DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Home & Community Based Services Oversight

November 19, 2009

Responses to Questions From October 14, 2009 Joint Committee Meeting

Don Jordan, Secretary

For Additional Information Contact:
Katy Belot, Director of Public Policy
Patrick Woods, Director of Governmental Affairs
Docking State Office Building, 6th Floor East
(785) 296-3271

Joint Committee on Home and Community Based Services Oversight

November 19, 2009

Responses to Questions From October 14, 2009 Joint Committee Meeting

Question #1: *Please provide the budgets for the Home and Community Based Service (HCBS) programs, with respect to state grants and what budget cuts have been made, excluding program waiver dollars.*

Response: A reduction of $6,788,174 (from a total of $11,684,364 – a 58% reduction) was made to the Day and Residential grant program for FY 2010 in order to meet the budget allocation. In addition, $2,500,000 in state general funds were transferred to the Developmental Disabilities (DD) waiver program to leverage federal dollars to provide supports for approximately 300 clients who might otherwise have been adversely impacted. These adjustments leave a total of $10,059,364 in state funds, including $5,163,174 State Aid funding, to provide Day and Residential Services, other direct care funding on behalf of clients not eligible for waiver programs, and necessary contractual obligations.

Question #2: *What is the projected number of individuals that will be on the waiting list for the Physically Disabled (PD) waiver at the end of FY 2010?*

Response: It is currently projected that 2,700 individuals will be on the PD waiting list at the end of FY 2010.

Question #3: *Please provide the following information pertaining to crisis exceptions.*

a.) Please provide the crisis exceptions, by waiver.

Response:

For Mental Retardation/Developmental Disability (MR/DD) services, the crisis determination language from the FY2010 contract with the CDDOs is as follows:

Persons who are in crisis or imminent risk of crisis and whose needs can only be met through services available through the HCBS/MRDD waiver are those persons who:

1. Require protection from confirmed abuse, neglect, or exploitation or written documentation of pending action for same; or
2. Are at significant, imminent risk of serious harm to self or others in their current situation.

Effective December 1, 2008, crisis exceptions for PD waiver services are approved by SRS and are limited to:

1. SRS APS confirmed abuse, neglect, or exploitation case; or
2. Risk of family unit dissolution (break-up) involving minor dependent child or dependent spouse; or
3. End stages of a terminal illness, and life expectancy is documented by a physician to be less than six (6) months; or
4. Individual is the victim of domestic violence.

A February 27, 2009, amendment added a fifth category of potential crisis exceptions for PD waiver services: Significant, imminent risk of serious harm because the primary caregiver(s) is/are no longer able to provide the level of support necessary to meet the consumer's basic needs due to the primary caregiver(s):

a. own disabilities;
b. return to full time employment;
c. hospitalization or placement in an institution;
d. moving out of the area in which the consumer lives; or
e. death.

b.) Historically, what has the impact been (increase) to waivers due to crisis exceptions?

Response: **Crisis history for MR/DD services**

Point in Time	Total added for Crisis	New Persons in Crisis	Savings from those leaving - costs of those in crisis	Waiting list Funds (AF)
Mar-05	220	no data	$611,928.00	$7,500,000.00
Mar-06	295	no data	$402,973.00	$6,250,000.00
Mar-07	256	no data	$1,021,041.00	$9,000,000.00
Mar-08	288	140	$956,958.00	$9,500,000.00
Mar-09	408	171	($853,347.00)	$600,000.00
Sep-09	139	46	($912,321.00)	$0.00

Crisis history for HCBS/PD waiver services

FY END	FY05	FY06	FY07	FY08	FY09	FY10 YTD
# of CE	303	12	0	0	171	129

Question #4: *Please provide a historical perspective of changes in the tier level of individuals coming into service. Has there been any significant movement between tiers - upward or downward?*

Response: The following chart gives the percentages, by tier, of all persons allocated funding for HCBS MR/DD services for Residential Supports, Day Supports and In-Home Supports (for adults and children) from FY2004 through FY2010.

Service Type	Percent of Persons by Tier, Per State Fiscal Year 2004-2010						
	FY04	FY05	FY06	FY07	FY08	FY09	FY10
Residential	n = 3834	n = 3940	n = 4080	n = 4314	n = 4474	n = 4566	n = 4467
Tier 1	26.29	26.90	27.06	28.00	27.63	26.95	26.8
Tier 2	18.00	18.05	18.48	18.75	18.92	19.29	19.3
Tier 3	21.00	21.45	22.06	22.04	23.02	24.44	26.15
Tier 4	14.45	14.57	14.34	14.39	15.14	14.45	13.9
Tier 5	20.16	19.04	17.82	16.81	15.28	14.87	13.86
Day	n = 4407	n = 4504	n = 4705	n = 4795	n = 5027	n = 5267	n = 5328
Tier 1	23.17	23.87	24.12	24.36	23.99	24.16	25.11
Tier 2	17.31	17.14	17.94	17.96	18.00	18.09	18.24
Tier 3	20.35	20.91	21.54	21.90	22.90	23.54	24.57
Tier 4	15.50	15.39	15.32	15.26	16.33	15.95	15.41
Tier 5	23.67	22.70	21.36	20.54	18.78	18.26	16.67
In-Home Adult	n = 978	n = 1089	n = 1181	n = 1245	n = 1370	n = 1467	n = 1517
Tier 1	27.91	29.84	29.55	29.80	28.10	29.37	29.53
Tier 2	18.00	15.89	16.43	14.86	15.11	15.21	16.02
Tier 3	18.30	18.37	17.02	19.68	18.18	17.72	18.59
Tier 4	16.46	15.70	17.61	15.10	18.03	17.93	17.53
Tier 5	19.33	20.20	19.39	20.56	20.58	19.77	18.26
In-Home Child	n = 972	n = 847	n = 950	n = 986	n = 1072	n = 1189	n = 1074
Tier 1	46.91	45.81	42.32	42.80	42.63	44.07	42.46
Tier 2	16.87	17.95	20.00	17.95	19.40	16.82	17.5
Tier 3	18.31	17.24	16.95	16.53	14.93	15.56	15.64
Tier 4	10.00	10.51	10.11	12.68	13.90	13.04	14.8
Tier 5	7.90	8.50	10.63	10.04	9.14	10.18	9.5

Question #5: *Please provide the number of children that have been placed on the Autism waiver and been removed from the waiver.*

Response:

- First Program Year – 25 children placed in program
- Second Program Year – 20 children placed in program
- Note: Since program implementation, 3 children have left the waiver program. The 3 openings were filled by 3 children from the waiting list.
- Current number of children on the waiting list – 279 children, as of November 9, 2009.

Question #6: *Please provide the following information on the Parent Fee Program.*

a.) What programs are included in the parent fee program?

- Developmental Disabilities (DD) Waiver program
- Technologically-Assisted (TA) Waiver program
- Serious Emotional Disturbance (SED) Waiver program

b.) How much revenue is generated, by program?

Waiver Program	SFY 2009	SFY 2010 - YTD
DD Waiver program	**$138,990**	**$47,937**
TA Waiver program	**$7,605**	**$6,870**
SED Waiver program	**$101,249**	**$39,873**

c.) What is the fee scale?

- The current fee scale has been provided as a handout.

d.) What is the Parent Fee collections policy, including policy with respect to non-paying families?

- During the time a child is receiving HCBS services and parent(s) fail to pay, SRS will not deny services to the child.

- For collection process description, please see the handout with the sliding fee schedule.

e.) What would the process and timing be to add the Autism Waiver to the parent fee program?

- To include the Autism Waiver in the Parent Fee program would require notification of the parents of the children currently on the waiver or on the waiting list, by way of letter, of the intended change and of the process by which they could formally comment following the publication of official notice in the Kansas Register. The notification would also be posted on the SRS Parent Fee Website. Manuals, policies and procedures would need to be updated, along with the sliding fee scale.

  SRS is in the process of adding the Autism Waiver, the TBI Waiver, and the PD Waiver to the Parent Fee program. Prior to those changes, affected parents will receiving written notification and opportunity to comment, which will occur before the end of this calendar year. It is the intent of SRS to include the additional waivers in the Parent Fee program, effective February 1, 2010.

f.) Provide status of the Centers for Medicare and Medicaid Services (CMS) review.

- CMS initiated a review of the SRS Parent Fee program in April 2005. During the active part of the review, multiple questions and potential concerns were identified by CMS and responded to by SRS. In August 2008, SRS had an extensive conference call with CMS, discussing their questions and concerns in detail. At the conclusion of the call, CMS staff indicated that a draft report of their findings would be forthcoming. To date, SRS has received nothing further concerning the review.

Question #7: *Please provide the distribution of the 21 admissions to KNI and Parsons, and whether any of the individuals were receiving waiver services prior to admission.*

Response:

- KNI – 4 admissions. All 4 adults were receiving waiver services before admission.
- Parsons – 17 admissions. Of the 17 admissions, 9 were children and 8 were adults. 5 of the children were receiving waiver services before admission and 7 of the adults were receiving waiver services before admission.

Question #8: *Please provide information as to how other states, particularly Oklahoma, serve individuals with Developmental Disabilities (DD) who also have inappropriate sexual behaviors.*

Response: There are multiple approaches across the states as how to support people with developmental disabilities with sex offending behavior. In most states, if a person has a conviction of a sexual offense the Department of Corrections manages the case.

If a person is known to have sex offending behavior but has not been convicted, then most states utilize their current HCBS systems, with additional offender specific supports/funding and collaboration, to individualize services for the person with offending behavior. Florida and New Mexico are examples of this approach.

SRS is aware of only one state that has a HCBS Waiver specific to sex offenders with developmental disabilities. In Washington State the program eligibility criteria focuses on those; convicted of, or charged with a crime of sexual violence; or those with a known history of behavior that demonstrates the likelihood of a sexually violent or predatory act.

Currently, there is no program in Oklahoma (model or statewide) that addresses and/or funds individuals with sexual offender issues, other than confinement in correctional type settings or halfway houses.

Question #9: *Please provide the number of individuals on the DD waiver waiting list both before and after the closure of Winfield.*

Response:

	SFY 95 ACTUAL	SFY 96 ACTUAL	SFY 97 ACTUAL	SFY 98 ACTUAL	SFY 99 ACTUAL
EXPENDITURES IN MILLIONS					
DD WAIVER	$45.46	$71.76	$91.40	$120.07	$156.89
PERSONS SERVED					
DD Waiver	1,864	3,147	3,872	4,891	5,120
HOSPITAL TOTAL	732	676	543	407	395
Persons Waiting	798	70	65	77	333

The above chart captures total costs for the HCBS/MR/DD waiver, number of persons served on the MR/DD waiver and number of persons served in MR State Hospitals for the period of SFY95 through SFY99.

As you can see for the periods SFY96, SFY97 and SFY98, the numbers of persons on waiting lists was very small. During this time, funds were diverted from WSH to the HCBS program to eliminate the waiting list and there was language in the contracts between SRS and the CDDOs that all eligible persons had to be served. During this time, the HCBS/MR/DD waiver grew from 3,147 persons to 4,891 and expenditures grew from $71.76 million to $120.07 million. The number of persons waiting in SFY95 was 798. From SFY96-SFY98 the numbers were almost zero. Understanding that not every person could be served immediately it would be expected that the number would have never gone to zero. We see the waiting list start to grown again in SFY99 to 333 persons.

Question #10: *Following the closure of Winfield, how many individuals remained in the Winfield area and how many went to other institutions?*

Response:

- 241 - Total population at time of closure
- 112 - Individuals remained in Cowley County (Winfield area)
- 93 - Individuals moved to receive community services in other Kansas counties
- 36 - Individuals transferred to other state hospitals
    - 26 - KNI
    - 10 - Parsons

Question #11: *Please provide the following information concerning the experience of other state closures of DD institutions.*

a.) List of 12 states that have closed all DD institutions.

b.) Were all the funds redirected to community services?

c.) What was the impact on their waiting lists?

d.) Were there any costs savings, and, if so, were the savings directed to HCBS programs?

Response: Below is comparative data for States that have closed all of their state DD institutions. The funding following an institutional closure has typically flowed into the HCBS funding for the individual's transition. Additional research could identify the mechanism if requested.

Also, listed are states that have no state operated ICF/MR facilities or no privately run ICF/MR facilities with some information about their funding levels.

Sources utilized were University of Minnesota data on Residential Services for persons with developmental disabilities: status and trends through 2007, The State of the States in Developmental Disabilities 2008, and NASDDS survey and consultation.

STATES	State ICF/MR	Private ICF/MR	Increase in HCBS funding? (at least doubled 1996-2007)	Current 2007 ICF/MR funding? (in thousands)
Alaska	No	No	Yes	0
District of Columbia	No	Yes	Yes	$85,050
Hawaii	No	Yes	Yes	$8,683
Maryland	Yes	No	Yes	$60,133
Maine	No	Yes	Yes	$75,512
Massachusetts	Yes	No	Yes	$206,594
Michigan	Yes	No	Yes	$44,729
Montana	Yes	No	Yes	$10,521
New Hampshire	No	Yes	Yes	$2,512
Oregon	Yes	No	Yes	$12,271
South Dakota	Yes	No	Yes	$20,148
Vermont	No	Yes	Yes	$978
West Virginia	No	Yes	Yes	$57,575
Wyoming	Yes	No	Yes	$20,006

Question #12: *Please provide an overview of DD waiver program costs for Kansas and surrounding states.*

Response: In addition to the information below, a handout is provided which details comparative information compiled last year for the committee.

Below are lists of services provided through the comprehensive HCBS MR/DD waivers for Oklahoma and Missouri. As you can see, they both offer many services in their waivers (i.e. OT, PT, speech therapy, audiology, foster care, and prescription drugs) that Kansas does not offer in its waiver. That is due to the fact that many of these services are available through the Kansas State Medicaid Plan and the services are not limited to those who are just on an HCBS waiver. To accurately compare the services available to persons on HCBS waiver programs, it is important to look at the array of services available to the persons not just through the HCBS program but also through each state's Medicaid plan. Only then could a person make an accurate representation of the costs to provide services to these individuals across states.

Oklahoma

Homemaker Services, Respite Care, Habilitation (prevocational, supported employment), Intensive personal Supports, Habilitation training specialists, Environmental Accessibility adaptations, Transportation, Family training, Specialized Foster Care, Physician Services, Home Health Services, Prescribed Drugs, Assistive Technology, Specialized Medical Equipment and Supplies, Dental, Nutritional Services, Psychological Services, Audiology Services, Occupational Therapy, Physical Therapy, Speech Therapy

It should also be noted that access to the Oklahoma comprehensive waiver is limited to those persons whom the State has determined cannot have their needs met through either their adult or children's in-home support waiver programs.

Missouri

Personal Assistance, Day Habilitation, Respite Care, Transportation, Community Specialist, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Crisis Intervention, Behavior Therapy, Communication Skills Instruction, Counseling, Physical Therapy, Speech Therapy, Occupational Therapy, Supported Employment

Question #13: *Please provide a list of the tiers and the range of reimbursement for each tier for individuals living at KNI and Parsons.*

Response: As of July, 2009, the tier breakdown of persons served at PSH and KNI, together with current reimbursement rates for the various MRDD waiver services by tier, are as follows:

PSH	Number		KNI	Number
Tier 1	47		Tier 1	74
Tier 2	43		Tier 2	35
Tier 3	50		Tier 3	32
Tier 4	32		Tier 4	15
Tier 5	15		Tier 5	2
Total	187		Total	158

FY09 HCBSMR/DD New Rates Revised July 2009		
Service	**Procedure Code**	**FY10 Rates**
Residential Habilitation		
Regular Tier 1	**T2016**	**$160.21**
Regular Tier 2	**T2016**	**$131.22**
Regular Tier 3	**T2016**	**$94.86**
Regular Tier 4	**T2016**	**$61.26**
Regular Tier 5	**T2016**	**$44.27**
Residential Habilitation		
Special Tier 1	**T2016**	**$192.05**
Special Tier 2	**T2016**	**$171.36**
Special Tier 3	**T2016**	**$152.56**
Special Tier 4	**T2016**	**$133.74**
Special Tier 5	**T2016**	**$114.55**
Day Habilitation		
Regular Tier 1	**T2020**	**$99.53**
Regular Tier 2	**T2020**	**$73.60**
Regular Tier 3	**T2020**	**$59.19**
Regular Tier 4	**T2020**	**$43.55**
Regular Tier 5	**T2020**	**$37.37**
Day Habilitation		
Special Tier 1	**T2020**	**$120.87**
Special Tier 2	**T2020**	**$111.12**
Special Tier 3	**T2020**	**$102.36**
Special Tier 4	**T2020**	**$93.31**
Special Tier 5	**T2020**	**$85.31**
Supportive Home Care	**S5125**	**$3.06**
Respite - Temporary	**S5150**	**$3.06**
Respite - Emergency	**T1005**	**N/A**
Respite - Overnight	**H0045**	**$58.34**
Personal Assistant Services	**T1019**	**$3.06**
Supported Employment	**H2023**	**$3.06**
Night Support	**T2025**	**$30.65**
Specialized Medical Care - RN	**T1000 - TD**	**$7.50**
Specialized Medical Care - LPN	**T1000**	**$7.00**

Question #14: *Please provide detailed information concerning the waiver enhancements requests.*

Response: Details are provided in the following chart. The funding amounts requested are the difference between what has been budgeted and our projections for expenditures.

FY 2011 Enhancement Requests

Priority	Division	Description	SGF	All Funds
1	DBHS/CSS	**Maintain Home and Community Based Services Physical Disabilities (PD) Waiver Services** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will support current waiver recipients and allow continuation of a rolling waiting list policy, with two people coming off the waiver for one person going on the waiver.	$3,621,250	$10,355,897
2	DBHS/CSS	**Maintain Home and Community Based Services Developmental Disabilities (DD) Waiver Caseload** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will support current consumers, and allow only new consumers in crisis to access services.	3,283,435	9,389,828
3	DBHS/CSS	**Maintain Home and Community Based Services Traumatic Brain Injured (TBI) Waiver Caseload** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will allow the program to continue to operate without a waiting list.	1,045,782	2,990,683
4	DBHS/CSS	**Maintain Home and Community Based Services Technology Assistance (TA) Waiver Caseload** This enhancement provides funding to maintain the current level of service in FY 2011. This level of funding will allow the program to continue to operate without a waiting list.	954,050	2,728,352

Question #15: *Please provide a synopsis of the PD waiver audits.*

Response: SRS requested these audits to provide us with information to determine how well the payment system was being managed by SRS. The results indicate there are no problems of fraud or mismanagement in the service billing system. This indicates we will need to undertake additional programmatic/system

management actions to further control costs. One of the significant challenges will be how to effectively identify and address consumer “needs” vs. consumer “wants.”

PD Waiver Sample Audit – This audit looked at claims paid for PD Waiver Services in April 2009. The purpose was to determine whether services were paid for only PD eligible individuals. We found all services were for eligible individuals and were either on the Plan of Care or were preapproved.

PD Claims/Services Verification Audit – This audit also used claims paid in April 2009. The purpose of this audit was to verify documentation existed which supported the service which was claimed and paid. In nearly every case, we were able to find documentation which supported the date and type of service.

PD Waiver Assessments and Services Audit – A sample for this audit was chosen using the April 2009 paid claims data. The purpose of this audit was to determine whether the services claimed and paid aligned with the client’s assessed needs as documented on the initial assessment or the Plan of Care. Most of the services claimed were identified as needs. Exceptions were noted most frequently for Sleep Cycle Support and Emergency Response System claims. The reason the auditors did not find these service needs documented on the initial assessment or Plan of Care is that these services would be documented on the worksheet used by case managers to demonstrate how a person’s needs are met for a 24 hour period. These two services are used as more cost effective substitutes for personal care attendants, and are used when sufficient to meet the consumer’s needs.

PD Waiver Audit – The purpose of this audit was to identify and determine possible causes related to the increase in PD eligible individuals and costs of the services received. Field work for this audit has been completed and it is in the process of being reviewed.

Question #16: *Please provide the number of individuals currently on conditional release and where they are located, and the number of individuals that have completed the program and where they are located.*

Response:

- SRS currently operates a transitional release program located on the grounds of the Osawatomie State Hospital.
- Legislation passed last year limits the program to 8 beds in any one county.
- Currently, there are 5 residents assigned to the transitional services program.
- Two SPTP residents have completed Transitional Release and Conditional Release (both granted by the Court) and achieved Final Release.
    - There are no supervision requirements or reporting requirements back to the program about residents who have achieved conditional or final release.

- It is our understanding one of the residents who achieved final release lives on his family farm near Springfield, Missouri and the other lives in Sedgwick County.

- Four residents have completed Transitional Release and are on conditional release under the supervision of the courts; we believe one individual resides in Miami County, one in Butler County, one in Johnson County, and one in Labette County.

Question #17: *Please provide the costs per individual to serve SPTP phase 1-5 at Larned State Hospital and SPTP phase 6 at Osawatomie State Hospital.*

Response:

Program	FY 2009 Expenditures	Average Daily Census	Average Annual Cost Per Person
SPTP at LSH	**$11,326,333**	**171**	**$66,236**
THS at OSH	**$601,081**	**9**	**$66,787**

Question # 18: *Please provide an overview of the Sexual Predator Treatment Program (SPTP).*

Response: Overview of Sexual Predator Treatment Program
The Sexual Predator Treatment Program (SPTP) was established in 1994 by the Sexual Predator Act (K.S.A. 59-29A01) to provide treatment for convicted sex offenders who have finished their prison sentences, and who have been civilly committed by the courts to the SPTP inpatient treatment program at Larned State Hospital (LSH). The SPTP was given a dual mission. First, SPTP's goal is to protect the public from any further victimization by sexual offenders committed to the program. Second, SPTP is required to provide a program of treatment which would assist motivated offenders to reduce their risk for re-offense to the point that they could safely live in open society and become contributing citizens.

The SPTP is comprised of 7 phases of treatment: 1) orientation and preliminary identification of issues; 2) academic learning of principles; 3) application of principles; 4) completion of inpatient issues and development of a relapse prevention plan; 5) reintroduction to open society and preparation of transition; 6) demonstration of ability to perform transition tasks (getting a job, paying bills, outpatient therapy, etc.) and 7) formal transition (ordered by the Court). Phases 1 through 5 are located at LSH; phases 6 and 7 are located at Osawatomie State Hospital.

Treatment Standards
States have an obligation to provide a minimally acceptable and appropriate level of professional treatment to those who are forcibly detained. It is a requirement of due process to provide available health treatment to a convicted individual with a mental condition. The Supreme Court has recited ten specific standards, known as the **Turay Standards,** by which an institutional based sexually violent predator program must be judged in order to meet due process constitutional muster (Turay v. Seling, 1999 Wash. LEXIS 74 (2000)). The standards consist of:

- Adequate, competent staff that is supervised by a mental health professional.
- Appropriate training of staff in order to ensure a consistency of treatment between all staff.
- Individualized treatment plans for patients. This includes providing the resident with a "roadmap" in a manner understandable to the resident as to what it takes to complete the treatment and show the progress of the resident.
- Appropriate behavioral management policies and procedures.
- Inclusion of the resident's family in the rehabilitation effort, including visitation, telephone, and mail.
- A treatment oriented "flavor" to the facility that is lacking a Department of Corrections "flavor".
- Separation of participating residents from non-participating residents, in order to avoid harassment of the participating residents.
- Educational, vocational, religious, and recreational opportunities.
- Availability of a grievance procedure.
- External oversight, either in the form of licensing, certification, or a consultation agreement.

Overarching Principle

The overarching principle of the program is "no more victims," which we believe is consistent with the legislative intent to protect the citizens of Kansas. Philosophically, we believe this goal allows for the possibility of positive, therapeutic change by the SPTP residents while also maintaining increased responsibility to protect the citizens of Kansas, especially its children. In that sense, the program views itself as part of the child protection network within SRS. The program is also structured to meet the Constitutional requirements set out by the United States Supreme Court.

Growth of the Program

The program has been steadily growing from its inception in 1994. We currently have 188 residents in the program at Larned and 5 residents in the transition program at Osawatomie State Hospital. It is difficult to predict the actual number of offenders who will enter the program from year to year. To illustrate this challenge, let me describe what the process is for a person to be committed to the program.

Within 90 days of release from prison or a state mental health hospital, an individual who has been convicted of a violent sex offense and has a mental abnormality, or has been found not guilty by reason of insanity for a violent sex offense, will be reviewed by the Multidisciplinary Team (MDT) to assess the level of risk to sexually reoffend upon release. The MDT is a group of five representatives from state agencies, mental health professionals, and sex offender treatment professionals, who are appointed by the Secretary of Corrections. Once assessed by the MDT, the case is reviewed by the Prosecutor's Review Committee within the Attorney General's (AG) office to determine if there is enough probable cause to detain the individual.

If so, there is a hearing in the county of the original conviction. If the probable cause of the AG's office is upheld, the individual is ordered to Larned State Security Program (LSSP) for an inpatient sexually violent predator evaluation. If the person is found by LSSP to meet the definition of sexually violent predator (SVP), he is returned to the county jail and awaits trial. He may stipulate to being a SVP and be immediately committed to the SPTP on the grounds of Larned State Hospital, or he may wait for a jury trial, which will determine if he is a sexually violent predator. At any time after the assessment by the MDT, if there is a determination made that the individual does not meet the criteria for SVP, he may be released.

Every person ultimately committed to the SVP program has been screened several times and determined to present an extremely high level of risk of repeating their prior sex offending behaviors. Currently, approximately 3.9% of those persons who are being released from DOC custody with a history of sexual offending behavior are committed under the law.

I have provided a handout which shows the number of possible SVPs assessed by the MDT and the final number who are committed to the SPTP. As you can see the number of inmates assessed fluctuates through the years as well as the number committed to the SPTP.

2006 House Bill 2576 (*Jessica's Law*) which was enacted on July 1, 2006, is another complicating factor in determining the growth of the program. With the passing of this law it was estimated that each year 77 sex offenders would be sentenced to 25 + years or more. Logically, this would suggest that commitments to the SPTP will decline at some future time due to these longer prison sentences. However, the exact impact on the number of new commitments into the SPTP is uncertain and will not be known for several years.

The Kansas Sentencing Commission's August 2009, Fiscal Year 2010 Adult Inmate Prison Population Projections, reported in FY 2009, there were 56 sex offenders admitted to prison under Jessica's Law. This accounted for an increase from 48 in FY 2008. Of the 56 admissions, 20 were sentenced to the "Hard 25 or more"; 3 to 300 months, 586 months, and 600 months; 33 were sentenced to below 300 months. The average length of sentence was 130.7 months.

Because of the large percentage of those sentenced with a downward departure under Jessica's Law the impact on admissions to the SPTP may be small. However, because this data is from only three years it is too early to identify any real effect.

The best estimates of growth at this time are the historical averages which are approximately 16 persons per year to the SPTP at LSH and approximately two persons per year moving from the inpatient program at Larned to the Transitional Housing Services at OSH.

Release Rates

An August 2007 comparison study of state laws authorizing involuntary commitment, by the Washington State Institute for Public Policy, compares 2006 discharge and release rates from the states with civil commitment laws. The numbers of persons released from similar programs around the country appear in general to be higher than in Kansas. This is due, in part, to the mechanism of release in some states, in which release is determined by an independent panel of persons and the courts with no direct input from the program. It is also due, in part, to the structure of the laws in some states which either require a periodic re-commitment of the individual or which have no provision for transition and take an "all or nothing" approach to offender release. In its 14-year history, Kansas has had 2 persons who have been granted final release by the courts. There are four residents currently on conditional release, and 5 persons in the transitional facility of the program at Osawatomie State Hospital.

Because of public concerns about locating sexual predators in the community, SRS has experienced difficulty in finding suitable placements for residents who have been determined to no longer be a threat due to their age and health condition. In addition, SB 506 which passed during the 2006 legislative session, included residency restrictions for sex predator transitional release and conditional release facilities. These restrictions, (facilities can't be within 2,000 feet of

churches, schools, homes with children residing in them etc.) will make it more difficult to place these individuals in the community. In addition, as I mentioned earlier, there is now a provision that limits the number of SVPs on conditional or transitional release to no more than 8 in any one county.

One aspect of the Kansas program which is widely admired around the country is the systematic structure of our transition programming. Few states, with the exception of Arizona, have been able to approach our 3-phase system with its separate facility for transitioning. This is a strong advantage of the Kansas approach but also adds to time required for a resident to complete the program. Given the focus of "no more victims" for the Kansas program, this additional time has the value of giving program staff the opportunity to observe the real-world behavior of the resident before any recommendation for conditional release is made.

Comparison to Other Programs

The Kansas SPTP compares well with other programs across the country. I have already mentioned the study by the Washington State Institute for Public Policy when I talked about the release rates, this same study compared the cost of the programs in different states as well. Kansas' program costs are about in the middle of all of the states reviewed.

In addition to this study, the SPTP was reviewed in July of 2008, by Robert J. McGrath, a nationally known consultant on Sexually Violent Treatment Programs. His review of the Kansas SPTP found that overall the program was sound, followed best practices, and administrators and staff were knowledgeable and committed. He also observed that the amount of treatment was average or slightly above average compared to other programs and that the rate of placement in the transitional release phase of the program (about 6% of the committed population) is similar to or slightly higher than other programs.

Summary

In closing I would like to reemphasize this program has been built on the overarching principle that there will be "no more victims," as well as a treatment program focused on reducing the risk of reoffending and meeting constitutionality requirements of the program.