THE COMMUNITY

A Network of Providers Deliver Services in the Community That Are Funded by Federal, State, And Local Moneys

As mentioned in the Overview, Kansas serves individuals with developmental disabilities in two State institutions and in the community. Most individuals with developmental disabilities live and receive services in a community setting.

To deliver services in the community, Kansas has a network of 27 Community Developmental Disability Organizations (CDDO) and numerous service providers. CDDOs are the single point of entry, eligibility, and referral for anyone seeking services for developmental disabilities. These organizations either serve or contract with community service providers to serve individuals with developmental disabilities.

Community service providers are licensed by SRS and must be affiliated with a CDDO. Currently, SRS licenses almost 200 community service providers. Typically, these organizations coordinate and deliver services such as direct care, work opportunities, and medical services on behalf of the individual.

Individuals served in the community live in a variety of settings including with relatives, with a roommate, or in a group home with up to seven others. A small number of individuals are served in private ICFMR settings. Individuals with developmental disabilities can choose services from providers available in their region. Additionally, State law requires CDDOs to provide or arrange services for eligible individuals with developmental disabilities seeking services within their region unless a court determines community placement is not appropriate.

Figure 2-1 on the next page provides more information about a number of key concepts relevant to this audit question.

In the community, developmental disability services are funded with federal, State, and local moneys. Providers receive the largest share of funding through the Medicaid Home and Community Based Services (HCBS) waiver. These funds are available to individuals who would have otherwise received services in an institution.

As with most Medicaid programs, waiver service payments are typically split 60% and 40% between the federal and State government. Reimbursements for day and residential services (the primary waiver services) vary based on the severity of the individuals' disabilities, while other services are paid on a flat rate. SRS is required to reevaluate these reimbursement rates periodically.

**Figure 2-1
Glossary of Important Terms and Concepts**

| Term | Definition |
|--|---|
| Community Developmental Disability Organization (CDDO) | CDDOs are the single point of entry, providing eligibility determination, and referral for anyone seeking developmental disability services within a designated region. By law, each CDDO must administer and maintain an organized network of community-based services within its area. CDDOs may provide some or all services themselves, or they may contract with other community service providers. Currently, Kansas has 27 CDDOs across the State. |
| Community Service Provider (Provider) | Providers within a particular region must be connected to a CDDO. Service providers provide or coordinate services, such as direct care, work opportunities, and medical services. SRS licenses nearly 200 community service providers. |
| Home and Community Based Services Waiver (HCBS) | Home and Community Based Services (HCBS) waiver programs are intended to allow individuals to get the services they need in the community, rather than in an institution. To offer waiver services, states must apply to the federal government for a "waiver" of the requirement that services be provided in an institutional setting. Kansas' Developmental Disability HCBS waiver includes services such as day and residential supports, respite services, nursing services, and others. Generally, the State pays 40% of the services' reimbursement rates, while the federal government pays 60%. |
| Assessment Scores | To determine whether individuals with developmental disabilities qualify to receive waiver services, CDDOs provide initial and annual assessments in three areas: health, maladaptive behaviors, and adaptive needs. The three scores are combined into a "converted" score which provides an overall picture of how disabled an individual is (the higher the score, the more severe the disability). |
| Tier Levels | <p>Kansas uses five tier levels to indicate the severity of an individuals' developmental disability. <u>Tier 1 is the most severe level</u>; tier 5 is the least severe. Tier level is determined by whichever of the health, maladaptive, or adaptive assessment scores is most severe. For example, if a person scores as a tier 3 on the health score, tier 2 on maladaptive, and tier 1 on the adaptive scale, then that individual is categorized as a tier level 1.</p> <p>In the community, tier levels determine funding rates for some waiver services: Tier 1 clients receive the highest funding levels; tier 5 receive the least. While residents at KNI are assessed by the region's CDDO annually, the tier level plays no role in KNI's funding.</p> |
| Extraordinary Funding (Super Tier and Individualized Rates) | <p>Super Tier: Service providers' overall reimbursements are expected to balance out. However, certain high-cost individuals require extraordinary funding levels. For those, a provider can apply to SRS for a super tier rate. If the provider can prove the individual's costs exceed 50% of the difference between the regular rate and the super tier rate, SRS will allow the provider to receive the super tier rate. As of August 2011, 384 (5%) of the more than 7,300 adults receiving community services qualified for super tier rates.</p> <p>Individualized Rates: Using a similar process as above, a provider can apply to get <u>actual costs</u> reimbursed for certain individuals. If approved, SRS will audit the provider's costs and provider must pay back any costs lacking proper documentation. Currently, 16 individuals receive these rates. More rules are described later in the report.</p> |

Source: Previous LPA audits and interviews with SRS officials.

CDDOs also receive funding from the State for administrative costs, and community providers may receive other State and federal funding through special grants. Community providers receive local funding in the form of mill levies, donations, and fund raising events, but information about those moneys isn't available because it isn't tracked centrally.

Kansas has a waiting list for individuals with developmental disabilities who want to be served in the community. As of August 2011, about 2,500 people were waiting for community-based waiver services. The primary reason for the waiting list is a shortage of State funding. Individuals relocating from institutions such as KNI and Parsons State Hospital typically are placed ahead of individuals currently on the waiting list.

In General, Individuals With Severe Developmental Disabilities Can Be Served In the Community, But There May Be Exceptions

As of August 2011, about 7,300 adults with developmental disabilities received community-based Medicaid services across Kansas. Individuals with severe developmental disabilities can access home and community based waiver services as an alternative to receiving services in an institution.

Community providers across Kansas are able to serve adults with health and behavioral issues similar to those of KNI residents. To determine how similar or different the two populations were, we analyzed the assessment scores, tier levels, and age of adults with developmental disabilities in the community and at KNI (*Figure 2-1* on the previous page provides more information about assessment scores and tier levels).

As explained in the Overview, KNI was home to 153 adults as of August 2011. The comparison population we analyzed included the 7,300 adults served through the HCBS waiver at that time. Our comparison found that:

- **Both settings serve adults with severe developmental disabilities.** Every year, individuals in the community and at KNI are assessed and assigned a tier level of one through five. Tier one is the most severe and tier five is the least severe. Of the 7,300 adults served in the community, 1,820 are classified as tier one, or the most severely disabled. As the map in **Appendix C** shows, these individuals are served all across the State. Similarly, KNI has 68 residents who are classified as tier one.
- **Both settings serve adults with severe health issues.** As part of the yearly assessment, individuals receive a health score between 0 and 31, with higher scores indicating more severe health issues (the health score measures things such as known illnesses and special medical needs). Of the 7,300 adults in the community, 976 had a health score of 15 or greater; 45 individuals at KNI had a health score of 15 or greater.

- **Both settings serve adults with severe behavioral problems.** The yearly assessment also includes a maladaptive score, which reflects a person's inability to adjust to particular situations, by measuring things such as how often an individual throws tantrums, disrupts others, or displays inappropriate behaviors. Maladaptive scores range between 0 and 200, with higher scores indicating more severe behavioral issues. Of the 7,300 adults in the community, 788 have a maladaptive score of 135 or greater; two KNI residents have a score greater than 135.
- **Both settings serve older adults.** Of the 7,300 adults in the community, 1,368 are 55 years of age or older. KNI has 42 residents that are at least 55 years old.

This analysis indicates that, at least on an individual basis, it's possible to serve people similar to residents at KNI within the community.

However, as a group KNI residents are older, more severely disabled, and tend to have more severe health issues than individuals who are served in the community. Although we found that community providers serve individuals who are comparable to the residents at KNI, we also wanted to compare these two populations as a group. Our comparison showed important differences between the KNI and community populations as a whole. As *Figure 2-2* shows:

| Figure 2-2 Comparison of KNI Residents And Individuals Living in the Community (as of August 2011) | | | | |
|---|--------------|-------------|------------|-------------|
| Category | Community | | KNI | |
| Average Age | 39 | | 48 | |
| Average Assessment Score by Setting | | | | |
| Adaptive | 210.6 | | 397.9 | |
| Health | 9.4 | | 12.2 | |
| Maladaptive | 75.2 | | 48.8 | |
| Converted | 128.3 | | 166.2 | |
| Number and Percentage of Individuals by Tier | | | | |
| Tier | Community | | KNI | |
| | # | % | # | % |
| 1 | 1,820 | 25% | 68 | 44% |
| 2 | 1,389 | 19% | 43 | 28% |
| 3 | 1,697 | 23% | 27 | 18% |
| 4 | 1,200 | 17% | 14 | 9% |
| 5 | 1,157 | 16% | 1 | 1% |
| Total | 7,263 | 100% | 153 | 100% |

Source: LPA analysis of SRS' BASIS database information.

- **The average KNI resident is nine years older than the average adult served in the community.** The average age of an adult served in the community is 39, while the average age of a KNI resident is 48. Illnesses associated with age (such as arthritis, diabetes, or dementia) can increase the complexity of a disability.
- **The proportion of individuals who are more severely disabled is much larger at KNI than in the community.** In the community, 44% of the individuals are categorized as tier one or two; 73% of KNI's residents fall within these two most severe tier categories.
- **On average, KNI residents have more severe health issues than adults served in the community.** The average health score of an adult in the community is 9.4; the average health score of a KNI

resident is 12.2. Our tests confirmed that the average health scores of the two populations were statistically different (in other words, the averages weren't different simply by chance).

In many ways KNI residents are more severely disabled than individuals living in the community. However, when comparing maladaptive behavior scores, individuals living in the community tend to have more significant behavior issues. The average maladaptive score for adults in the community is 75.2 compared to an average score of 48.8 for KNI residents. The lower KNI average is likely due to the fact that many KNI residents' physical disabilities are too severe for them to exhibit maladaptive behaviors.

Although community providers can serve most types of individuals, there may be some KNI residents who cannot be served in a group home setting. We heard from several stakeholders that KNI residents can be served in the community. Although this may be true for some residents, it may not be true for all of them. That's because:

- **Some residents have health issues that require intensive medical care that may not be feasible in the community.** Community providers struggle to provide nursing care and are unlikely to provide the 24/7 nursing care some KNI residents need. Some providers told us that individuals requiring this level of care could need nursing home services.
- **A number of current KNI residents have tried to live in the community, but were unsuccessful.** Of the 153 residents currently living at KNI, 29 have tried to live in the community at some point in the past, but were not successful. Several of these residents returned to KNI because the community couldn't provide the necessary medical and behavioral support services the individual needed. It's important to note that fewer residents have relocated to the community in recent years. Between 1991 and 2000, 140 residents moved to the community, while only five residents have relocated since 2001.

Additionally, the Closure and Realignment Commission's 2009 report (described more fully in the Overview) noted a number of KNI residents would need to be transferred to Parsons State Hospital because SRS officials thought they weren't able to move to a community setting.

***KNI and Local Communities
Provide Similar Core
Services, But Provide
Medical Services Differently***

To assess how community providers provide services, we visited three CDDO regions. We toured a number of group homes and day services facilities, interviewed officials from the CDDO and several affiliated service providers, and talked to several staff and individuals who lived in those homes. This work, and what we learned about KNI operations in Question 1, helped us identify a number of similarities and differences in how the community and KNI provide services to developmentally disabled adults.

Two of the primary differences in how the community and KNI provide services largely stem from two factors:

- KNI's funding structure allows it to cover almost all its costs through Medicaid, while community providers receive Medicaid reimbursements for only certain services.
- KNI provides services in a centralized setting, which gives it some unique advantages in providing specialized services. However, community providers operate in a decentralized setting which can make it more difficult to provide some services.

These factors confer different financial and service delivery advantages and disadvantages to each setting.

KNI and community providers deliver similar types of core services. Both settings provide similar basic services, and the day-to-day routines of individuals living in both settings are comparable:

- Direct Care – Direct care comprises the day-to-day tasks individuals might need assistance with, such as personal hygiene, eating, going to a job, or household chores. Individuals in both settings participate in these activities to the best of their abilities.
- Medical Services – Although each setting differs in how they approach medical care, staff in both settings told us they make necessary medical services available to individuals through various specialists, therapists, and routine medical care.
- Clean and Appropriate Housing – Our limited review of housing conditions in three CDDO regions found very few substantive differences between community and KNI housing. In both settings, individuals lived in clean and appropriate housing where they had privacy and personal belongings.

KNI and community providers differ in how they provide medical services to residents. Some of those key differences are:

- **Medical necessity drives the medical services that are provided in the community.** At KNI, most medical services are provided by KNI staff on campus. This makes it possible for KNI to provide services to some residents that may be beneficial, but not medically necessary, such as occupational or speech therapy. Conversely, several community providers told us they provide these services only if they are medically necessary.
- **Community providers typically have fewer nurses and other licensed health care professionals available.** Community service providers typically have few nurses on staff because Medicaid doesn't always cover these costs. According to providers we spoke with, the lack of nursing staff often makes delivering certain medical services such as intramuscular injections difficult.

Providers may find alternative solutions by changing the drug delivery method (for example, using a skin patch instead of an injection). Nurses also teach direct care staff to perform certain tasks while providing oversight. Additionally, community service

providers generally don't require their direct care staff to become a Certified Nurse or Medication Aide. KNI requires these certifications for direct care staff, thus increasing their skill levels.

- **Medicaid rules for community-based care restrict payments for certain medical services.** For example, individuals who receive residential services don't qualify for certain nursing services otherwise available through the waiver program. Additionally, some services, such as preventative dental care, are not covered through the waiver at all. Lastly, providers told us Medicaid doesn't pay for certain services that don't lead to progress in a person's abilities, even if those services may be medically necessary. This can put financial strain on community providers if they pay out of pocket, and may also reduce the likelihood that the service will be provided.
- **Community providers have more difficulty in providing certain specialized medical services, such as occupational or speech therapy.** That's because, unlike a public institution that brings specialists to a single location, community providers have to go wherever a specialized service is provided. Some providers told us they sometimes have to get creative or drive long distances to provide the services an individual needs. This is especially problematic for smaller community providers with fewer resources.

COST IMPLICATIONS OF SERVING KNI RESIDENTS IN THE COMMUNITY

Serving KNI Residents In The Community Could Save The State About \$5 Million a Year, Once All The Residents Are Relocated

Our work in this section evaluates the cost implications of closing KNI and moving its residents into the community. The next section examines the safety implications of such a move.

We calculated the potential savings to the State if all KNI residents were relocated to the community. To do this, we compared KNI's current expenditures to the potential cost of caring for those individuals in the community. Our work is similar to the work the Closure and Realignment Commission did in 2009, but it includes costs that were omitted from the Commission's work and is based on more recent expenditure and funding data.

Our cost estimate is based on a number of assumptions, the most of important of which are:

- **All KNI residents would be served in a community setting, but would not live with relatives.** In reality, some residents may remain in an institution (for example, Parsons State Hospital) and others may end up living with relatives. However, there was no way to know how many individuals might be served in these settings, so we assumed that all KNI residents would relocate into the community and would not live with relatives.
- **KNI residents would incur similar costs as comparable adults who are already served in the community.** We estimated KNI residents would use the same level of medical services in the community as adults with similar health scores who currently live in the community.

- **KNI residents would receive various levels of super tier funding, but none would receive individualized rates.** As described in *Figure 2-1* on page 31, SRS allows providers to receive larger reimbursement rates for very expensive individuals. In all likelihood, most KNI residents would qualify for super tier rates but it's difficult to know how many (when Winfield State Hospital closed, 75% of the residents received super tier rates). As a result, we developed multiple scenarios with various super tier rates.

Additionally, community providers can seek individualized rates, which cover the cost of care entirely. Because very few people qualify for this rate (as of August 2011, only 16 of the 7,300 adults served in the community did) and because it's difficult to know how many KNI residents might qualify, we assumed none of the KNI residents would receive an individualized rate. If any KNI residents received individual rates, State savings would decrease accordingly.

- **The cost of services is based on the current Medicaid reimbursement rates.** Changes in these rates would affect the amount of State savings. Our analysis is based on fiscal year 2010 KNI costs and current reimbursement rates (the last year rates were adjusted was 2009). SRS' 2011 cost study indicates that rates may not fully cover certain provider costs. If rates are increased, State savings would decrease. However, SRS officials told us they have not yet determined if a request for a rate increase is appropriate.

This analysis excludes relocation or initial one-time costs, although we discuss those costs in later sections. *Appendix D* provides the detailed methodology, assumptions, and limitations of our cost savings estimate.

Closing KNI could save the State between \$4.7 million and \$6.2 million annually depending on the number of residents who qualify for super tier rates. We created several eligibility scenarios to determine potential savings, based on special super tier rates. Because super tier reimbursements are higher than standard rates, the State's savings will diminish if more residents are eligible for super tier rates. As shown in *Figure 2-3* on the next page, the State saves the most (\$6.2 million) when none of the KNI residents receive super tier rates. However, we think (based on the Winfield State Hospital closure) that 75% of KNI residents are likely to receive super tier funding, which would result in State savings of about \$5.1 million.

Our estimated savings are lower than the Closure and Alignment Commission's estimate because we included a number of community costs the Commission left out. The 2009 report showed total estimated savings of \$15 million and State savings of about \$6.3 million (these savings were based on

75% of KNI residents receiving super tier rates). We included a number of costs in our estimate that the Commission didn't include, such as housing and medical costs. Consequently, the Closure Commission slightly understated the cost to provide care in the community and thus slightly overstated the State's potential savings.

Figure 2-3
Sources of Savings by Cost Category Based on KNI Expenditures and Community Setting Reimbursements

| Cost Category | KNI's Current Average Costs per Resident | | Savings per Resident | | Savings All Residents | |
|--|--|------------------|----------------------|-----------------|-----------------------|--------------------|
| | KNI (a) | Community (b) | Total (100%) | State (40%) | Total (100%) | State (40%) |
| 75% of 153 KNI Residents Would Receive Super Tier Reimbursement Rates | | | | | | |
| Direct Care | \$93,500 | \$86,400 | \$7,100 | \$2,900 | \$1,088,000 | \$435,200 |
| Medical | \$49,300 | \$9,200 | \$40,100 | \$16,000 | \$6,130,100 | \$2,452,000 |
| Housing and Facilities | \$32,200 | \$7,700 | \$24,500 | \$9,800 | \$3,746,200 | \$1,498,500 |
| Administration | \$9,000 | \$2,600 | \$6,400 | \$2,600 | \$977,900 | \$391,200 |
| Education & Research | \$4,700 | \$0 | \$4,700 | \$1,900 | \$724,500 | \$289,800 |
| Total (c) | \$188,700 | \$105,900 | \$82,800 | \$33,100 | \$12,666,700 | \$5,066,700 |
| None of the 153 KNI Residents Would Receive Super Tier Reimbursement Rates | | | | | | |
| Total | \$188,700 | \$87,900 | \$100,800 | \$40,300 | \$15,425,500 | \$6,170,200 |
| All 153 KNI Residents Would Receive Super Tier Reimbursement Rates | | | | | | |
| Total | \$188,700 | \$112,000 | \$76,800 | \$30,700 | \$11,747,000 | \$4,698,000 |
| (a) KNI's expenditures are based on actual costs for fiscal year 2010. | | | | | | |
| (b) Community costs represent the estimated cost to serve a KNI resident in the community based on the most current reimbursement rates. | | | | | | |
| (c) Total may not add up due to rounding. | | | | | | |
| Source: LPA analysis of Medicaid, Medicare, and SRS data. | | | | | | |

The State Would Realize Savings by Cutting Some Costs and Shifting Other Costs to Service Providers

To determine whether the State would save money by closing KNI, we compared the reimbursement rates community providers would receive for KNI residents to KNI's actual costs, by category, to see where the savings would be achieved. *Figure 2-3* above shows this comparison. Although these categories didn't line up perfectly, it was apparent that some savings would come from costs that go away completely, while other costs would be shifted to federal agencies such as the Department of Health and Human Services for Medicare and the Department of Housing and Urban Development for housing costs. Additionally, community service providers, local safety net clinics or charity organizations, and families may carry some of these costs.

Additionally, to get a sense of how much it might actually cost community service providers to provide care for KNI residents—not just what they would receive reimbursements for—we asked three CDDOs (Shawnee County, Sedgwick County, and Developmental Services of Northwest Kansas) to estimate the potential cost of serving five current KNI residents who we selected. We created profiles for each of the five residents for CDDOs to use in creating their estimates. We didn't choose these individuals randomly, and the information the CDDOs provided varied significantly and couldn't be verified. Consequently, this cost information can't be projected and serves only as an indicator of actual costs. *Appendix E* details our work and includes the profiles of the five KNI individuals.

The reader should be aware of two important points about the work we did in this area:

- **We couldn't determine exactly how much of the savings came from shifting costs to providers and how much came from eliminating services.** That's because we don't know how community providers will choose to provide services for each individual.
- **The current HCBS funding structure is intended to cover costs on a system-wide basis, rather than on an individual basis, which may cause providers to be affected differently.** This means that although any one individual may cost more or less than the funding the provider receives, the total funding the provider receives should balance out costs. If a large proportion of KNI residents—who are likely to be very high cost—relocated to a single area, this balance would be disrupted and the provider likely would find it difficult to fund the necessary services.

Our findings below explain how some State savings would be achieved through reductions in service, and how others would be achieved by shifting costs to community providers.

The State's share of direct care costs would decrease by only \$435,000 because direct care costs are similar in both settings. Direct care is the day-to-day assistance provided to help individuals with things like personal hygiene, eating, and dressing. It is the largest cost driver for both KNI and community settings. As *Figure 2-3* on the previous page shows, direct care costs at KNI are only slightly greater than the reimbursements community providers may receive for KNI residents. However, the actual costs may exceed those reimbursements:

- **Community providers must cover a number of unfunded expenditures through waiver reimbursements or other revenues.** Even though direct care costs seem to be similar in both settings, community providers must provide more services with that funding than KNI does. Because the HCBS waiver

doesn't provide dedicated funding for costs such as transportation and staff training, community providers must cover those costs through other waiver service reimbursements or revenues. Conversely, KNI's funding covers costs for those services. For the most part, those costs would be shifted to community service providers.

- **Community provider estimates for five KNI residents show anticipated actual direct care costs are higher than reimbursement rates.** The potential direct care costs for these five individuals were, on average, about \$144,000. This is significantly higher than the maximum reimbursement rate for direct care of about \$102,000. The cost above and beyond the reimbursement rates would have to be absorbed by the service provider. **Appendix E** shows potential costs for five KNI residents served in the community.

The State's share of medical costs would decrease by about \$2.5 million by eliminating or reducing services and by shifting other costs to community providers. As mentioned before, KNI and community providers differ in how they provide medical services. Typically, medical necessity drives which medical services are provided in the community and community providers sometimes have difficulty providing certain medical services. Other differences in how KNI and community providers provide medical care may contribute to the State's savings. Here's how the savings would be achieved:

- **Some of the current medical expenditures will be eliminated because the services won't be provided in the community.** Many of KNI's medical costs are based on services provided by 46 nurses that provide 24/7 care in KNI's residential buildings. Community providers generally don't have that level of nursing staff because it's not funded. Additionally their de-centralized locations make it more difficult to provide these services cost-efficiently.
- **Some of the current medical expenditures will be shifted to Medicare.** Of the 153 KNI residents, 127 (83%) are eligible for both Medicaid and Medicare. Currently, if a KNI resident is admitted to KNI's medical unit, the costs are covered by Medicaid (where the State pays 40%). In the community, a hospitalization for dual-eligible residents is covered by Medicare, which is paid for 100% by the federal government.
- **Some of the current medical expenditures will be shifted to medical and service providers.** At KNI, the State pays roughly 40% of the actual costs (salaries and benefits) for 61 medical and ancillary program staff. However, in the community, the State pays 40% of the reimbursement rate, and medical and community providers must absorb the remainder. Additionally, community providers must absorb costs related to any medical services they provide but Medicaid doesn't pay for.

The State would save about \$2.2 million in housing, administration, and training costs. Though the largest State savings comes from medical costs, the State will also achieve

significant savings through housing, administration, and training costs. These savings are likely achieved through service reductions and cost shifting.

- **Some housing costs would be eliminated, but others would be shifted to individuals, service providers, and other entities.** The KNI campus costs about \$5 million a year to operate, which includes the power plant, land and building maintenance. If KNI were closed, these costs would go away.

In the community, housing costs are paid for with individuals' supplemental social security income (SSI) or other income that is available. If these sources don't cover the cost of housing, food, and personal items, community service providers may be able to access federal Section 8 housing, low income energy assistance, or food stamp assistance programs, or make up the difference themselves.

- **Administration costs may shift to service providers.** Under the current reimbursement structure, the State pays about \$2,600 per client to community providers for administrative costs per year. Typically, that money is split between the CDDO and the service provider, so if administrative costs exceed their portion, the provider or CDDO will have to cover the difference.
- **Staff education costs will shift to service providers.** The funding structure for community providers doesn't provide any funding for staff training costs. The cost of staff training will shift entirely to service providers.

Community Service Providers Would Need To Use a Number of Cost-Containment and Revenue-Producing Strategies To Avoid Losses

The reimbursement rate structure in place for community services is intended to cover costs on a system-wide basis. As the previous section showed, reimbursement rates do not cover the same types of costs covered at KNI.

Actual costs community providers incur may exceed reimbursement rates. The average estimated costs for the five KNI residents we reviewed in-depth approached \$187,000 (more details about that estimate can be seen in *Appendix E*). This estimate is very similar to KNI's actual cost per resident, but is much higher than the potential average reimbursement rate of \$106,000 per person shown in *Figure 2-3* on page 38. The reader should keep in mind that the cost estimates we received from the CDDOs are based on a hypothetical scenario, and we couldn't verify it to establish true community costs. In addition, costs varied significantly by KNI resident within and across the three CDDOs.

SRS' latest cost study, published in March 2011, involved cost data for 70 developmental disability providers and found considerable variation in reported costs between the providers. More importantly, for the two main services (day and residential

supports), the analysis showed that at least one-quarter of providers couldn't cover their costs through the reimbursement rates. While the study doesn't conclude on the adequacy of rates, it included a recommendation for the State to apply an annual inflation factor.

To the extent actual costs—especially for high needs individuals—can't be covered by reimbursement rates, community providers have to find other funding sources or reduce costs.

Community providers can reduce costs in a variety of ways.

In our discussions with officials from three CDDOs and several of their providers we learned they use several methods to reduce their costs. Community providers can:

- **Hire fewer certified staff and pay lower wages.** Officials in three CDDO regions told us they hire few nurses and other certified staff, which are more expensive. Additionally, our work showed that community providers tend to pay direct care staff about \$3.50 an hour less than what KNI staff is paid.
- **Increase the size of group homes.** One CDDO official told us they have recently begun consolidating group homes to reduce costs. They also told us they have increased the size of their group homes from six individuals to seven.
- **Rely more on public transportation.** One service provider told us they use public transportation to reduce unfunded transportation costs for residents.
- **Provide only medically necessary treatments.** As mentioned previously, community service providers typically only provide medically required services. Providers may have to appeal to Medicaid for medically required services that aren't covered.

Community providers can also enhance revenues in several ways. Currently, providers use several methods to create and increase different funding streams. Community providers can:

- **Require individuals to help pay for transportation costs.** While we didn't survey providers in general, a couple of CDDO officials told us they require individuals to pay a monthly transportation fee.
- **Send individuals to day services to qualify for more Medicaid reimbursement.** For a provider to be eligible for day service funding—which includes job, volunteer, or other activities—an individual must participate in activities outside of the home for at least 25 hours per week. A couple of providers told us some individuals would prefer to not participate in that many activities outside the home. Consequently, they either have to create special programs to encourage individuals to participate or take individuals to these programs despite their desire to stay home. Individuals who are medically fragile can be granted an exception and the provider can still receive funding for day services.

- **Raise money through donations, fund raisers, and local mill levy taxes.** Local funding sources aren't tracked centrally, so we weren't able to determine how much local funding community providers receive this way. According to SRS officials, all 27 CDDOs have a dedicated mill levy which provides some funding for community services. CDDOs and community service providers also receive donations and bequests, and hold fundraisers to generate additional income.
- **Apply for extraordinary funding from SRS to better cover their costs.** Providers can apply for two types of extraordinary funding to better cover high-cost individuals: super tier and individualized rates.

A few providers expressed confusion about which individuals might be eligible for individualized rates. Certain high-cost individuals may qualify for a super tier or an individualized reimbursement rate. Super tier reimbursements vary with severity level but are defined (for example, day services for a tier one client are reimbursed at about \$100 per day), while individualized rates allow a provider to bill SRS for their actual costs. SRS requires a provider to choose a single reimbursement method for all of its high-cost clients, with two exceptions:

- individuals moving out of an institution who qualify for a joint State-Federal grant (this grant is discussed in more detail in a later section).
- individuals with developmental disabilities who have been designated as a sex offender.

For individuals qualifying under those exceptions, providers can request individualized rates, regardless of how their other clients are funded. Some providers told us that SRS has been reluctant to put rules concerning these rates in writing. This appears to have created confusion among some providers as to when they can apply for individualized rates. We learned that SRS had established a work group to address this issue, but the task wasn't completed because other work took priority. SRS officials told us they explain the rules to anyone who asks.

SAFETY IMPLICATIONS OF SERVING KNI RESIDENTS IN THE COMMUNITY

The State Doesn't Track Certain Safety Outcomes For Developmentally Disabled Adults To Allow For Good Comparisons Between KNI and the Community

Our work in the previous section evaluates the cost implications of closing KNI and moving its residents into the community. This section examines the safety implications of such a move.

As part of that work, we wanted to compare abuse and neglect incidents in both settings. To do this, we searched for national studies that compared incidents in institutions and in the community, reviewed the State's inspection requirements for

institutions and community facilities, and tried to examine Kansas statistics in both settings.

For this audit, we defined safety as: “*being in an environment where an individual’s medical or behavior conditions will not inflict harm on that individual or on others because of a lack of appropriate supervision or care.*”

We couldn’t compare abuse, neglect or exploitation statistics because the data aren’t readily available for the community.

SRS has a Kansas Protection Report Center which receives calls on allegations of abuse, neglect, and exploitation (critical incidents) for adults and children. Staff within the Division of Community Supports and Services screens and investigates those reports dealing with individuals with developmental disabilities living in the community.

Although the Division collects the data, it doesn’t maintain it in a way to produce abuse and neglect statistics for adults with developmental disabilities living in the community (e.g. number of alleged and confirmed critical incidents). While each of the 27 CDDO regions also report critical incident data back to SRS, we didn’t feel comfortable relying on that data without further work. As a result, we couldn’t compare safety outcomes for KNI residents with individuals living in the community.

Medical professionals thought examining mortality rates would be necessary to determine what impact a hospital closure would have on KNI residents. We asked a number of doctors what they thought the safety implications of transferring KNI residents to the community might be. During these conversations, a couple of them suggested examining mortality rates as the only way to really know whether a community setting is safe for particularly medically fragile individuals, such as those at KNI. However, we were unable to find any relevant mortality studies and were unable to conduct such a study on our own due to time and data constraints.

Many Stakeholders Expressed Concerns About Addressing KNI Residents’ Medical Needs in the Community

To assess the safety implications of transferring KNI residents to the community, we interviewed a number of stakeholders knowledgeable about the needs and challenges of providing care for developmentally disabled individuals. We also sent surveys to 204 parents and guardians of KNI residents, 30 KNI direct care staff, 38 community service providers, and 7 medical professionals in the community who are familiar with treating KNI residents. **Appendix F** includes response rates and quotes from survey respondents.

Although we did extensive work in this area, we can only highlight the potential problems and challenges we identified. We can't predict with certainty how relocating KNI residents to the community would affect their safety.

Certain medical services KNI residents currently receive may not be available or easily accessible in the community. Our survey and interview respondents expressed two primary concerns:

- **Certain doctors or services may not be available or are difficult to access in a community setting.** It's often difficult to find doctors who are willing to accept Medicaid or Medicare patients. Additionally, community providers in rural areas may have to drive long distances to access some services. Survey responses from parents and guardians, as well as medical professionals, expressed similar concerns. Neither of these issues can be remedied by the service provider. Availability or accessibility issues would make it more difficult for KNI residents to receive the services they need in the community.
- **Medicaid or Medicare may not pay for services in a community setting, even if they are deemed medically necessary.** Services that are medically necessary may not be reimbursable through Medicaid or Medicare. For example, if the resident isn't likely to make progress while receiving the service, Medicaid may not pay for it. Similarly, neither Medicaid nor Medicare currently pays for preventative oral care.

Survey respondents questioned whether a community setting could adequately meet KNI residents' medical needs. As *Figure 2-4* on the next page shows, only community providers thought that medical services would be readily available in a community setting, however, a clear majority of doctors, KNI direct care staff, and parents and guardians disagreed. Both community providers and doctors were generally optimistic that necessary medical equipment would be available in the community. KNI direct care staff and parents and guardians disagreed, but their responses varied a little more on the subject of medical equipment than on medical services.

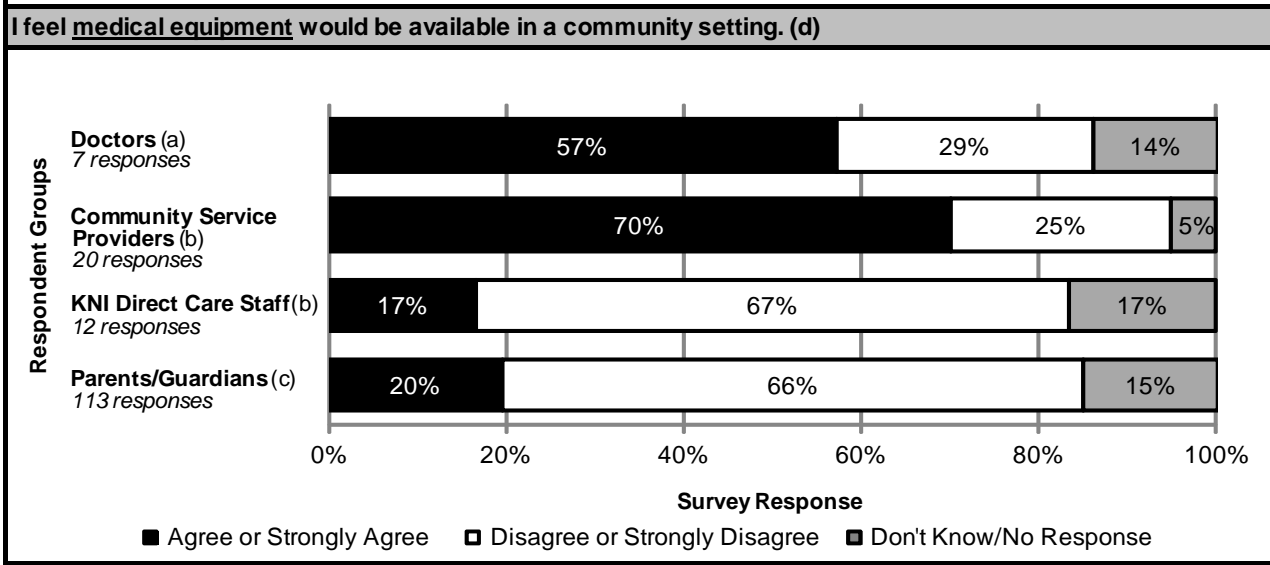
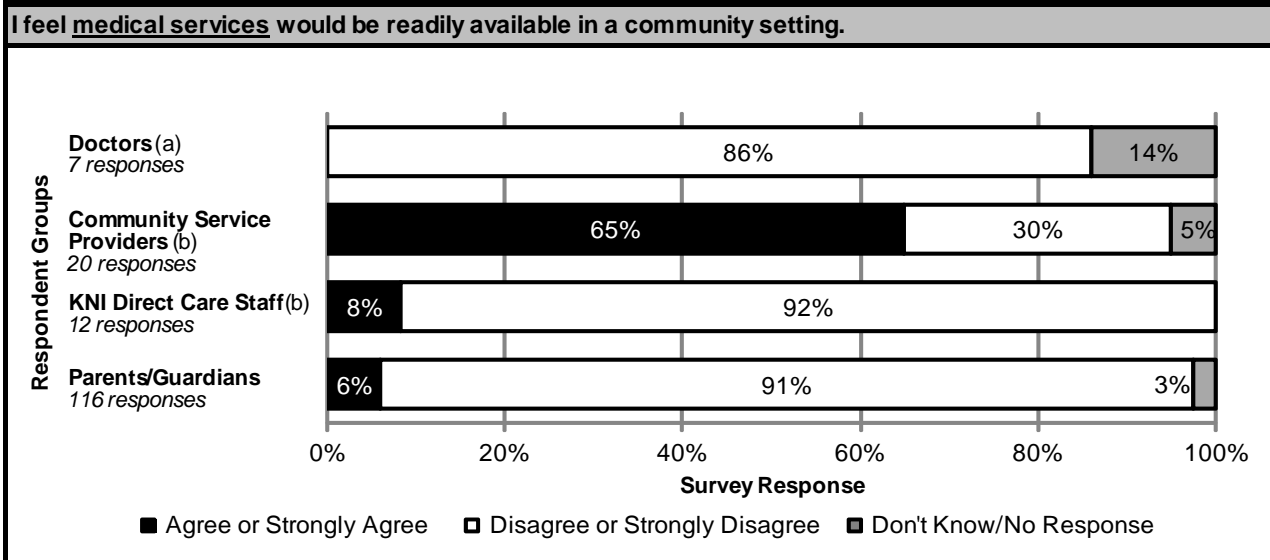
Additionally, a number of parents and guardians also expressed specific concerns that the medical services their children or wards need wouldn't be fully addressed in the community.

Fewer Stakeholders Expressed Concerns about Addressing Residents' Behavioral Needs, But Some Residents May Have Trouble Adapting to Community-Based Services

Generally, adequate medical services are the primary concern for KNI residents, but safety could also be an issue for people with severe behavioral needs.

Some KNI residents have severe behavioral issues, but community providers appear to have experience handling similar individuals. A number of KNI residents have severe

Figure 2-4
Summary of Survey Responses to Questions
Related to Medical Services by Respondent Group



(a) Responses for doctors in this category came from six doctors and one nurse.
 (b) Responses for these respondents are specific to tier one and two individuals (tier one and two are the most severely disabled individuals).
 (c) Three respondents gave multiple answers for this question and were excluded from the analysis. Therefore, these percentages are based on a total of 113 responses.
 (d) Percentages don't add to 100% due to rounding.
 Source: LPA analysis of survey responses.

issues, and survey responses from parents, guardians, and KNI staff expressed concerns about the community's ability to handle KNI residents' behavioral needs. However, community providers already serve people who have even greater needs. Currently, about 11% of the adults served in the community have severe behavior issues (defined as someone who has a maladaptive score of 135 or higher). Additionally, as shown in **Figure 2-2** on page

33, the average maladaptive score for KNI residents is lower than those served in the community.

KNI officials told us that's because many of their residents' medical conditions prevent them from acting out. In addition, KNI officials stated that the maladaptive scores are a poor indicator to measure the need for proper supports to avoid problems. According to officials, individuals who exhibit frequent, but minor, nuisance behaviors score higher than individuals with high-intensity/low-frequency maladaptive behaviors, such as biting staff members.

Our observations of community group homes showed homes had appropriate safety features for individuals who present a risk of running off or are aggressive. Furniture was made of metal and was bolted down, TVs were placed behind Plexiglas, kitchen drawers and medical equipment were appropriately secured, and we saw few decorations that could be thrown. Homes also had hurricane-strength windows, fences, alarm systems, and other security mechanisms. In several residences, we saw individuals with protective headgear.

Many stakeholders expressed concerns that KNI residents may have trouble adapting to community-based services, especially residents with behavioral issues. Parents, guardians, and KNI staff raised concerns that community providers might not have the staffing levels needed to appropriately manage individuals with severe behavioral issues. They were also concerned that significant changes in their children's or ward's environment will increase behavioral problems. Additionally, some KNI parents and guardians expressed concerns that community providers may deal with behavior problems by over-medicating individuals.

The box on the next page contains some of the concerns parents and guardians expressed about the safety of their child or ward in the community. *Appendix F* provides our survey response rates and quotes from various stakeholders.

It's important to note that many KNI residents have lived at the facility since childhood, which may make relocating to the community especially difficult. As of August 2011, the average length of stay for the 153 KNI residents was almost 31 years. KNI officials and parents and guardians emphasized that for many residents, KNI is the only home they've ever known.

Some Parents and Guardians Expressed Serious Concerns about the Level of Care Their Child or Ward Would Receive in the Community

We surveyed parents and guardians of KNI residents to get their opinions on the feasibility of transferring their children or wards into a community setting. Many of them feared their children or wards would receive insufficient or inadequate services in the community. Below are some of their comments.

- “Community placement advocates will often say that we guardians are just afraid because we don’t know what’s available ‘out there’ in the community, when in fact the opposite is true: we’re terrified because we do know what’s out there.”
- “The quality and level of care in the Topeka community varies so widely that, although we have investigated some promising possibilities, we have little confidence in community services at the level needed for our daughter.”
- “My ward spent two miserable, unsuccessful years in community placement. At the end, he was dropped back off at KNI. Because of his unhappiness, his behaviors had escalated to an intolerable level. When he returned to KNI, his behavior rapidly improved.”

Community Providers May Struggle To Offer the Same Continuity of Care That Residents Receive at KNI

Continuity in direct care staff allows long-term relationships to be formed with the developmentally disabled individual being served. Staff more familiar with their clients may be in a better position to recognize subtle changes in a person’s mood or health, especially for individuals who don’t communicate well. Finally, staff who have worked with an individual for a longer period of time may be in a better position to know what works and doesn’t work to manage that person’s behavior problems.

Continuity of care is considered by many to be one of the strengths of KNI. A number of survey respondents expressed concerns about staffing issues in the community. There appear to be two issues with continuity of care in the community:

- **Higher turnover among direct care staff in the community could adversely affect continuity of care.** A 2009 study conducted by the American Network of Community Options and Resources (ANCOR) found Kansas’ turnover rate for staff at State institutions was 28%, compared to 43% in the community. Additionally, KNI officials reported their turnover rate was about 15%, while service providers we talked to reported a turnover rate of 35% to 60%.

KNI officials also mentioned that KNI pays higher wages than community providers, which may result in less turnover. We weren’t able to evaluate the effect of pay on turnover rates. However, based on the average hourly pay for four community providers we selected for a limited review, KNI’s average pay was almost \$3.50/hour higher than the community providers’ pay.

- **The decentralized nature of medical care in the community could also affect the continuity of care.** As mentioned in Question 1, KNI has a medical unit and full-time medical staff available to treat residents who are ill. Community providers lack these resources and told us they have difficulties finding doctors who will accept Medicaid patients. As a result, medical care in the community may be more piece-meal or may involve more trips to the emergency room. Doctors we talked to expressed concerns that this approach will prevent the continuity of care needed to adequately care for individuals with complex medical needs.

KNI officials also contend that they provide more training to direct care staff, making them better able to care for residents. Based on our limited review, we found that KNI does provide more training to direct care staff than the three community providers we contacted. We found the number of training hours for those three providers ranged from 25 to 121 depending on the provider and other circumstances. In comparison, KNI requires between 170 and 238 training hours for new direct care staff, with additional hours necessary to achieve the required nurse aide and medication aide certifications. We weren't able to evaluate whether more training improves safety.

Stakeholders Strongly Disagree on Whether KNI Residents' Quality of Life Would Improve or Worsen In a Community Setting

Another important aspect of assessing the implications of transferring KNI residents to the community is the potential change in quality of life. Quality of life issues are difficult to assess because they're often very personal and subjective. For this audit, we defined quality of life as: "*all the intangible and subjective factors affecting how happy, comfortable, or independent an individual is.*"

Again, we surveyed and talked to service providers, and parents and guardians about how a KNI resident's quality of life might change if transferred to the community.

Parents and guardians expressed concerns about moving their children and wards into the community, although community providers were more optimistic. Our surveys revealed a significant difference of opinion between parents or guardians and community providers regarding the quality of life KNI resident might experience in a community setting.

- **Parents and guardians expressed serious concerns about the quality of life their child or ward would experience in the community.** Of those who responded to our survey, 114 of 116 (99%) said they thought the quality of life of their child or ward is "better" or "much better" at KNI than it would be in the community.
- **KNI staff unanimously agreed that the quality of life of KNI residents would be better at KNI than in the community.** All 12 of the KNI staff who responded to our survey said the quality of life of KNI residents would be "much better" at KNI than what a resident would experience in the community.

- **Conversely, community providers were generally optimistic about the quality of life KNI residents would experience in the community.** Our survey of community service providers showed that 12 of 20 (60%) said the quality of life of KNI residents would be “better” or “much better” in the community than at KNI, while two respondents stated quality of life would be worse in the community than at KNI. However, six of the 20 didn’t know what the quality of life would be like for KNI residents in the community.

A 1998 study of the Winfield State Hospital closure concluded that individuals’ quality-of-life outcomes improved, but some have questioned its validity. Although the study found improved outcomes, peer reviewers have questioned the methodology the researcher used in similar studies. Essentially, data used to form the report’s conclusions only included 88 individuals who may not have been representative of the 209 Winfield State Hospital residents who transferred to the community. 42 of 251 former Winfield residents (17%) were transferred to KNI or Parsons State Hospital when it closed.

Lastly, the study’s outcomes may not be as relevant to the potential closure of KNI. That’s because the facility’s care and treatment approach for individuals with developmental disabilities has changed dramatically since 1998.

In May 2011, the Centers for Medicare and Medicaid Services released a study assessing the quality of life of individuals who relocated from an institution to the community. The study included 228 respondents with developmental disabilities across 22 states. Participants reported significantly higher quality of life compared with life in an institutional setting after one year of community living.

One thing to note about this survey is that it only surveyed individuals who had qualified for a “Money Follows the Person” grant (see page 52 for more information on this grant). These individuals may not be representative of all individuals who relocate from an institution to the community.

Some stakeholders have outdated notions about what life is like for individuals with developmental disabilities in each setting. During our work, it became apparent that a number of stakeholders may not fully appreciate how KNI or the community settings operate. As described earlier, the philosophy for treating individuals with developmental disabilities has changed dramatically over the past 20 years, especially in institutional settings such as KNI.

Based on our observations of how individuals with developmental disabilities spend their time, and how their surroundings look, it appears that the two settings are more similar than many perceive them to be. For example, **Figure 2-5** provides several pictures of bedrooms and bathrooms in both settings. As the figure shows, both environments appear clean, well maintained, and appropriate for the individual.



RELOCATION ISSUES WITH SERVING KNI RESIDENTS IN THE COMMUNITY

Transitioning Residents From KNI to the Community Would Take Time and Money

Relocating KNI residents into the community likely would present a number of challenges. We couldn't identify all of those challenges because there are simply too many variables to consider. However, we did identify a few significant issues that would need to be addressed if KNI was closed.

Community providers likely will need time to build the necessary capacity to serve KNI residents. Community service providers told us that the number of residents moving to their area could significantly affect the amount of time it takes to build appropriate infrastructure, but that given enough time they think they can provide the necessary services. SRS estimated seven residents could be moved into the community per month, which means it would take about 22 months to relocate 153 residents.

Additionally, CDDO officials we spoke with estimated it would take between 4 to 18 months to relocate a single individual. Shawnee County CDDO officials expressed concerns about this time table because they think many KNI residents would relocate to their area, which is supported by past institutional closure trends. They also had concerns about whether Shawnee County has the capacity to provide medical services for a large number of residents. Some local doctors also expressed concerns about the community's capacity to absorb large numbers of KNI residents.

During the transition period, the State will pay for some costs twice. That's because some of KNI's costs are fixed and don't decrease at the same rate as the population. This means the State will continue to pay its share of maintaining the campus, even as it pays for the care of those residents transferred into the community.

Federal funding may help cover some, but not all, of the relocation costs. As mentioned earlier, we didn't include any relocation costs in our cost savings estimate. The Center for Medicare and Medicaid Services currently operates a grant program called Money Follows the Person, which provides additional funding for individuals moving out of an institution and into a community setting. While this program may provide some relocation funding, several limitations include:

- **Individuals who transfer into group homes with more than four people don't qualify for federal funding.** At least one CDDO told us they're consolidating group homes to save money, and would find it difficult to place individuals in smaller homes.
- **Some funding for certain costs is capped.** The funding available for certain transition costs is capped at \$2,500 per

person. CDDOs told us transition costs could range from a few thousand dollars to tens-of-thousands of dollars depending on whether an individual moves into an existing, or a new, group home.

- **Additional funding for waiver services is only available for one year.** The federal government will pay 80% of the waiver service rates for the first year rather than the standard 60%. The rates return to the typical 60% after the first year.

One additional caveat is that an individual's services cannot be significantly altered after the first year. For example, if an individual is placed in a home with two other individuals, he or she cannot suddenly be moved to a home with five or six individuals when the funding ends.

Conclusion

The cost and safety implications of closing KNI and serving its residents in a community setting are both complex and far-reaching. Although both settings provide similar core services to individuals with developmental disabilities, they operate under very different circumstances. KNI is a highly centralized institution, employs a large number of specialists whose services are available to its residents, and has virtually all of its expenditures reimbursed by Medicaid. Community providers by their nature are decentralized, must transport their clients to obtain many important services, and must live within more restricted Medicaid reimbursement rates and other funding sources they can put together. These fundamental differences create the potential for about \$5 million in State savings by relocating KNI residents into a community setting. They also raise concerns about the safety and quality of life of those residents in a community setting, specifically the adequacy and availability of medical care and their ability to adapt to a new environment. Policymakers who might be interested in closing KNI should carefully weigh the potential savings and consequences of such an action.

Recommendations for Executive Action

1. To better track abuse, neglect, and exploitation data for adults with developmental disabilities and allow better comparisons between institutional and community settings, the Department of Social and Rehabilitation Services should improve its data tracking capabilities to allow it to report and evaluate statistics (allegations and confirmed cases) over time for each of the various population groups for which it is responsible.
2. To reduce confusion among community service providers and CDDOs regarding when they can seek individualized rates, SRS officials should clarify their policies of the availability of super tier and individualized rates community service providers can seek by putting those rules in writing.

APPENDIX A

Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on April 27, 2011. The audit was requested by the Topeka Legislative Delegation.

Kansas Neurological Institute: Evaluating the Efficiency of the Institute’s Operations and the Cost and Safety Implications of Moving Its Residents into Local Communities

The Kansas Neurological Institute (KNI) in Topeka is an intermediate-care facility for developmentally disabled adults and youth. Since the early 1990s, KNI has treated residents using a “person-centered” approach that focuses on allowing residents to experience as independent and normal a lifestyle as possible. This approach moves away from scheduled routines and focuses on having staff engage residents in activities such as grocery shopping, laundry, and community events like movies and basketball games. To accomplish this, KNI administers several programs including:

- **Support Living Services**—support teams develop, implement, and monitor each resident’s treatment and support plan.
- **Community Services**—staff coordinate resident community outreach services in areas such as dental care, behavioral support, assistive technology, and medical evaluations.
- **Ancillary Services**—staff provide clinical and therapeutic services for residents.
- **Medical and Surgical Services**—staff evaluate, monitor, and treat illnesses and injuries, and help prevent infectious disease.

The number of staff and residents at KNI have steadily declined over time. Since 1995, KNI staff levels have decreased from 815 to 574, or 30%; while the number of residents has declined from 254 to 156, or 39%. In fiscal year 2010, KNI spent a total of about \$29 million (including \$10.7 million in State appropriations and \$16.5 million in Medicaid). Most of those costs, about \$24 million, were for salaries and wages; the remainder was for contractual services and commodities.

Legislators have expressed interest in knowing whether KNI provides services to community members that it doesn’t charge for, whether some KNI services could be made available to others in the community, and whether KNI is using its building and land resources efficiently. Additionally, legislators would like to know how much it could cost to move KNI residents into local communities and how such a move might affect the overall safety and wellbeing of the current residents.

A performance audit in this area would address the following questions:

1. **What opportunities exist for the Kansas Neurological Institute to decrease costs through improved use of its buildings and land, or by eliminating or restructuring non-essential services?** To answer this question, we would inventory KNI’s existing

physical resources including its land, buildings, and power plant, and the costs associated with maintaining them. We would further review KNI's use and management of those resources to identify areas of possible inefficiencies such as underutilized space. In addition, we would interview KNI officials to identify services they considered essential, and those that could be eliminated or restructured to save money. For any of these services we identified, we would talk with KNI staff to estimate how much money might be saved, and what the implications might be for KNI residents.

2. **To what extent could the Kansas Neurological Institute increase revenues by charging for services it currently provides for free, or by providing services to non-resident community members?** To answer this question, we would create an inventory of KNI's medical, therapeutic, and specialized care services. In inventorying these services, we would also evaluate historic service trends such as the number of residents served, the severity of their disabilities, and how many of the residents that left KNI came back. We would interview KNI officials and staff to identify any services that KNI provides to non-resident community members that it's not compensated for, such as dental care or posture seating services. Finally, we would look for opportunities for KNI to expand the services it provides to make better use of its existing staff and building space. We would consult with KNI staff to determine the feasibility of providing those services to nonresident community members, and how much money that might generate.

3. **What are the cost and safety implications of moving current Kansas Neurological Institute residents to local communities?** To answer this question, we would interview officials from a wide spectrum of organizations knowledgeable about serving individuals with developmental disabilities such as KNI, Community Development Disability Organizations, the Kansas Health Institute and others. Based on those interviews, we would identify the major safety and medical issues related to moving KNI residents into the community. We would select a sample of residents and explore what would need to happen for those residents to be placed in a community near a close family relative, instead of in Topeka. In conducting this analysis, we would estimate what it would cost to replicate the services and staff resources currently available at KNI in local communities. Potentially relevant factors would include building renovations, transportation costs, staffing costs, and the difference between private sector medical costs and those currently incurred by KNI. Finally, we would contact a number of other states to determine how they provide services to individuals with disabilities similar to those of KNI residents.

Estimated resources: 4 staff for 18-20 weeks (plus review)

APPENDIX B

Information on Cost Savings and Revenue Enhancement Ideas We Found That Were Not Feasible or We Didn't Pursue

The following list shows cost savings ideas we evaluated, but didn't analyze in-depth because they weren't likely to result in significant savings, or would have compromised KNI's main service philosophy. Here are a few examples:

- **Contract out services:** KNI employees perform a wide variety of tasks on campus. These include grounds keeping and maintenance, custodial services, dietitian services, carpentry, painting, and physical therapy. We reviewed existing State contracts and KNI documentation, and interviewed Department of Administration officials. We found it could cost KNI more to enter contracts for these services than what KNI currently pays staff to perform the duties. Additionally, having staff perform these duties gives KNI management the flexibility of assigning tasks and more control over performance.
- **Change the pay differential policy:** A KNI staff survey response indicated KNI could save the State money by not paying the shift differential for all 8 hours staff work during second shift hours. However, we found that KNI's interpretation and actions related to the differential pay policy is in accordance with State law.
- **Begin a community garden:** Stakeholder proposed to grow a community garden on the KNI campus and to sell the produce to raise funds for KNI operations. The amount of money generated from a community garden would be minimal.
- **Reduce outings and travel with residents:** Several stakeholders told us that staff frequently take residents to see their family or guardians, or take residents on vacations. Additionally, stakeholders have questioned trips to out-of-state rodeos or events, and suggested outings should stay closer to campus to save money. We didn't pursue this idea because the audit efforts for this would exceed likely savings from changes in these areas.
- **Centralize food services operations:** In previous years, KNI centralized its food services operations in one building. Currently, each housing unit within each residential building is responsible for preparing meals for each of its residents. We didn't pursue this idea because a change in food services operations would change the care-model at KNI and is unlikely to yield significant savings.
- **Reduce the amount of overtime for KNI employees:** KNI's expenditures for overtime have increased over the past 10 years. We learned that KNI started following personnel rules on giving employees the option of getting paid overtime wages instead of compensatory time, and determined significant savings aren't likely in this area.

APPENDIX C

Distribution of Adults with Developmental Disabilities Served in Community Settings throughout Kansas

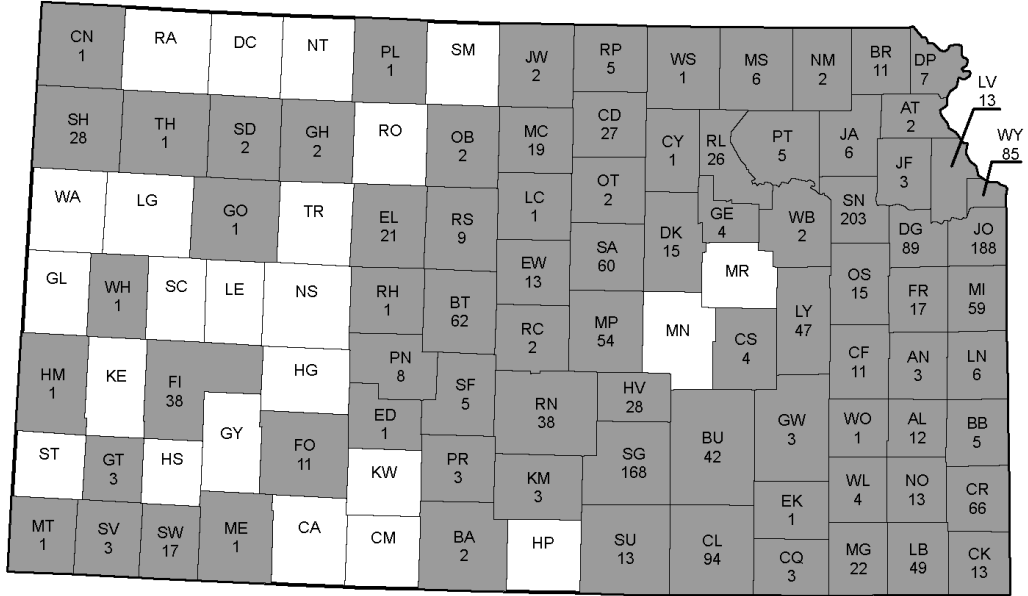
This appendix includes four maps that show the distribution of certain individuals with developmental disabilities served through the HCBS waiver across Kansas as of August 2011.

- Map #1: Shows the number of tier one (the most severely disabled) adults served in the community by county.
- Map #2: Shows the number of adults with severe medical conditions (defined as a health score of 15 or greater) served in the community by county.
- Map #3: Shows tier one adults as a percentage of all individuals with developmental disabilities being served in the community by county.
- Map #4: Shows adults with severe medical conditions as a percentage of all individuals with developmental disabilities served in the community by county.

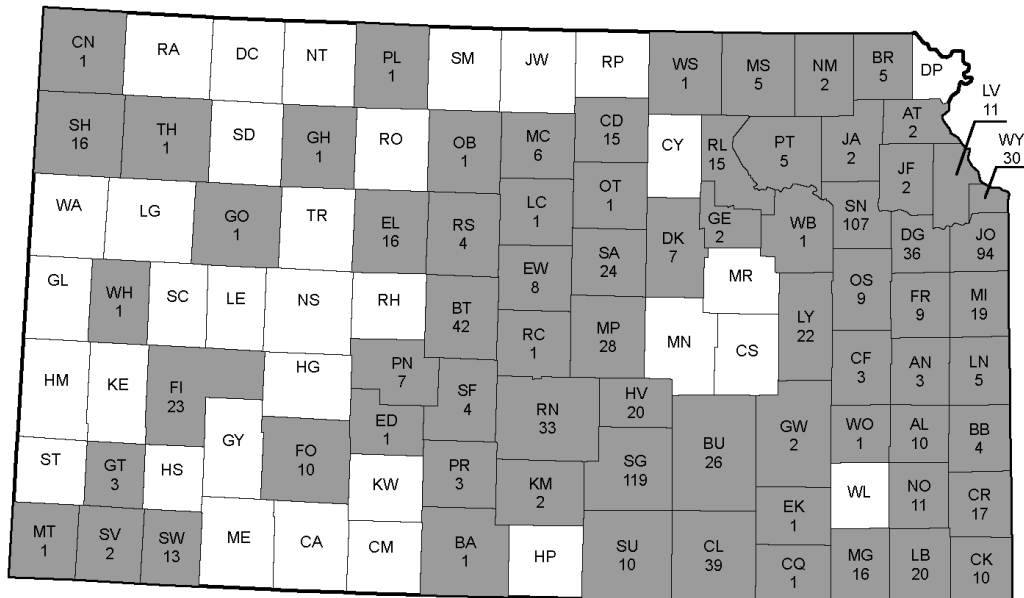
APPENDIX C

Number of Adults with Tier One or Severe Health Conditions Being Served in a Community Setting, by County

Number of Tier One Adults Served in a Community Setting



Number of Adults with Severe Medical Conditions Served in a Community Setting (a)

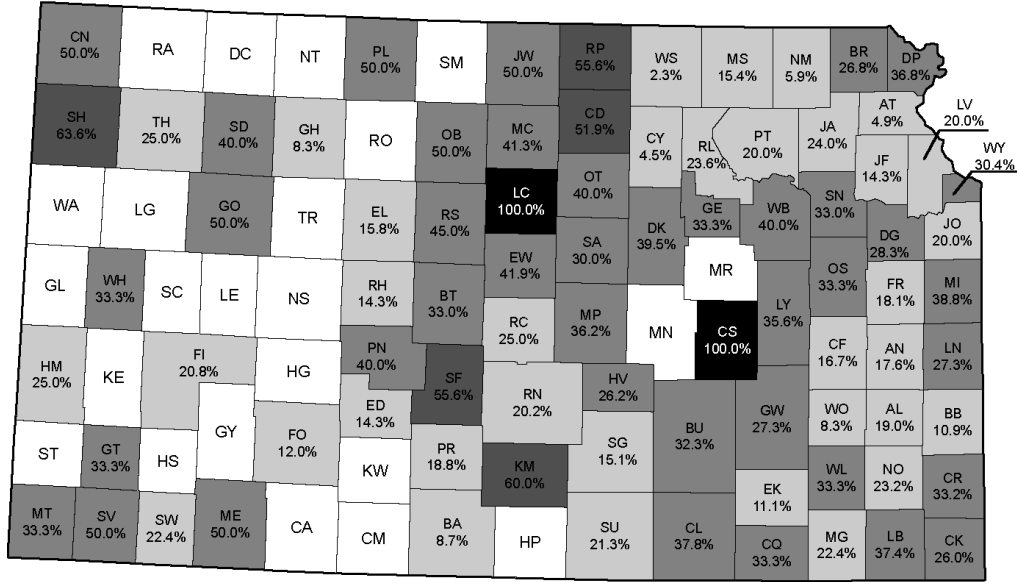


(a) Individuals with a health assessment score of 15 or higher.
Source: LPA analysis of SRS data.

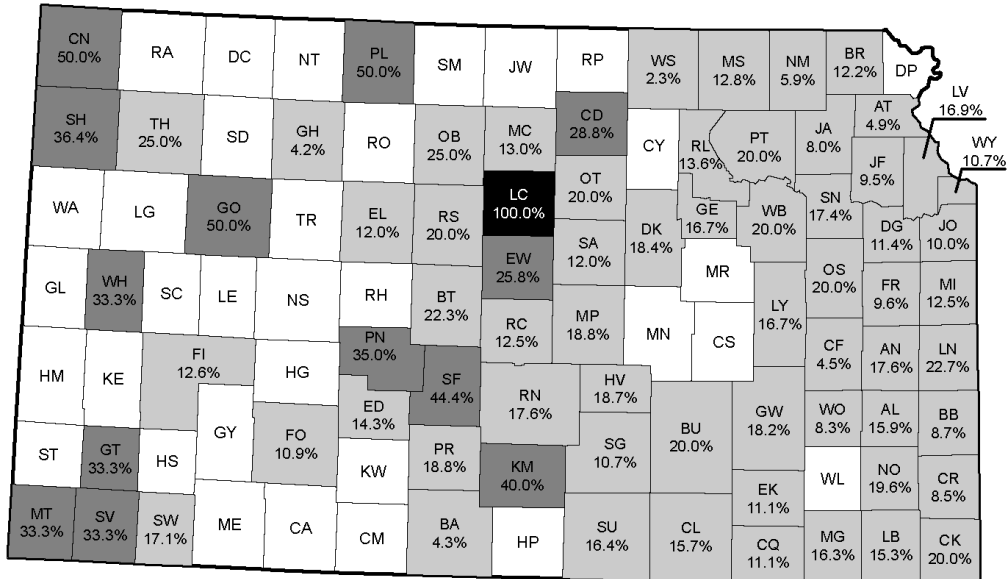
APPENDIX C

Percent of Adults with Tier One or Severe Health Conditions Being Served in a Community Setting, by County

Percent of Tier One Adults Served in a Community Setting



Percent of Adults with Severe Medical Conditions Served in a Community Setting (a)



None 1% to 25% 26% to 50% 51% to 75% 76% to 100%

(a) Individuals with a health assessment score of 15 or higher.
Source: LPA analysis of SRS data.

APPENDIX D

Methodology for Estimating Costs and Savings To Transfer KNI Residents to a Community Setting

This appendix provides the detailed methodology, assumptions, and limitations of our cost-savings estimate for serving KNI residents in a community setting.

GENERAL METHODOLOGY

To estimate potential State savings by relocating KNI residents to the community we:

- Estimated the potential cost (reimbursement rates) of serving KNI residents in the community. The costs we included were:
 - Day and residential Home and Community Based (HCBS) waiver services
 - Targeted case management
 - Administrative costs
 - Medicare costs
 - Medicaid costs for non-waiver services
 - Housing costs
- Calculated the actual per resident cost at KNI as of fiscal year 2010.
- Calculated the cost at KNI and estimated the reimbursement amounts for community providers by funding source (State, federal, local or private).
- Subtracted the estimated cost of serving a resident in the community from the per person cost at KNI.

ASSUMPTIONS

To calculate cost and savings we had to make a number of assumptions, as follows:

- All 153 KNI residents will need day and residential services because they won't live with relatives. This assumption increases our cost estimate (reduces Total and State savings estimate), but is realistic based on what is already occurring in the community. Because we assumed KNI residents to receive residential services, they wouldn't be eligible for most other waiver services, especially supportive home care. As a result, we didn't include any estimated costs for those services. We used current day and residential reimbursement rates, which were last updated in FY 2009.
- All 153 KNI residents will incur per-person targeted case management and administrative costs.
- KNI residents' use of Medicare and Medicaid services for non-waiver services will be similar to the adult individuals with developmental disabilities in the community (based on FY 2010 health scores).
- KNI residents will use most (95%) of their supplemental social security income to pay for room and board in the community.
- The estimates we calculated are based on varying percentages of individuals getting super tier funding, but not individualized rates. It is possible providers would request individualized rates to help cover the costs of very expensive individuals. In that event, our cost estimate would be understated, and State and total savings would be overstated.

LIMITATIONS

Our estimate has three main limitations:

- **Reimbursement rates don't equal costs:** The analysis is based on reimbursement rates for the vast majority of the costs. Reimbursement rates don't necessarily equal costs, especially in light of the recession—which could discourage rate increases and result in additional funding cuts for services already provided (e.g. dental, respite overnight). Without adjustments, reimbursement rates are increasingly less reflective of true costs. To the extent that reimbursement rates don't reflect true costs, the State's savings are increasingly achieved by shifting costs to providers.
- **Not all services are covered through the reimbursement rates:** For example, specialized medical care cannot be used for clients getting residential services. That's due to various SRS rules that help ensure providers are reimbursed for the more inclusive service, and not again for a specialized service that's expected to be covered through the first payment. This may put constraints on smaller service providers who can't hire or contract for a nurse cost-effectively. Similarly, periodic SRS cost studies point to non-reimbursable transportation costs as a problem, especially for more rural providers. In essence, these non-covered services may need to be subsidized with aid from federal programs, or local dollars if the Community Service Provider (CSP) has a high number of high cost clients and reimbursement rates as a whole don't cover the costs. Another possibility is that clients would not receive services they need because providers aren't able to pay the cost out of pocket.
- **Relocation costs were not included:** The model skips the years taken to relocate residents (and the dual expenditures that exist during that time period), and is based on fiscal year 2010 expenditure and reimbursement rates. The model also doesn't include any residual costs that may need to be paid by the State for maintenance of KNI grounds.

The following page shows savings by cost category based on KNI expenditures and community reimbursement rates for three different super tier assumptions (no KNI resident receives super tier funding, 75% receive super tier funding, and all residents receive super tier funding).

APPENDIX D
Sources of Savings by Cost Category Based on
KNI Expenditures and Community Setting Reimbursements

SCENARIO 1: None of 153 KNI Residents Would Receive Super Tier Reimbursement Rates

| Cost Category | KNI's Current Average Costs per Resident | | Savings per Resident | | Savings All Residents | |
|------------------------|--|-----------------|----------------------|-----------------|-----------------------|--------------------|
| | KNI (a) | Community (b) | Total (100%) | State (40%) | Total (100%) | State (40%) |
| Direct Care | \$93,500 | \$68,400 | \$25,100 | \$10,000 | \$3,846,900 | \$1,538,700 |
| Medical | \$49,300 | \$9,200 | \$40,100 | \$16,000 | \$6,130,100 | \$2,452,000 |
| Housing and Facilities | \$32,200 | \$7,700 | \$24,500 | \$9,800 | \$3,746,200 | \$1,498,500 |
| Administration | \$9,000 | \$2,600 | \$6,400 | \$2,600 | \$977,900 | \$391,200 |
| Education & Research | \$4,700 | \$0 | \$4,700 | \$1,900 | \$724,500 | \$289,800 |
| Total (c) | \$188,700 | \$87,900 | \$100,800 | \$40,300 | \$15,425,500 | \$6,170,200 |

SCENARIO 2: 75% of 153 KNI Residents Would Receive Super Tier Reimbursement Rates

| Cost Category | KNI's Current Average Costs per Resident | | Savings per Resident | | Savings All Residents | |
|------------------------|--|------------------|----------------------|-----------------|-----------------------|--------------------|
| | KNI (a) | Community (b) | Total (100%) | State (40%) | Total (100%) | State (40%) |
| Direct Care | \$93,500 | \$86,400 | \$7,100 | \$2,900 | \$1,088,000 | \$435,200 |
| Medical | \$49,300 | \$9,200 | \$40,100 | \$16,000 | \$6,130,100 | \$2,452,000 |
| Housing and Facilities | \$32,200 | \$7,700 | \$24,500 | \$9,800 | \$3,746,200 | \$1,498,500 |
| Administration | \$9,000 | \$2,600 | \$6,400 | \$2,600 | \$977,900 | \$391,200 |
| Education & Research | \$4,700 | \$0 | \$4,700 | \$1,900 | \$724,500 | \$289,800 |
| Total (c) | \$188,700 | \$105,900 | \$82,800 | \$33,100 | \$12,666,700 | \$5,066,700 |

SCENARIO 3: All 153 KNI Residents Would Receive Super Tier Reimbursement Rates

| Cost Category | KNI's Current Average Costs per Resident | | Savings per Resident | | Savings All Residents | |
|------------------------|--|------------------|----------------------|-----------------|-----------------------|--------------------|
| | KNI (a) | Community (b) | Total (100%) | State (40%) | Total (100%) | State (40%) |
| Direct Care | \$93,500 | \$92,400 | \$1,100 | \$400 | \$168,300 | \$67,300 |
| Medical | \$49,300 | \$9,200 | \$40,100 | \$16,000 | \$6,130,100 | \$2,452,000 |
| Housing and Facilities | \$32,200 | \$7,700 | \$24,500 | \$9,800 | \$3,746,200 | \$1,498,500 |
| Administration | \$9,000 | \$2,600 | \$6,400 | \$2,600 | \$977,900 | \$391,200 |
| Education & Research | \$4,700 | \$0 | \$4,700 | \$1,900 | \$724,500 | \$289,800 |
| Total (c) | \$188,700 | \$112,000 | \$76,800 | \$30,700 | \$11,747,000 | \$4,698,000 |

(a) KNI's expenditures are based on actual costs for fiscal year 2010.
(b) Community costs represent the estimated cost to serve a KNI resident in the community based on the most current reimbursement rates.
(c) Total may not add up due to rounding.

Source: LPA analysis of Medicaid, Medicare, and SRS data.

APPENDIX E

Summary of Five KNI Residents Reviewed

This appendix includes an average estimated cost of each of the five KNI residents we reviewed. The costs are made up of the following five cost categories:

- **Direct care:** Represents expenditures associated with providing staff to assist residents in various areas such as bathing, eating, managing medications, and other every day activities.
- **Medical:** Expenditures related to the various medical appointments and specialists the resident would need to visit to meet their medical and behavioral needs.
- **Administrative:** A 15% allowable charge used by the CDDOs to account for extraordinary funding cost calculations.
- **Other:** Includes such things as transportation and ongoing medical equipment costs.
- **One-time relocation costs:** Includes costs such as remodeling a house to be ADA compliant or purchasing specialized vehicles.

Below is the average community cost estimate of each of the KNI residents.

| Average Estimated Community Costs to Provide Services for Five KNI Residents (a) | | | | | | |
|--|------------------|------------------|------------------|------------------|------------------|--------------------------------|
| Cost Categories | Resident 1 | Resident 2 | Resident 3 | Resident 4 | Resident 5 | Average For All 5 Residents |
| Direct Care | \$152,039 | \$177,002 | \$122,934 | \$153,038 | \$113,621 | \$143,727 |
| Medical (b) | \$4,501 | \$11,399 | \$17,468 | \$4,743 | \$4,500 | \$8,522 |
| Administrative | \$29,207 | \$33,686 | \$26,468 | \$28,239 | \$22,455 | \$28,011 |
| Other | \$8,964 | \$2,489 | \$9,583 | \$2,240 | \$9,124 | \$6,480 |
| Total Annual Costs | \$194,711 | \$224,575 | \$176,453 | \$188,260 | \$149,699 | \$186,740 |
| <i>One-Time Relocation Costs</i> | \$31,077 | \$15,673 | \$43,577 | \$7,061 | \$31,444 | \$25,767 |
| (a) The data presented here represent the average of three CDDOs estimated costs for 5 non-randomly selected KNI residents. This work was based on a hypothetical situation, so this information should be viewed as an indicator of potential costs only. It doesn't necessary reflect what costs would actually be for any or all KNI clients in the event of a relocation to the community. (b) Medical costs are understated because providers generally don't know or have access to Medicaid or Medicare cost data. | | | | | | |
| Source: LPA analysis of cost information provided by three CDDOs. | | | | | | |

This appendix also includes demographics, disability information, and service needs for the five KNI residents, shown on the next page. This information came from our review of the KNI residents' health files, interviews with their direct care staff, and other related information.

**APPENDIX E
Summary of KNI Residents Reviewed**

| | Resident 1 | Resident 2 | Resident 3 | Resident 4 | Resident 5 |
|--|-------------------------------|-----------------|--------------------------|--------------------------|--------------------------|
| Gender | Female | Male | Female | Male | Male |
| Age | 37 | 20 | 42 | 41 | 60 |
| Tier Score | 1 | 2 | 1 | 4 | 3 |
| Adaptive Score | 351 | 284 | 500 | 303 | 391 |
| Health Score | 16 | 9 | 10 | 6 | 10 |
| Maladaptive Score | 91 | 133 | 0 | 86 | 75 |
| Converted Score | 198 | 171 | 150 | 135 | 167 |
| Primary Disability | Developmentally Disabled | Autism | Developmentally Disabled | Developmentally Disabled | Developmentally Disabled |
| Other Disability(ies) | Autism, Seizures | Seizures | Seizures | Autism, Seizures | Autism |
| Use a wheelchair? | Yes | No | Yes | No | Yes |
| Other health issues | Uses a vagus nerve stimulator | N/A | Uses a gastrostomy tube | N/A | Blind |
| HABILITATION SERVICES (Daily Services) | | | | | |
| Assistance taking prescription medications | Daily | Daily | Daily | Daily | Daily |
| Assistance with bathing and personal hygiene | Daily | Daily | Daily | Daily | Daily |
| Assistance getting dressed | Daily | Daily | Daily | Daily | Daily |
| Assistance with preparing/eating meals | Daily | Daily | Daily | Daily | Daily |
| Someone to be present when using the bathroom | Daily | Daily | Daily | Daily | Daily |
| Money management | Daily | Daily | Daily | Daily | Daily |
| MEDICAL SERVICES (c) | | | | | |
| Physician | Every 6 months | Every 12 months | Monthly | Every 12 months | Every 3 months |
| Neurologist | Every 3 months | N/A | Every 3 months | Every 6 months | N/A |
| Podiatrist | N/A | N/A | Monthly | Monthly | Every 3 months |
| Speech/Hearing Pathologist | Every 12 months | Weekly | Every 12 months | Every 12 months | Every 12 months |
| Social Worker | As needed | As needed | As needed | As needed | As needed |
| Nursing | As needed | As needed | Daily | Weekly | As needed |
| Dietitian | As needed | As needed | As needed | As needed | Monthly |
| Dentist | Every 6 months | Every 6 months | Every 3 months | Every 6 months | Every 6 months |
| Endocrinologist | N/A | Every 6 months | N/A | N/A | N/A |
| Psychiatrist | N/A | Every 6 months | N/A | Every 4 months | Every 4 months |
| Psychologist | N/A | As needed | N/A | Every 6 months | Every 3 months |
| Oral Surgeon | N/A | Every 12 months | N/A | N/A | N/A |
| Physical/Occupational Therapy | N/A | N/A | Weekly | N/A | Every 12 months |
| Optometrist | N/A | N/A | Every 12 months | Every 12 months | Every 12 months |

(c) The information included in this table is as of August 2011 and based on a review of each resident's file and in our conversations with KNI staff at that time. Upon review of the document in November 2011, KNI officials told us they believed that a couple of residents who are indicated as not receiving certain medical services actually do. We didn't update the information because of time constraints and because the estimated cost of medical services represent a very small part of the total costs providers estimated and isn't likely to significantly affect our findings.

Source: LPA analysis of KNI residents' medical and other files.

APPENDIX F

Summary of KNI Stakeholders Survey Information

We administered surveys to parents and guardians of KNI residents, a portion of experienced KNI direct care staff, medical professionals familiar with KNI residents, and a number of Community Developmental Disability Organizations (CDDOs) and Community Service Providers (CSPs) throughout Kansas. Some CDDO and CSP respondents had concerns about the level of knowledge we assumed they would have regarding KNI operations and residents in some of our survey questions.

- KNI Parents/Guardians: 116 responses out of 204 surveys sent (57% response rate)
- KNI Direct Care Staff: 12 responses out of 30 sent (40% response rate)
- Medical Professionals: A total of 7 phone surveys were administered to medical professionals (six doctors, one nurse) familiar with KNI residents' medical issues
- CDDO/CSPs: 20 responses out of 38 surveys sent (53% response rate)

We provided space on each survey for respondents to provide additional comments. A sample of these comments is provided below.

Comments Related to Services in Both Settings:

“Periodically KNI is threatened with closure and we are forced to start looking at community living. Every facility we look at tells us they wouldn’t be able to care for him and give him what he needs for his special care.” – *KNI Parent/Guardian*

“Community services should be more than adequate to meet the needs of most KNI residents.” – *CDDO/CSP*

“I would define KNI as a home that offers a safety net protecting all the residents in a close knit community campus; a place with exceptional caregivers who provide 24/7 medical care, behavioral intervention, emotional support for both residents and their families...Their list of needs is very extensive and well met by KNI staff.” – *KNI Parent/Guardian*

“The goal would be to provide a comparable quality of life with the intent to offer new levels of community inclusion that improve the quality of life for many people.” – *CDDO/CSP*

Comments Related to Transition Issues:

“We have already experienced 2 state hospital closures (successfully).” – *CDDO/CSP*

“The intent is that services will be comparable to what they receive at KNI. If comparable services cannot be provided for some reason, that may be an individual who is not yet ready to transition to community services.” – *CDDO/CSP*

“In general, we believe residents of KNI would adapt well to community services. Some individuals may have specialized support needs that cannot be sufficiently duplicated in community settings.” – *CDDO/CSP*

“(KNI Resident) does not adapt easily to change, and behavioral problems have resulted from moves in past. Must have 24/7 care for multiple meds, toileting, food prep, etc. Early discussions with local providers indicate it will be difficult to provide the extensive care that is required.” – *KNI Parent/Guardian*

“Community staff have the skills necessary to meet day-to-day needs, but would need to learn about each individual transitioning from KNI before they would be able to provide appropriate care for that person.” – *CDDO/CSP*

Comments Related to Medical Issues:

“We currently support people with all types of medical needs in the community, but it is possible that some residents of KNI may need specialized medical needs that require resources we don’t currently have.” – *CDDO/CSP*

“Most rural communities don’t have ready access to specialists that are available to the clientele at KNI.” – *CDDO/CSP*

“I am (Name)’s Sister/guardian. I have been an RN for over 40 years. With my brother’s level of severe disability and based on my experiences, he would never be a candidate for a setting outside KNI. He is medically fragile and I would fear for his life if he were to be placed in a “community setting.” Besides, he is already in a fine community at KNI.” – *KNI Parent/Guardian*

“Quality of life for those without high medical needs would be better in the community.” – *CDDO/CSP*

“In this day and age, there are still doctors who don’t want to deal with or treat these people. Some doctors have done only the minimum when dealing with this population...” – *KNI Staff*

“There are a limited number of physicians who accept Medicaid recipients.” – *CDDO/CSP*

Comments Related to Abuse and Neglect Concerns:

“We have tried community services twice (residential, etc) and a placement at Parsons. All three placements failed because of an inability to recruit, hire, train and retain consistent, appropriate staffing. My poor brother suffered the consequences of all three failed attempts. He was injured when staff were unable to manage him; he was taken to hospital by police who handcuffed him and scared him to death; he was over-medicated. Each time a placement failed, (name) was returned to KNI to bring him back to where he was before leaving KNI. My brother is safe, happy, and well-cared for by consistent well trained staff at KNI. If KNI closes down, THERE WILL BE NO SAFETY NET when community placements fail.” – *KNI Parent/Guardian*

“Community settings were the absolute worst! Poor supervision, apathetic workers, high turnover, etc.”
– *KNI Parent/Guardian*

“We have always been very comfortable having [KNI resident’s name] stay at KNI with his care, safety, and medical needs. We feel this attention will be lost in a community setting.” – *KNI Parent/Guardian*

“I don’t feel comfortable with putting [KNI resident’s name] in a community setting. I have two other wards in the community and it isn’t working the way I would have liked it.” – *KNI Parent/Guardian*

“We looked into community living and realize as his family it’s not what is right for him. He needs supervision that I don’t see those in community homes getting.” – *KNI Parent/Guardian*

“She has been getting excellent support and care at KNI. We just don’t think that she would get this much personal attention in a community setting.” – *KNI Parent/Guardian*

“There are major issues with most community programs that make them unrealistic placements for our wards and family members: High direct-care staff turnover, undertrained, underqualified direct-care staff, which leads to unreported medication errors, an inability to handle or prevent aggression of housemates against each other (SRS seems to underplay peer-on-peer violence, as though it’s not “real” abuse), lack of vehicles and staff, which leads to isolation, rather than inclusion, in the larger community, lack of adequate medical services and equipment, lack of on-site supervision, which leads to abuse and neglect.” – *KNI Parent/Guardian*

Comments Related to Funding Issues:

“To ours and other families it [KNI] is not simply a budget line on a piece of paper, it’s our children’s home, the place where our children grew up” – *KNI Parent/Guardian*

“...I also strongly believe that the cost to the state is actually higher by placing Tier 1 level residents and others in a community home setting. Because of my son’s behavioral problems and extreme medical issues, there will be a consistent 911 response team required for emergency care and added burden to Stormont Vail Hospital...It is not anyone’s right to determine or expedite his passing by placing him in a place which offers substandard and inadequate medical care and no safety net...” – *KNI Parent/Guardian*

“Current HCBS rates do not support sufficient wages for direct care staff to minimize staff turnover.” – *CDDO/CSP*

“When rates are so low and therefore wages are low, experienced staff are hard to find and keep. Good quality employees are going elsewhere where they can make more money for less stressful work.” – *CDDO/CSP*

“My concern is they don’t pay well in the community so the staff turnover is higher than KNI so the people don’t get to have close relationships with staff like they do at KNI.” – *KNI Staff*

APPENDIX G

Agency Response

On November 18, we provided copies of the draft audit report to the Department of Social and Rehabilitation Services (SRS) as well as the Kansas Neurological Institute. We made minor changes or clarifications to the draft report as a result of KNI's informal and technical responses and additional information.

As KNI's umbrella agency, SRS chose to provide a single response, which is included in this Appendix. In their response, SRS officials did not comment on the report's findings and conclusions. While officials did not indicate whether the agency would implement the report's recommendations, they did say they planned to study the recommendations further.

Office of the Secretary
915 SW Harrison St., 6th Floor
Topeka, KS 66612-1354



Phone: (785) 296-3271
Fax: (785) 296-4685
www.srs.ks.gov

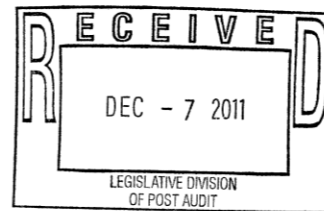
Robert Siedlecki, Secretary

Sam Brownback, Governor

December 6, 2011

Re: LPA Audit – Kansas Neurological Institute: Evaluating the Efficiency of the Institute’s Operations and the Cost and Safety Implications of Moving Its Residents into Local Communities

Mr. Scott Frank, Legislative Post Auditor
Legislative Division of Post Audit
800 Southwest Jackson Street, Suite 1200
Topeka, Kansas 66612-2122



Dear Mr. Frank:

Thank you for the opportunity to respond to the draft performance audit report, *Kansas Neurological Institute: Evaluating the Efficiency of the Institute’s Operations and the Cost and Safety Implications of Moving Its Residents into Local Communities*. We appreciate the time your staff devoted to this audit work.

At the Department of Social and Rehabilitation Services (SRS), we strive to maximize the use of resources that have been granted to us as we serve those entrusted to our care. Your recommendations contained in the audit report provide us with additional ideas for achieving such operational efficiencies. We will work with legislators, stakeholders and others to review and assess the feasibility of implementing the recommendations suggested under Question 1. We will also study the feasibility of implementing the recommendations for Question 2.

Should you have additional questions or need further information, please contact Barney Hubert, Superintendent, Kansas Neurological Institute. He can be reached at (785) 296-5301 or by email at Barney.Hubert@kni.ks.gov.

Best regards,

A handwritten signature in black ink, appearing to read "Robert Siedlecki".

Robert Siedlecki, Secretary

CC: Barney Hubert, Superintendent, KNI
Jeff Kahrs, Chief of Staff, SRS
Pedro Moreno, Deputy Secretary, SRS DBHS
Greg Harris, Deputy Secretary, SRS Administration
Mary S. Hoover, Director, SRS Office of Audit and Consulting Services