MINUTES

JOINT COMMITTEE ON CHILDREN'S ISSUES

December 1, 2003
Room 313-S—Statehouse

Members Present

Representative Brenda Landwehr, Chair
Senator Nick Jordan, Vice Chair
Senator David Corbin
Senator Henry Helgerson
Senator David Jackson
Senator Janis Lee
Representative Patricia Barbieri-Lightner
Representative Willa DeCastro
Representative Sue Storm
Representative Roger Toelkes

Staff Present

Hank Avila, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Renae Jefferies, Revisor of Statutes Office
Almira Collier, Committee Secretary

Morning Session

The Chair, Representative Landwehr, called the meeting to order.

Staff called attention to a letter from Andy Allison, Kansas Health Institute, providing information relative to the differential in the number of applications for the state child health insurance plan between urban and rural areas. This information had been requested by the Committee at a previous meeting (Attachment 1).

Committee Minutes

A motion was made and seconded to approve the Committee minutes for October. Motion carried.

Children's Cabinet Activity

Melissa Ness, Chair, Kansas Children's Cabinet, referred to written testimony covering the functions of the Children's Cabinet relative to childrens' programs in early education and fact sheets showing where the investment of dollars is made (Attachment 2). Ms. Ness gave a summary of how the Kansas Children's Cabinet evolved, the current obligations, and priority areas. The Cabinet, established by statute in 1999, was given four major functions:

- Advise the Governor and Legislature regarding the use of moneys credited to the Children's Initiative Fund from the Master Tobacco Settlement;
- Assess and evaluate initiatives receiving moneys from the Children's Initiative Fund;
- Assist the Governor to develop and implement a coordinated, comprehensive delivery system to serve families and children; and
- Support the prevention of child abuse and neglect through the Children's Trust Fund.

Identifying early childhood as the most effective area for a positive return on the investment of state dollars, the Cabinet carries out the mission of "putting kids first" by funding initiatives that enhance the lives of children through comprehensive and integrated community-based programs. Guided by the principles that early investment is smart, working collaboratively maximizes results, local control works best, and proven strategies should be used to achieve success, the activity of the Cabinet has been focused in three key areas:

- Programming for early education with Smart Start, a concept by which communities develop programs to assist children enter school ready to learn, as the top priority;
- Evaluation and funding; and
- Education and building local support.

Addressing the responsibility for evaluating initiatives receiving moneys from the Children's Initiative Fund, Ms. Ness stated there is an outside consultant working with the Cabinet to evaluate the investments in Smart Start, and good data is being developed relative to the value of the investments.

Although only a small percentage of the Children's Initiatives Fund was allocated to Smart Start last year, the Cabinet's intention, using evaluative data, is to work toward increasing the funding for this initiative. The Cabinet's recommendation to the Governor is to increase Smart Start funding up to $10 million which would mean shifting moneys from programs that have received Children's Initiatives Fund monies in the past but do not meet Smart Start criteria. However, the Cabinet does not advocate the removal of funds from early childhood education programs that have demonstrated effectiveness. Rather, there is a need to develop a multi-layered strategy of looking for revenue.

Noting the membership of the Cabinet is diverse, Ms. Ness said she would provide the Committee with a membership list.

Smart Start Kansas

(See Attachment 2). Joyce A. Cussimano, Executive Director, Kansas Children's Cabinet, stated Smart Start Kansas is a model for community planning and decision-making that provides local communities both the structure (the implementation of five core service areas which have been proven effective) and the flexibility to meet their specific needs. The long-term evaluation of the effectiveness of this initiative will include assessment of school readiness among the children participating in local community programs. In 2002, 13,136 children ages 0-5 were served by Smart Start Kansas activities. Turnover rates for early childhood professionals are lower in centers where Smart Start Kansas wage supplementation programs are implemented. Forty-one early child care centers and preschools are participating in the National Association for the Education of Young Children accreditation process and eight have completed the process. There have been 5,134 health consultations for children ages 0-5, with 974 referrals and 1,642 follow-up contacts facilitating connections with health services. There have been 859 educational and family support home visitation services to families with children ages 0-5 and 777 referrals, with 631 follow-up contacts to facilitate connections with needed services. In addition to the statistics, narrative reports, and systems and community level changes are reviewed. Some communities have reported the elimination of duplication of services thereby freeing resources for other types of services. Included in Attachment 2 is further information about the programs receiving Smart Start Kansas Grants and Early Childhood Comprehensive Planning Grants. The latter grants will help communities improve local decision making relative to early childhood programs and to secure access to Smart Start Kansas funds or other funding sources.

Children's Trust Fund Prevention Grants

Ms. Cussimano stated funding for the Children's Trust Fund Prevention grants comes from federal Community Based Family Resource and Support (CBFRS) funds which were matched originally with Children's Trust Fund monies resulting in a depletion of this fund. In FY 2003, the Cabinet began utilizing Smart Start Kansas family support expenditures as the matching funds. The funds are awarded to community coalitions to develop, operate, expand, and enhance programs aimed at child abuse and neglect prevention. A total of $661,301 is currently released to local entities in both multiple-year grants with reducing amounts over a five-year period and in one-time special project grants. Five sites have successfully maintained programming established by these grants in recent years. Grants have also been awarded to communities to support service planning. The Cabinet is currently looking at how to link the Smart Start Kansas and federal funding more closely to enhance services provided through both funding sources. Included in Attachment 2 is further information relative to entities receiving grants and the activities supported by each.

Also included in Attachment 2 are the Children's Initiatives Fund Recommendations for FY 2005 submitted to the Governor. The Cabinet is recommending an increase in Smart Start Kansas with all other programs held at the current level. A separate line item for Children's Cabinet administration is recommended to reflect more clearly the cost of administering the program.

Responding to a question, Ms. Cussimano stated the 5 core areas of services are quality of care and education for children, affordability of early child care and education, availability of child care and education, health care services for children, and family support services.

The conferee, in answer to a question, stated there are three reasons for the dramatic reduction in turnover rates for early childhood professionals in Smart Start Kansas locations. People are becoming educated about child development and, when one knows his job, it is more rewarding; supplementing salaries means people can make a living wage; and scholarship money has given workers the opportunity to get degrees. Based on stories from the sites, it appears to be more than just a tight job market.

Responding to a question, Ms. Cussimanio stated she would provide the Committee information showing a comparison of starting salaries for Smart Start Kansas sites and sites not in the program.

Attention was called to the fact that the FY 2005 budget recommendation to the Governor exceeds the total Children's Initiative Fund monies for FY 2005. Ms. Cussimanio noted there will be some additional money coming into the Fund. Ms. Ness stated the Cabinet is hoping to work with the legislature to find where efficiencies can be realized and new revenues can be generated.

Staff was asked to provide a list of all programs currently providing services to children 0-5 years of age and the services each provides in January. It was noted it may be important to look at how these programs were funded prior to the Children's Initiative Funds and if the latter funding is supplanting other funding contrary to the original intent.

In response to a question, Ms. Ness stated the Cabinet administers the Children's Trust Fund and receives some revenue from the sale of license plates and limited edition prints. Ms. Ness was asked to provide a flow chart showing the funding sources and the amounts received from each funding source for the last three years. Ms. Ness, answering a question, stated there is a separate application for each funding stream since the focus of each stream is different. Communities are breaking out the streams of funding for various activities or programs.

Answering a question, Ms. Cussimanio stated she did not have the exact figure of how much came to the state from the tobacco settlement last year but thought it was around $56 to $60 million. The Children's Initiative Fund received a little over $46 million. The remainder is to be put in the Key Fund which is the investment account. Last year it was all used so the current balance in the Key Fund is zero (Attachment 3).

Ms. Cussimano was asked to provide more details about the programs listed in the written testimony for the appropriate legislative committees at the beginning of the legislative session.

Answering a question, Ms. Ness stated there is no data showing how many children are served in all programs or how many are being served in multiple programs. A problem is arriving at a common definition of "early childhood" so there is consistency in the data collected. There is no data currently showing how many children may be income-eligible for some programs.

Ms. Cussimano, in response to a question, stated the $500,000 recommended for tobacco programs in FY 2005, which is the same as for this year, is for tobacco specific programs. However, other programs impact risk factors associated with tobacco abuse as well as other addictions. Ms. Ness added the Cabinet felt there was not the capacity to evaluate all of the former programs in order to make a recommendation on a "go forward" basis. This does not mean that programs funded by the Legislature are not good programs which would be beneficial to communities. However, the decision of the Cabinet was to make Smart Start Kansas a priority.

Kansas Children's Campaign

Nancy Lindberg, Director, Kansas Children's Campaign, presented an outline of testimony (Attachment 4), and provided copies of "Invest Early Good Beginnings Last a Lifetime," an information sheet about Smart Start published by Kansas Action for Children (Attachment 5), and a copy of a Topeka Capital-Journal editorial, "Smart Start" (Attachment 6). Ms. Lindberg stated the Kansas Children's Campaign established in 2001 is a non-partisan initiative of Kansas Action for Children for improving the lives of children and families by making children's issues a top priority. Based on town hall meetings, surveys, forums, and polls, the Campaign's Leadership Committee developed the "Three Promises to Kansas Families" platform. The promises are:

- Affordable and accessible early care and education opportunities,
- Effective parent and family support services, and
- Safe and constructive out-of-school programs.

The way the Campaign is putting the first two promises into action is by supporting expanded funding for Smart Start Kansas and joining forces in this effort with the Kansas Children's Cabinet. This program puts an emphasis on prevention and reaching children at an early age with a focus on meeting children's needs at the community level. The Kansas Children's Campaign also hopes to educate the public about the importance of early care and education for children and what this can mean to the community. The aims of Smart Start are:

- Better preparation for school.
- Better support and more resources for parents,
- Better education for early childhood teachers and child care workers,
- Improved quality and availability of child care,
- More access to comprehensive education and support services for families,
- Healthier children, and
- More skilled and better-trained workforce for the business community.

Noting there are seven Smart Start programs that include 19 counties, Ms. Lindberg stated there are two counties waiting to see if funding will be available and additional counties have expressed an interest in the initiative. In Garden City, 13 counties have come together to submit a planning grant to the Children's Cabinet. The Hutchinson community, which was denied funding in 2001, has plans in place to provide a program for its children.

Ms. Lindberg introduced Steve Kearney, Chair, Out-of-School Program Task Force, to discuss the third promise of the Campaign, safe and constructive out-of-school programs. Mr. Kearney stated The Task Force, which has had one meeting, consists of law enforcement officers, police chiefs, sheriffs, and prosecutors from all around the state. The membership is listed on the Web site, ks4kids.com. There is a need for out-of-school programs from 3:00 to 6:00 p.m, a high crime rate time for youth. This group will be looking at what communities have programs, how programs are being funded, what types of programs are working, and what the needs are. The plan is to bring the information collected to the Joint Committee next year with some thoughts about meeting the identified needs.

HealthWave

Staff apologized that the legislative staff was not aware the Medicaid portion of HealthWave has included some adults since the October 2002 addition of managed care for the Title XIX portion of HealthWave. It was noted that legislators had not been aware of the inclusion of adults either. For this reason, one needs to be aware that data related to Health Wave presented by various entities to the Joint Committee as well as other committees in the past year may not reflect just children and youth. Staff reviewed the background of the state legislation creating the children's health insurance program in response to federal enactment of Title XXI of the Social Security Act enacted in 1997. At that time the Health Care Reform Legislative Oversight Committee began studying the provisions of the new Title XXI and both the Commissioner of Insurance and the Secretary of Social and Rehabilitation Services appointed task forces to look at the new legislation. The Health Care Reform Legislative Oversight Committee incorporated the recommendations of the two task forces into the committee recommendations and introduced 1998 Senate Bill 424 providing for the expansion of the Medicaid Program to include children and youth eligible under the new federal legislation. Once the bill was introduced, the leadership of the House and Senate appointed a task force which included

four members from the executive branch and members from each house of the legislature (Attachment 7). The report of this task force was given to the Senate Committee on Commercial and Financial Institutions in the form of Senate Substitute for SB 424 which, rather than expanding the Medicaid program, created a separate Title XXI Child Health Insurance Program providing for a capitated managed care health plan covering children up to age 19 with coverage subject to appropriations. The House Committee on Appropriations proposed amendments, which made few substantive changes, that resulted in House Substitute for Senate Substitute for Senate Bill 424.

One provision that was in the legislation from the time of the first substitute bill with no changes in the wording was that the Secretary of Social and Rehabilitation Services, in contracting for capitated managed care for children shall include in the pool of persons to be covered those eligible children covered by the Kansas Medicaid Program as the law allows. The House added sections creating the Joint Committee on Children's Issues, requiring the Secretary to review and report on specific issues to this Joint Committee, and sections relating to funding and the initial transfer of funds. The final version provided that the Secretary, when contracting for services for Title XXI children, is to include that population within the pool that represent the children in Medicaid. (See Attachment 8 for the Supplemental Note on House Substitute for Senate Substitute for Senate Bill 424 and Attachment 9 for Chapter 125 of the 1998 Session Laws) The only change since enactment has been to delete the provision that any child with coverage in the prior six months who dropped that coverage without cause would not be eligible for the Title XXI portion of the plan for 12 months.

Staff noted nothing in the legislation, the minutes of the Senate Committee on Commercial and Financial Institutions, the task force reports, or the house subcommittee notes indicates it was the intent of the legislature to include persons other than children and youth in the program that is authorized by Chapter 125. Rather, the emphasis appears to be on creating a program that applies just to children and youth eligible for either Title XIX or XXI by creating specific program components applicable only to such children and youth. An example is 12-month eligibility for the children and youth covered either as Medicaid eligible or the state children's health insurance program. Another is the emphasis throughout discussion of the legislation on "one card" for children and youth eligible for health coverage regardless of whether eligibility arises from Medicaid or the state child health insurance program. The intent appears to have been to include children and youth who were Medicaid eligible and children and youth who become eligible under Title XXI in one program with clear direction that when possible the two groups were to be merged into a health care program that resembles regular health insurance.

Current Merged Medicaid Program

Becky Ross, Administrator for Medicaid/Medical Policy, Department of Social and Rehabilitation Services, presented written testimony relative to adult enrollment in HealthWave (Attachment 10). Ms. Ross stated that the intent of the State Children's Health Insurance Program (SCHIP - Title XXI) since its inception has been for the plan to be as seamless as possible for families who also interacted with the Medicaid program. Initially, however, in order to implement the new program and provide beneficiary coverage as soon as possible, the Title XXI program was contracted separately. This meant in some instances that families with children in the Medicaid managed care program and children in the Title XXI program might have different health plans and different providers, based on the age of the child. In October, 2001, the Title XXI program was blended with the Medicaid capitated managed care program (FirstGuard) enabling families with children eligible for both programs to have the same health plan and health provider for all family members. The blended program (HealthWave) not only serves Title XXI eligible children, but also Medicaid eligible adults and children in the Temporary Assistance to Families (TAF) and poverty level eligible programs who opt for managed care. Since its inception in 1995, the Medicaid capitated managed care program has included children, pregnant women, and TAF adults who choose

managed care as their provider. Currently adults comprise 11 percent of the total HealthWave population and 17 percent of the total Title XIX population. Excluding adults from HealthWave would require a separate capitated managed care program for adults and necessitate contracting separately for the two populations. Each population group in HealthWave has its own eligibility requirements and there has been no expansion of eligibility for adults. Adults and children receive coverage for the same services, with the exception of dental care coverage wherein adults receive coverage only for emergency extractions. Noting that some questions had been raised as to whether the Department was overstating the number of children who have benefitted from the inception of Title XXI, Ms. Ross stated that more than 100,000 Kansas children who were uninsured at some point from January 1999 - September 2003 gained access to medical coverage with approximately one-third enrolled in the state child health insurance program and two-thirds in Medicaid. These numbers reflect children added and do not count adults who may be receiving services under the combined product known as HealthWave.

In response to questions, Ms. Ross stated that only Title XIX adults who choose managed care are in HealthWave. Title XIX adults who choose HealthConnect are not included in HealthWave. Medicaid covers 230,000 persons, but only 92,000 of them are in capitated managed care. The application figures from Maximus would include adult applications. Persons are encouraged to send their applications into the clearinghouse, but they can start the process at an agency area office.

Ms. Ross, answering a question, stated she would provide the Committee with a chart showing figures for the various populations, *i.e*., elderly, SSI, disabled, TAF. Ms. Ross was asked to include a breakdown by age.

Coverage for Children of State Employees

Terry Bernatis, Health Benefits Administration, presented written testimony summarizing the results of a study to determine the number of potentially eligible employee's children and the potential cost to provide a subsidy for health insurance for children of state employees who would otherwise be eligible for the state child health insurance program. (Attachment 11). A more detailed description of the study and the results was also provided (Attachment 12). Ms. Bernatis stated a population of 29,000 state employees earning less than $45,000 per year was identified as the target population. Eight hundred thirty employees in the less than $25,000 salary range, 1,000 in the $25,000 to $35,000 salary range, and 580 in the $35,001 to $45,000 salary range were surveyed. There was a 37 percent return rate which surpassed the expected rate and appears to be indicative of a high level of interest. Analysis of the data resulted in an estimate that out of 29,000 state employees, approximately 3,500 would be eligible for the pilot program. It was also determined that not all eligible employees would take advantage of the pilot program due to current enrollment in or access to other health plans.

Using three funding scenarios, the employer rate ranged from $125 to $200 in addition to the current 35 percent already provided by the state. The estimated participation rate was from 1,300 to 2,600 employees, with a range in cost of $1,200,000 to $4,560,000. Ms. Bernatis also noted coordination between the company that determines eligibility for HealthWave and SHARP programming would require additional human and financial resources that have not been estimated at this time. Another factor is that when non-state groups, *i.e.,* school districts, counties, cities, join the state health plan their dependents also lose their eligibility to participate in Title XXI. At least one school district decided not to join the state plan because of this restriction.

After School Programs Regulation

Bridgitt Mitchell, Assistant to the Secretary, Kansas Department of Health and Environment, presented written testimony giving an update on the efforts to reach a compromise on proposed regulations for after school programs (Attachment 13). This section of the proposed regulation defines "Drop-in-program" as a verified program for school-age children or youth which are not enrolled in a school-age program as defined in K.A.R. 28-4-546 (jj), and school-age children and youth are allowed to arrive and depart from the program at their own volition and at unscheduled times and creates a category of "verified program" which means a program that is not subject to school-age regulations if the program verifies annually to the Kansas Department of Health and Environment that:

1. All staff working with children sign an affidavit which permits a background check to be performed as defined in K.A.R. 28-4-584;

2. Parents and/or guardians of children using the program receive written disclosure that describes the program characteristics and that sets out the parameters of child supervision provided by each program; and

3. There is governance by a local or national entity that upholds their standards to promote the safety and well-being of children served.

The Department feels that each program must meet all three of the characteristics above to be a drop-in program and there can be one affidavit per program.

In response to a question, Ms. Mitchell stated exempting local units of government and school districts has been recommended, but this language reflects only the recommendations made at the meeting on November 5.

The Committee was recessed until 1:00 p.m.

Afternoon Session

The meeting was reconvened by the Chair.

Child In Need of Care Procedure

As requested at an earlier meeting, a set of flow charts showing the pre-petition process, the post-petition/pre-adjudication process, the post-adjudication process and the pre-adjudication child-in-need-of-care process were distributed (Attachment 14).

Mental Health Services for Children

Sue McKenna, Assistant Director of Children and Family Services, Department of Social and Rehabilitation Services, presented an update on mental health services for children (Attachment 15). The Child Welfare Mental Health Partnership Steering Committee has formed a subcommittee to focus on problems faced in delivering services to children in rural areas. The University of Kansas provides support in researching data specific to rural service delivery. Recommendations are being formulated. Issues in training being prepared for community mental health center and contractor staff are also being addressed.

The Department has formed a workgroup to develop a strategic plan to assure that child welfare staff and the public understand how to access mental health services; is developing web site-based training on mental health services to be presented or available for all key stakeholders; and is mandating that all child welfare staff complete the training. The Department is also developing a brochure for the public on available mental health services and how to access them.

Response to Committee Questions and Requests

A list of child welfare mental health services issues identified in the testimony presented at the August, 2002 meeting of the Committee were distributed (Attachment 16). Sue McKenna, Department of Social and Rehabilitation Services stated progress has been made on addressing these issues.

Social and Rehabilitation Services staff noted there is data to indicate improvements have been made. Time expectations statewide are currently being met 90 percent of the time although there are fluctuations from month to month and by mental health center. The system in western Kansas is not where the Department would like it to be but, as noted in earlier testimony, this issue is being addressed. Also, although it may be more difficult to provide services in rural areas, there is information that even in these areas more children are being served by mental health centers and more hours of service are being provided. Mental health centers have also extended hours to help families access services. When mental health centers have achieved the 10 day expectations, the Department may want to reestablish these time lines at 5 days. The issue may be one of not understanding what services are available and how to access the system rather than a breakdown in the system. There is also the perception of time when dealing with a severely emotionally disturbed child versus actual time.

A question was raised as to who does not know what is available or how to access services. These are children in the system and the people who are advising them and the parents, foster or biological, ought to know exactly what is available, what to ask for, and how to access it.

During discussion, it was noted that 10 days for assessment and 10 days for initiation of needed services is not acceptable. Graphs may indicate there has been progress, but there are still too many stories from constituents and round table participants that children are not getting appropriate services or are not getting services in a timely manner. Rather than hearing about graphs, the Committee wants to know that only on rare occasions does a child not get appropriate services in a timely manner. From what the Committee has heard, it does not seem that sufficient progress has been made. "Child time" needs to be considered as well as what the foster parent is asked to cope with during these time expectations.

In response to a question, Pam Alger, Department of Social and Rehabilitation Services, stated the contractor makes the initial determination of whether or not there is a mental health need. Referrals are made to the mental health center which is responsible for the assessment, diagnosis, and determination of what, if any, services are needed. The contractor establishes the urgency of the situation and notifies the community mental health center which responds according to the urgency.

During discussion, it was pointed out there are still factors that negatively impact the availability or continuity of treatment for children and can cause delays in receiving treatment. Because private practitioners cannot access the Medicaid card, children receiving therapy from a private practitioner when they enter the system must change therapists; if a mental health center does not have a therapist trained in the type of therapy the child needs, notably attachment disorder, a child cannot go to a trained private therapist in the community; or the child must go to the community mental health center even if a private therapist is much closer. These factors can impact

rural areas especially since there is a shortage of professionals. The question was raised as to whether legislation is needed or whether the Department can address the issue of extending access to the medical card internally. It was noted the fact each mental health center has its own catchment area can also mean a change in therapist if the child is placed in another catchment area after an assessment is made.

Ms. Alger stated utilization of private practitioners is a conflict question. If a mental health center cannot provide certain required services, the center must contract for those services. Ms. McKenna stated currently, private practitioners have to be affiliated with a mental health center to bill Medicaid and some who are willing to provide services prefer not to be affiliated. The issue of expanding access to Medicaid to persons in private practice raises issues of quality control and cost. However, the Department is looking at this issue.

Concern was expressed that when issues are raised, the Committee hears why things do not happen but the issue itself never seems to get addressed. It was noted that the Committee is trying to figure out how the Legislature can be of assistance in finding and implementing solutions. Is additional or clarifying legislation needed to improve services to children and youth in the system or can these issues be addressed adequately internally?

Concern over what diagnoses children in the system receive and the prevalence of the use of psychotropic drugs, especially for AHD, was expressed. Are there sufficient time lapses before certain diagnoses are made? For example, if there is a significant number of children being diagnosed as AHD, are the time expectations for an assessment sufficient to make this diagnosis. Behavior at the time of removal from the home may look like AHD but may be a reaction to what has happened. Note was made of the upward national trend in the use of psychotropic drugs and the increasing concern about the potential long-range effects of the drugs. Questions raised were: Are children being mis-diagnosed and over medicated and how do we protect children from this; is the use of psychotropic drugs for children within the system following the national trend; what are the criteria for the various diagnoses?

Ms. Alger stated that every diagnosis has a time frame during which the child must have exhibited the symptoms in order to receive that diagnosis. A child cannot be diagnosed as AHD unless the criteria for that diagnosis have been met.

The Committee asked for a breakdown of diagnoses and how each relates to the time expectations for assessments.

It was noted the Department of Social and Rehabilitation Services has been looking at outcome measures to determine that things being measured are measurable and whether the outcomes measured are appropriate.

During a discussion of the development of therapeutic foster homes, the following questions were raised. What are the problems in recruiting and retaining therapeutic foster homes? Is sufficient emphasis given to recruitment? Is sufficient training being provided? Are these families given sufficient support? How do we know what is happening and where the problems are?

Ms. McKenna stated therapeutic foster homes have gone through a lot of changes. Currently the Department is standardizing the definition of a therapeutic foster home so when a foster home is labeled therapeutic it will mean additional training and support for the foster family rather than just higher payment. Standards have been set and communicated and are being implemented. It is believed this will attract more people to the program. Another thing being looked at is the fact that when a child requires this level of care and the care provider is successful, the child does not continue to need the therapeutic level of care. The catch is, the reward for success is a decrease in payment, an issue that needs to be addressed.

The Committee asked for a report on the progress of the implemented changes during the legislative session. How many therapeutic foster homes were there before implementation of the changes? How many of these families have gone through the training? How many new therapeutic foster homes have been recruited?

Bill Drafts Relating to Child Advocacy Centers

Reference was made to testimony at the October Committee meeting relating to child advocacy centers that bring all the child-in-need-of-care or abuse and neglect investigative services together in one place. The conferees had asked that consideration be given to introducing legislation that would define a child advocacy center. The Chair stated she and the Vice Chair, had met with the child advocacy advocates who had suggested looking at the legislation enacted in Texas and Florida. Based on the testimony and the discussion, it is important to keep any legislation as simple as possible and to see that the state is not so financially involved that centers advocacy centers cannot maintain their neutrality.

Staff reviewed the provisions of the proposed bill draft which defines a child advocacy center and prescribes certain standards and requirements (Attachment 17). Referring to subsection (2) which requires the adoption of protocols that comply with the national children's alliance, staff noted there was a question raised about whether this constitutes an unlawful delegation of legislative authority. However, because it states the center has to adopt only protocols that meet the requirements rather than saying the center has to adopt the specific requirements, there is no constitutional issue. Subsection 6 which sets out what data the center shall collect includes some federal requirements. Subsection (9) requires that employees be screened in accordance with the Kansas Department of Health and Environment child care and adult care home requirements to eliminate unfit persons from employment. Subsection (10) refers to eligibility to receive state funds appropriated by the Legislature.

In response to a question, it was noted the proposed legislation gives communities the option to develop a child advocacy center, but does not require any community to have such a center; defines what a center is; and establishes requirements to be met to be a child advocacy center. Points from the testimony presented at the October Committee meeting were reviewed.

Staff explained the second bill draft establishing the children's advocacy center fund, noting it uses the approach used last year when setting up a fee for the Board of Indigent Defense (Attachment 18). A fee of $50 will be assessed up front, payment of which will be a condition of release. If it appears to the satisfaction of the court that payment will pose manifest hardship on the defendant, the court may waive the fee. If the defendant is acquitted or the case is dropped, the fee is refunded. It appears the centers will not be attached to any state agency, so the proposed bill states the fund will be administered by the Attorney General which seemed appropriate because of the prosecutorial nature of the center's activities.

It was moved and seconded to adopt both proposed bill drafts and to introduce the bills through the House Appropriations Committee by request of the Joint Committee on Children's Issues. Motion carried.

Recommendations and Directions to Staff

Staff distributed a listing of the most often occurring issues and concerns expressed during the roundtable discussions in August, September, and October (Attachment 19). It was noted each of the three roundtables had emphasized the problems that arise from having separate contracts for foster care and adoption.

After a review of the discussion earlier regarding the impact the inability of private mental health practitioners to access the Medicaid card has on continuity of care for children, the Committee recommended the Department of Social and Rehabilitation Services meet with representatives of the mental health professions regarding this issue and make a report to the House Appropriations Committee and Senate Ways and Means Committee during the 2004 legislative session.

Foster Care and Adoption Contracts

In response to a question, Ms. McKenna, Department of Social and Rehabilitation Services, stated the Department is still reviewing the concerns expressed about the continuation of separate contracts for foster care and adoption. The RFP is due out in May with the Department making decisions regarding the awarding of contracts at the end of the year. The reason for the delay is to allow more time for input and to consider alternatives that will meet the concerns that have been expressed.

Committee members expressed concern that this time line leaves the legislature out of the process and eliminates any legislative response. It was noted the RFP process is set up to protect the bidders and create fairness which precludes input during the development of the RFP. This process works well when applied to highways but can create some problems when applied to care of children. Providing a draft document for comment might be an answer. The possibility of sharing the policies which are used to determine the specifics of the RFP for comment was suggested. The Department will send the Committee copies of the guiding principles utilized to guide the Department's decision making. Ms. Racine stated the Department would talk to the Department of Administration to determine to what extent the legislature can be involved in the RFP process.

Trudy Racine stated the Department will continue to be as open as possible given the restrictions of the law governing the issuance of RFPs. The Department conducted a series of meetings statewide in July which generated lists of what people liked and did not like about the current contracts. An internal steering committee and an advisory committee, with a wide representation of stakeholders, have reviewed the information from the public meetings. The advisory committee will meet with the Department again in December to review some additional responses from the current contractors. There will be a meeting in Salina with 135 individuals representing foster parents from all the contractors to identify their concerns and a meeting in January with the subcontractors. These meetings are not only to solicit concerns but also suggestions for solutions.

Ms. McKenna stated another suggestion received was to have two contracts, one for family preservation and one for adoption with both contractors purchasing foster care in the community from licensed child placing agencies and foster homes as needed. The reason for the separate contracts was that when a single agency provided both services, foster care used up the resources because foster care is crisis driven. There needed to be a staff that focused on recruiting and supporting adoptive families. The Department understands the impact of fragmentation. The issue is not so much whether there are one or two contracts but how do we maintain stability for the child to the extent possible while moving the legal process forward.

A Committee member noted there had not been a full hearing on whether or not there should be separate contracts for foster care and adoption. Proposing a piece of legislation stating foster care and adoption contracts shall be seamless which would give all parties, including the adoption contractors, an opportunity to be heard was suggested. This would send a directive to the Department of Social and Rehabilitation Services and the policy and RFP would have to comply with the legislation. Committee members were asked to send suggestions for what should be included in such legislation to staff and legislation can be drafted at the beginning of the legislative session. The Committee report is to state in generic terms this Committee thinks there needs to be some

legislation relative to making foster care and adoption seamless in terms of case management. Staff noted the legislature has enacted legislation in other areas that sets out specific things which must be included in contracts, for example in the child health insurance legislation reviewed earlier.

The Committee Report is to indicate the Committee makes a strong recommendation to the Department of Social and Rehabilitation Services that foster parents be provided more complete information on the foster children coming to them and that foster parents be more involved in the treatment process.

After School Programs Regulation

Bridgitt Mitchell, Department of Health and Environment, presented a proposed change to the after school program regulations presented earlier (Attachment 20) and, based on the Committee's discussion, under "Verified program" (1) signing an affidavit permitting a background check was changed to "will submit a request for a background check to be performed." In response to a question, Ms. Mitchell stated the Department has tried to create a specific definition for drop-in programs that would not be applicable to other school programs such as those included in the 12-hour stipulation.

A motion was made and seconded to exempt programs offered by local units of government and schools. Motion carried.

A motion was made and seconded to put the proposed regulations in legislation as further encouragement for their adoption and to express the Committee's interest in this issue to the Department of Health and Environment. Motion carried. Staff was asked to draft a proposed bill.

Tuition Waiver Program

Staff reviewed some of the issues raised by the Committee in discussion of the report by Regent's staff previously, noting the Committee found Chaffee funds are being utilized to reimburse the post secondary institution for tuition waivers which may not have been the Committee's original intent. Increasing the number of students each institution is to take had been suggested. Another concern was, as enacted, the legislation excludes Washburn University. Staff was asked to include in the report the Committee recommends the Regents become more of a partner in this program. The Department of Social and Rehabilitation Services was asked to meet with the Regents to determine to what extent the Regents are willing to partner by waiving reimbursement for waived tuition. Persons explaining the tuition assistance program to eligible youth are also to be made aware of the programs and scholarships offered by private trade schools and other private institutions and are to be ready to assist with applications for such scholarships.

It was noted that since the state has become the parent of these young people, the cap of three per institution should be lifted and the Regents cover the tuition cost. This would free the Chaffee funds to be used for books and other expenses.

Judicial System and Code Changes

Staff stated a quick review of some of the states listed as having open child welfare proceedings indicates, in some instances, proceedings are open only if the judge orders them open, in other cases proceedings are open unless the judge orders them closed, and sometimes proceedings are open only to certain persons.

The Committee recommended the items under "Judicial System and Code Changes" be sent to the appropriate judiciary committee in each house, with a summary of what the Committee heard and indicating these are issues the Committee feels need to be addressed by the appropriate committees of the Legislature. The committees are also to be asked to review the authority of the child death review board to determine if any additional authority should be given to this board relative to a child in need of care and to make recommendations.

Staff was asked to draft legislation requiring the Department of Social and Rehabilitation's Services regulations pertaining to abuse and neglect to utilize the same standard of proof as is in the statutes. It was noted that a provision on the order of what the Committee wants, was included in an extensive bill which died on the floor of the House last year.

Priorities in the Child Care System

The Committee's report is to include a strong recommendation that foster care should be used as a last resort. The order of priority should be identification, prevention, family preservation, and then foster care. A letter from Janet Schlansky responding to questions raised by the Committee at the October meeting was distributed to the members (Attachment 21).

The Chair thanked the Committee members for their work during the interim.

The meeting was adjourned.

Prepared by Almira Collier
Edited by Emalene Correll

Approved by Committee on:

January 23, 2004
(date)