Approved July 6, 1990
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by SENATOR AUGUST "GUS" BOGINA at
Chairperson

10:15 a.m./~~p.m.~~ XX on APRIL 23, 1990 in room 123-S of the Capitol.

All members were present except:

Committee staff present:

Research Department: Diane Duffy, Leah Robinson, Laura Howard, Kathy Porter
Revisor: Norm Furse, Gordon Self
Committee Staff: Judy Bromich, Administrative Assistant
Ronda Miller, Committee Secretary

Conferees appearing before the committee:

Mr. Paul Klotz, Executive Director, Association of Community Mental Health Centers of Kansas
Mr. Winston Barton, Secretary, Department of Social and Rehabilitation Services
Mr. Al Nemec, Commissioner, Department of Social and Rehabilitation Services
Dr. Mani Lee, Director of Mental Health Institutional Programs
Mr. Dave Seaton, Chairman, Governor's Task Force on Mental Health Reform and Kansas Mental Health Services Planning Council
Mr. Bill Simons, Mental Health Services Consumer and Coordinator of Project Acceptance
Mr. Mark Burkhart, Attorney, Department of Revenue
Mr. Chuck Simmons, Chief Legal Counsel, Department of Corrections
Mr. Michael O'Keefe, Governor's Office
Mr. Jim Hays, Kansas Association of School Boards, KNEA, United School Administrators, and Unified School Districts 512,259,229,501
Mr. Ed DeSoigne, Kansas Contractors Association
Mr. Allen Bell, President, Kansas Development Finance Authority

SUB HB 2586 - Mental health reform act

The Chairman announced that because Sub HB 2586 had been formally heard in Public Health and Welfare, no testimony would be heard.

Mr. Paul Klotz distributed and reviewed Attachment 1, which provided an overview of HB 2586. He stated that the first twelve sections of the bill are new law and represent mental health reform; the remaining sections of the bill are primarily amendments to existing law. Mr. Klotz noted that the main controversy of the bill has been that community mental health centers would become the gatekeepers and would be made fairly exclusive. He stated that community centers would want to continue to use private providers through subcontracts.

In answer to a question, Mr. Klotz stated that the community mental health bill is paid equally by the state and federal government, the county government, and the private sector. He noted that the state is approaching a statewide average of half the 2 mill levy allowed by law for mental health facilities. He said the mechanism to assure quality services is a elaborate licensing and standards process.

There was discussion regarding a negative evaluation of the Sedgwick County Mental Health Center by Willard and Associates. Senator Feleciano charged the Department of Social and Rehabilitation Services with having done a poor job of oversight. It was noted that although some of the allegations may have been inaccurate, a long term administration problem had been remedied. Members of the Committee pointed out that a law was passed giving authority over the county mental health department to the Board of County Commissioners

in Sedgwick and Johnson counties. Mr. Klotz stated that SRS is prepared to assist the Sedgwick county facility.

Senator Kerr noted that the mental health reform proposal, as presented during interim studies, was a much costlier plan, and asked how the Department could expect results from a fraction of the original request. Mr. Klotz replied that, ideally, the plan would require more moneys. Because of budget constraints, the plan will be implemented on a phase-in basis which will cost $10-11 million over 5-6 years. He cautioned the Committee that the proposal may require a supplement, due primarily to unknowns regarding mentally ill children.

In answer to a question, Mr. Klotz stated that Norma Stephens, Director of the Osawatomie State Hospital, told a House subcommittee that there are indications that Osawatomie will be decertified. Appropriations have been made in the Governor's Budget Amendment for temporary help to avoid decertification.

Senator Parrish questioned why the pilot program for services for children (new section 11 of the bill) would not begin until FY 92. Mr. Klotz responded that section 11 was designed to obtain a special Medicaid Title XIX waiver that SRS now says cannot be obtained. He noted that the overall bill addresses the reduction of the hospital population of children and adults. In discussing whether to include section 11 in the bill, Mr. Klotz stated that children are the least served population in the state and, if for no other reason, need to be considered for the reason of cost containment in the future.

Secretary Winston Barton appeared before the Committee in support of HB 2586.

Commissioner Al Nemec distributed and reviewed Attachment 2, and reviewed background information regarding the decision to implement the program in Osawatomie. Comm. Nemec was asked if the $500,000 (Attachment 1-2) was requested by SRS or the providers. He stated that SRS did not oppose a start up fund, but could not agree with the centers on the amount. The centers discussed implementation costs for the Osawatomie catchment area, which is what the $500,000 represents. In answer to a question, he noted that the counties share the additional cost through local mill levies.

In answer to Senator Salisbury, Dr. Lee stated that centers would be allocated a certain number of bed days, and when the beds were full, staff of the centers would determine which patient would be discharged in order to accommodate a person needing inpatient care. Secretary Nemec noted that this language would be included in additions to the agency's rules and regulations.

Senator Hayden asked Dr. Lee to explain the status quo inflation rate for the 3 different catchment areas on page 28 of Attachment 2. Dr. Lee stated that the inflation rate was determined by looking at the 20 year historical inflation rate of each hospital. The reasons for the inflated rate at Larned State Hospital were added programs (security) and HCFA mandates to increase staffing. In response to a question, Dr. Lee stated that he did not know if Larned would be able to maintain services with an 8.0% inflation rate.

Senator Kerr noted that the fiscal note for the original bill was $10 million in SGF funds in FY 91, and $43 million in SGF moneys and $53.5 million in all funds for FY 92 and every year thereafter. In answer to his question, Comm. Nemec stated that he believed that everything would be accomplished by Sub HB 2586 as would have been accomplished by the original bill because the original bill was unrealistic in terms of statewide implementation, expansion and additions to the program. Commissioner Nemec reiterated that the requests are for implementation of mental health reform in each of the

catchment areas and that the program will cost more in the future. In answer to a question, he stated that he does not anticipate coming back to the Legislature for major supplements in the 6 year period of implementation.

In answer to a question, Dr. Lee stated that $1.2 million of the $2.4 million designated in FY 92 for maintenance of Osawatomie State Hospital represents the amount that would be used toward the pilot project if the waiver is not obtained. (Attachment 2 - reverse side of page 18) Dr. Lee noted that Topeka comes on line for the adolescent program in FY 93.

In response to a concern regarding potential costs of youth programs, Comm. Nemec acknowledged that the Department may not be able to live within the budget or serve everyone. He added that this proposal would, however, reduce the institutional populations and help resolve some certification issues. The Commissioner stated that the Department may need to reevaluate old programs to determine if it would be advisable to shift moneys. He said that SRS would allocate funds on the basis of service needs through a contractual arrangement with individual centers in the Osawatomie catchment area.

In regard to item 3, Attachment 2-2, Senator Winter expressed concern about initiating a program without estimates of the start up costs. The Commissioner noted that start up costs would be dependent upon what was needed in the communities. However, he said that it was his intent to use existing buildings wherever possible. Senator Winter requested that Mr. Klotz and Comm. Nemec jointly present a request for the minimum appropriation needed for the program.

Of concern to Senator Winter was the possibility that local mental health facilities might refuse to admit clients if the facilities were inadequately funded. Comm. Nemec stated that there is a financial incentive for centers in the catchment area to work together to serve all clients.

Senator Gaines pointed out that an estimated $17 million would be required by FY 97 for services in all 3 hospitals, and inquired about the reliability of the numbers of patients who would be served. Dr. Lee noted that the numbers provided are only projections.

Senator Hayden asked whether HB 2586 was income discriminatory because wealthy patients would obtain better service from private practitioners. Comm. Nemec responded that the intent of the bill, like all social welfare programs, is to make services better for more clients.

Senator Rock expressed concern about the future for patients who would have been serviced by the 270 beds which would be closed at Osawatomie, and stated that he felt there would be substantial supplementals requested at a later date.

The meeting was recessed until 2:00 P.M.

Comm. Nemec distributed and reviewed Attachment 3. He noted that the last 2 requests for appropriations were not specifically related to mental health reform. In answer to a question, Norm Furse, Revisor of Statutes, stated that one amendment (new section 12) added to the bill in Public Health and Welfare stated that the governing board of the mental health centers must approve expenditures. Comm Nemec noted that this new section would not be a problem for the Department, and stated that, because the centers will have an approved contract with SRS, he does not foresee problems with centers not living up to the terms of the contract.

In response to Senator Winter's statement that the state might be better served by having state operated facilities with gatekeeping authority, Comm. Nemec stated that there is some benefit in having community operated

facilities that monitor the local programs. He noted that he would not object to the amendment proposed by the Kansas Association of Professional Psychologists (Attachment 4-4) that would expand the definition of "participating mental health centers" to include "other treatment facility" as long as the community mental health center has a legitimate contract with the providers. He stated that if a center does not fulfill its obligations, SRS feels free to contract with other community providers in the catchment area.

Mr. Dave Seaton told the Committee that when the Governor's Task Force met a year ago, they estimated the cost of mental health reform at $14.5 million per year without considering the shift of money from institutions to community programs. At the end of the reform period, the state will have $17 million to use for this purpose, which will be adequate. He stated that community centers have been involved in the development of mental health reform during the last 18 months. He reiterated that the purpose of mental health reform is not to close hospital beds or save money, but to improve lives of the mentally ill.

Senator Winter asked Mr. Seaton to respond to his concern regarding a court system that cannot commit persons. Mr. Seaton stated that the Task Force recognizes the need for crisis interventions beds, but does not have a funding source. He added that Kansas should not imprison persons who are mentally ill and in a crisis.

Mr. Bill Simons told the Committee that consumers of mental health services support the concept of mental health reform, but have the following concerns regarding HB 2586:

1. cutting the number of beds for consumers without adequate monetary support
2. the waiting list of persons currently needing services
3. gatekeeping as a management tool
4. third party consortium as recipient of funds
5. money following the patient

Norm Furse explained technical amendments included in Attachment 5 and noted that it was also necessary to amend KSA 59-2916 to reconcile that section of the bill with HB 3099. Senator Gaines moved, Senator Winter seconded, that HB 2586 be so amended. The motion carried on a voice vote.

The technical amendments outlined on page 3 of Attachment 1 were explained by Norm Furse. Senator Winter questioned why SRS would not want the flexibility to contract with mental health centers and other treatment facilities. Senator Winter moved, Senator Allen seconded, that Sub HB 2586 be amended with the technical amendments found on Attachment 1-3 and with the language "or other treatment facility" (Attachment 4-4). When asked, Mr. Klotz stated that he felt the need to maintain exclusivity in gatekeeping because private facilities are not required to meet stringent licensure requirements, nor do they provide the gamut of services provided by a community mental health center. The motion failed on a show of hands.

Senator Salisbury moved, Senator Parrish seconded, that Sub HB 2586 be amended by inserting the word "state" before "psychiatric hospitals" on page 40, line 39. (Attachment 1-3) The motion carried.

Senator Winter moved, Senator Gaines seconded, that Sub HB 2586 be amended by Item 1, Attachment 1-3. The motion carried.

Senator Johnston moved, Senator Winter seconded, that Sub HB 2586 be amended with Item 3, Attachment 1-3. The motion carried.

Senator Winter moved, Senator Gaines seconded, that the words "consumers of mental health services" be replaced by "representatives of mental health

consumer groups" wherever it appears in Sub HB 2586. The motion carried.

Senator Winter inquired about potential liability problems in the situation of a court determined hospitalization denied by a community mental health center. Norm Furse noted that the language of Subsection F, page 29 of the bill, would limit the court's authority to order treatment at a state treatment facility. Chairman Bogina requested that Senators Winter and Parrish work with staff to clarify the language.

Senator Parrish moved, Senator Hayden seconded, that Sub HB 2586 be amended by inserting "shall" for "may" on page 10, lines 8 and 30. The motion carried.

Senator Winter moved that the new language on lines 5-10, page 12 be stricken from the bill. Following discussion, he withdrew his motion.

The Chairman announced that Sub HB 2586 would be held until the afternoon of April 24. Attachments 6 and 7 were distributed to Committee members.

SB 423 - Military retirement benefits exempt from income taxation

Mr. Mark Burkhardt told the Committee that SB 423 was a recommendation of the interim committee on Taxation. A U.S. Supreme Court decision in the case of Davis vs. Michigan stated that a state could not tax military retirees more than civil retirees. Kansas does not tax federal civil service benefits or KPERS benefits, but does tax military retirement pay. Mr. Burkhardt pointed out that a class action lawsuit has been certified in Shawnee County District Court in which the plaintiffs are seeking in excess of $50 million for back years. Two issues to be decided are 1) can the state legitimately tax these benefits and, 2) are refunds due? Mr. Burkhardt stated that the answer to the summary judgment had just been filed which stated that military retirement pay is not a pension, but simply reduced pay for reduced service. Mr. Burkhardt noted that if the Legislature would pass legislation next session, argument could be made on appeal before the Supreme Court for prospective treatment.

Senator Gaines moved, Senator Harder seconded, that SB 423 be referred to the interim Budget Committee. The motion carried with Senators Johnston and Feleciano voting no.

SB 787 - Work release programs, limitations on employment that effects private sector workforce

Mr. Chuck Simmons reviewed Attachment 8, stating that "minimum negative impact" has different interpretations and that language in lines 32-43 of SB 787 is the Department's attempt to define when inmate labor can be appropriately assigned to a project. He noted that the proposed language would have satisfied the instance that precipitated the Hutchinson court case.

Senator Allen expressed concern regarding the potential of budget manipulation in order to obtain free inmate labor. Mr. Simmons responded that the Department discussed utilizing these provisions for one year to determine if a record of abuse is established.

Senator Harder moved, Senator Allen seconded, that SB 787 be recommended favorable for passage. The motion carried on a roll call vote.

HB 2867 - State finance, limitations on state general fund appropriations and transfers, state cash operating reserve fund and state capital improvements reserve fund

Mr. Michael O'Keefe appeared before the Committee in support of HB 2867 and

reviewed Attachment 9.

Senator Johnston distributed Attachment 10, a memorandum from the Research Department. He noted that passage of HB 2867 would require either fairly dramatic decreases in general fund obligations or increases in revenue given the revenue growth projected by the most recent consensus group.

In answer to a question, Mr. O'Keefe stated that the 2/3 majority vote makes it more difficult for the Legislature to spend more money than it has.

Mr. O'Keefe told the Committee that supplemental bills would be exempt from the provision that "no appropriation bill can take effect without the passage of an Omnibus reconciliation spending limit bill." In answer to a question, he stated that the omnibus reconciliation concept does not specify appropriations made earlier that year or demand transfers.

Mr. O'Keefe noted that the problem with the overall use of veto is that it means holding a special session if appropriations bills are not sent to the Governor until the end of the session.

Mr. Jim Hays (Attachment 11), Mr. Ed Desoigne (Attachment 12), and Mr. Allen Bell (Attachment 13) appeared before the Committee in opposition to HB 2867. Mr. Allen told the Committee that the freeway bonds issued in the 1970s have not been legally defeased and would have to be counted against the limitations of 7.8% of taxable property in Kansas, which would add to the delay in the amount of time it would take to issue the last of the highway bonds.

The Chairman adjourned the meeting at 5:30 P.M.

GUEST LIST

COMMITTEE: SENATE WAYS AND MEANS DATE: 4-23-90

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
KAY COLES	TOPEKA	K-NEA
JIM HAYS	TOPEKA	KASB
NANCY WILSON	LAWRENCE	PROJECT ACCEPTANCE
Bill Simons	Lawrence	Project Acceptance
Judy Arentson	Lawrence	KANSAS AMI
Penny Sue Johnson	Overland Pk	The Ks. Coalition, Inc
Sonya Harmond	SRS/MH Gov's P.C. on MH Topeka	
Bob Chase	Iola	Ks. MH Svcs Pl. Council
Richard H Pfeiffer	Pittsburg KS.	Crawford Co. MHC
Samuel J. Nicoletti	Arma, Kans	Crawford Co. MHC
Dave Seaton	Winfield, Kan.	MH Planning Council
Rose Mary Mohr	Wichita Kansas	MH Planning Council
Connie Hartman	316 S. Cherry Olathe, Ks 66061	Self-Help Resources & Development Inc
Betty Stowers	Topeka Ks	MHAK M H Planning Council
Lori Clark	Topeka, Ks	Mental Health Association in Kansas
Tim Hamilton	PO 8107 Prairie Village Kansas 66208	Dual Disorders Recovery Foundation
Edward DAVIES	MARION KANSAS	Governors Mental Health Services Planning Council
Cecil Eyestone	2055 Jay Ct Manhattan, Ks	KANSAS AMI (Pres.)
Jerry Larson	P.O. Box 675 Topeka 66601	Kansas AMI
Barbara Huff	700 SW Jackson Suite 1024 Topeka Ks.	Keys for Networking Inc
Howard Snyder	4811 W 77 Pl. P.V. Ks 66208	Kansas AMI
LARRY MEIKEL	TOPEKA	Mental Health Consortium
Kent Munzer	Topeka	SRS Adult Services
Marnette Hitchcett	Newton	Prairie View MHC
Jody Unruh	Larned	Kans MH Planning Council
Jim Marshall	Topeka	Ks Dept of Ed
Lewis Allen	Tope Ks	Ks Health CARE Assn
Gary Blank	"	MH/RS
Steve Solomon	36th & Eaton Kansas City KS 66103	Wyandot Mental Health Center
David Wiebe	6000 LAMAR Mission, Ks 66202	Johnson County Mental Health Center
Patrick Hurley	Topeka	McGee Walker Mental Health Consortium
Kathy Mason	Wichita	St. Joe Med Ctr.
Laura Spencer	Topeka	SRS Adult Svcs
Bill Rudy	Topeka	SRS Legal Div.

GUEST LIST

COMMITTEE: SENATE WAYS AND MEANS DATE:

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Marni Lee	MH/RS SRS	

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

This packet includes the following items related to MENTAL HEALTH REFORM

1. The money to implement Sub. for HB 2586

2. Technical amendments to Sub. for HB 2586

3. Key points in Sub. for HB 2586

4. A plan for funding the implementation of Sub. for HB 2586

5. A letter from the 12 Mental Health Centers in the OSH catchment area supporting start-up funds.

SWAM
April 23, 1990
Attachment 1

To implement Substitute for HB 2586 the following financing is necessary.

1. Agree to the GBA April 16, 1990, page 17, 628-15, $1,017,000

   $ 289,557. from Alcohol and Drug Abuse and Mental Health federal grant money

   $ 727,443. SGF

   $1,017,000. (New funding)

2. $400,000. SGF put in by the House to be used for stabilizing persons in the community.
   (Existing funding)

3. $500,000. SGF for start-up funds for Mental Health Reform, limited to two years per catchment area.
   (New funding)

4. $163,420 SGF to maintain the status quo in the Community Support Program.
   (Existing funding)

5. A provision concerning liability insurance:

   Provided that any insurance premimum increase in excess of an annual rate of 10% will be viewed as a cost of Mental Health Reform and will be paid by SRS.

TECHNICAL AMENDMENTS TO SUB. HB 2586:

1. On page 2, line 10, insert, ["Participating mental health center" means: 1) a mental health center which has entered into a contract with the secretary of social and rehabilitation services to provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the treatment act for mentally ill persons, in keeping with the phased concept of this act; or

2) a mental health center which is under contract with a contracting agency which has entered into a contract with the secretary of social and rehabilitation services to provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the treatment act for mentally ill persons, in keeping with the phased concept of this act.]

2. Page 40, line 39, after the word "the" insert the word "state" so it will read, "continuity of care in the state psychiatric hospital".

3. On page 15, line 15, following the word "means" insert [: 1) a mental health center which has entered into a contract with the secretary of social and rehabilitation services to provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the treatment act for mentally ill persons, in keeping with the phased concept of this act; or

2) a mental health center which is under contract with a contracting agency which has entered into a contract with the secretary of social and rehabilitation services to provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the treatment act for mentally ill persons, in keeping with the phased concept of this act.]

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

MEMORANDUM

TO: MEMBERS OF THE SENATE

FROM: PAUL KLOTZ PK

RE: KEY POINTS IN SUBSTITUTE FOR HB 2586

DATE: APRIL 23, 1990

The following are some of the key points related to mental health reform as contained in substitute for HB 2586:

1. New section two, line 35, paragraph B — an outline of the community based mental health services to be provided by participating health centers.

2. Page 2, line 10 -- a proposed amendment indicating the participating mental health center as one which has entered into a contract with the secretary of SRS to carry out the mental health reform program.

3. Page 2, line 18 -- mental health reform phase program indicates the timetable for the implementation of mental health reform.

4. Page 2, line 30, paragraph H -- screening is a key issue in mental health reform. The centers are to screen individuals to determine the least restrictive location for treatment, prior to sending patients to state hospitals.

5. Page 4, line 1 -- limiting language as it relates to the implementation of the act within the appropriations available.

6. Page 4, line 2 -- no person shall be inappropriately denied necessary mental health services provided there is money for such services.

7. Page 5, line 10 -- there is language to indicate that the program will be directly related to outcomes agreed upon by SRS and the centers.

8. Page 5, line 15 -- additional language indicating the implementation of mental health reform is directly related to appropriations available.

9. Page 6, line 21 -- there is provision for the establishment of the Governor's mental health services planning council.

10. Page 8, line 1 -- provides for the transfer of certain functions from adult services to mental health retardation services.

11. Page 9, line 1 -- lays out the phase program for the implementation of mental health reform.

12. Page 10, line 1 -- provides a mechanism for the state psychiatric hospital staff and the mental health center staff to get together to formulate admission and discharge planning criteria for all patients.

13. Page 10, line 7 -- permissive legislation related to the establishment of a pilot project, for youth.

14. Page 10, line 37 -- this language sets forth the provision that the Secretary of Social Rehabilitation Services cannot require the mental health centers to make expenditures other than expenditures agreed to by the governing board of the center.

15. Page 34, line 16 -- raises the issue of liability as it relates to mental health reform.

16. Page 40, line 37 -- makes provision for the handling of confidential information. In that section, a technical amendment needs to be made on line 39. After the word "the" insert the word "state" so it will read, "continuity of care in the state psychiatric hospital".

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

MEMORANDUM

TO: Members of the Senate

FROM: Paul Klotz -- Association of Mental Health Centers PK
234-4773

DATE: April 2, 1990

RE: Mental Health Reform (HB 2586)
and
Funding for Mental Health Reform

The Centers support mental health reform (HB 2586). We have been active players in this process for a number of years.

We support SRS's plan of implementation. It is phased in over a period of time to take into account the State's current fiscal condition.

HB 2586 with amendments and appropriate funding will implement the recommendation coming from the Governor's Task Force on Mental Health Reform. It has the potential to meet all of the mandated requirements of Public Law 99-660.

The Centers support the request from SRS for FY 1991 for $417,000 ($834,000 annually) and $600,000 ($1.2 million annually for therapeutic services). We also support the statement of Commissioner Nemec recognizing the need for separate start-up funds for housing and housing related support services. It has been suggested to have a pool of money of $500,000. to $1. million for a period not to exceed two years. The money would be available to the Centers only on the basis of a demonstrated need.

The Centers also think that some form of General Assistance and Medikan needs to be maintained for persons coming out of hospitals or being diverted from hospitals.

As a minimum, the mental health services in the community will include:

1. 24 hour Emergency and Screening services
2. Outreach/case finding
3. Medication management
4. Case management
5. Daily living and supportive therapy services
6. Vocational programs
7. Residential services
8. Short term community psychiatric in-patient services
9. Intermediate care facility service for the mentally ill

There are many advantages to this plan:

1. It is attentive to patient needs.
2. It is comprehensive and unifies the two mental health systems into one system.
3. It has a wide base of public support.
4. It is responsive to the Governor's Task Force and Federal Requirements.
5. It is cost effective.
6. It is a way to strengthen local programs.
7. It is a way to reduce hospital beds and budgets.
8. It is a way to provide increased therapeutic services for the mentally ill in local communities.
9. It is workable beginning July 1, 1990.

If you have any questions, please let me hear from you.

EXECUTIVE SUMMARY

Cost containment through mental health reform unites budget controls with the necessity for significant re-structuring of the mental health system in Kansas.

Because of the many unknown factors related to accreditation and certification and the demands of the federal government; there will be significant increase in the Health Reform (HB 2586) over the next seven years.

The enclosed plan places a cap on the state hospital budgets. It outlines a mental health reform plan which responds to the issues raised by the Governor's Task Force on Mental Health Reform. It implements legislative proposal number 17. It has the potential to meet all of the federal requirements as imposed through Public Law 99-660.

This plan provides for systematic, phased planning and implementation over a seven year period. It provides for mental health services to be primarily delivered at the local level with the state maintaining an overall monitoring and supervising role.

This plan calls for outcomes tied to patient services and dollars spent in the program. This plan gives immediate attention to the need for providing comprehensive mental health services to patients in the least restrictive environments.

The financing of this plan can begin on a very modest basis; approximately $1.5 million during fiscal year 1991. The increased local funding can be handled over a period of time and as such, can be funded out of state hospital budgets as the state hospital begins to close wards, units, and programs.

This plan capitalizes on the current interest in mental health reform while at the same time places a fixed limit on state hospital budgets.

Prepared by McGill & Associates
February 27, 1990

MH/RS PLAN WITH MODIFICATIONS

MENTAL HEALTH REFORM ACT- IMPLEMENTATION

Osawatomie State Hospital

		FY '91 7/1/90	FY '92 7/1/91	FY '93 7/1/92	FY '94 7/1/93	FY '95 7/1/94	FY '96 7/1/95	FY '97 7/1/96	TOTAL MILLIONS
Hospital Budget +7.0%:		$20.6	$22.0	$23.6	$23.5	$23.5	$24.2	$24.8	
(Close Ward)				($0.7)	($0.6)				
				$22.9	$22.9				
Overhead:	-4.0%			($0.9)	($0.9)	($0.9)	($1.0)	($1.0)	
Inflation:	7.0%	$20.6	$22.0	$22.0	$22.0	$22.6	$23.2	$23.8	$156.2
Shelter Pool:		$0.5	$0.5						
Screening:	5.0%	$0.4	$0.8	$0.8	$0.9	$0.9	$1.0	$1.0	
Adult Pts. In Comm.:	5.0%	$0.6	$1.2	$1.3	$2.6	$2.8	$2.9	$3.1	
Child. Pts. In Comm.:	5.0%		$1.2	$1.3	$1.3	$1.4	$1.5	$1.5	
		$1.5	$3.7	$3.4	$4.9	$5.1	$5.3	$5.6	$29.5
Total:		$22.1	$25.7	$25.3	$26.8	$27.7	$28.6	$29.5	$185.7
Hospital Budget w/7.0%: (Without Reform)		$20.6	$22.0	$23.6	$25.2	$27.0	$28.9	$30.9	$178.3
Difference:		$1.5	$3.7	$1.7	$1.6	$0.7	($0.3)	($1.5)	$7.4

PREPARED BY MCGILL & ASSOCIATES February 27, 1990

MH/RS PLAN WITH MODIFICATIONS

MENTAL HEALTH REFORM ACT- IMPLEMENTATION

Topeka State Hospital

	FY '91 7/1/90	FY '92 7/1/91	FY '93 7/1/92	FY '94 7/1/93	FY '95 7/1/94	FY '96 7/1/95	FY '97 7/1/96	TOTAL MILLIONS
Hospital Budget +7.0%	$22.1	$23.6	$25.3	$26.1	$25.8	$25.5	$26.2	
(Close Ward)	PLANNING		($0.9)	($1.0)	($0.9)			
			$24.4	$25.1	$24.9			
Overhead: -4.0%				($1.0)	($1.0)	($1.0)	($1.0)	
Inflation: 7.0%	$22.1	$23.6	$24.4	$24.1	$23.9	$24.5	$25.2	$167.8
Shelter Pool:		$0.5	$0.5					
Screening: 5.0%		$0.8	$0.8	$0.9	$0.9	$1.0	$1.0	
Adult Pts. In Comm.: 5.0%		$1.2	$1.3	$1.3	$2.8	$2.9	$3.1	
Child. Pts. In Comm.: 5.0%		$1.2	$1.3	$1.3	$1.4	$1.5	$1.5	
		$3.7	$3.9	$3.5	$5.1	$5.3	$5.6	$27.1
Total:	$22.1	$27.3	$28.3	$27.6	$29.0	$29.9	$30.8	$195.0
Hospital Budget w/7.0%: (Without Reform)	$22.1	$23.6	$25.3	$27.1	$29.0	$31.0	$33.2	$191.3
Difference:	$0.0	$3.7	$3.0	$0.6	$0.0	($1.1)	($2.4)	$3.7

PREPARED BY MCGILL & ASSOCIATES February 27, 1990

MH/RS PLAN WITH MODIFICATIONS

MENTAL HEALTH REFORM ACT- IMPLEMENTATION

Larned State Hospital

	FY '91 7/1/90	FY '92 7/1/91	FY '93 7/1/92	FY '94 7/1/93	FY '95 7/1/94	FY '96 7/1/95	FY '97 7/1/96	TOTAL MILLIONS
Hospital Budget +7.0%: (Close Ward)	$30.4	$32.5	$34.8	$37.2 ($1.0)	$37.2 ($1.0)	$37.2 ($1.0)	$37.1	
PLANNING			$34.8	$36.2 ($1.4)	$36.2 ($1.5)	$36.2 ($1.5)	($1.5)	
Overhead: -4.0%								
Inflation: 7.0%	$30.4	$32.5	$34.8	$34.8	$34.7	$34.7	$35.6	$237.6
Shelter Pool:			$0.5	$0.5				
Screening: 5.0%			$0.8	$0.8	$0.9	$0.9	$1.0	
Adult Pts. In Comm.: 5.0%			$1.3	$1.4	$1.4	$3.0	$3.2	
Child. Pts. In Comm.: 5.0%			$1.3	$1.4	$1.4	$1.5	$1.6	
			$3.9	$4.1	$3.7	$5.4	$5.7	$22.9
Total:	$30.4	$32.5	$38.7	$38.9	$38.5	$40.1	$41.3	$260.4
Hospital Budget w/7.0%: (Without Reform)	$30.4	$32.5	$34.8	$37.2	$39.8	$42.6	$45.6	$263.1
Difference:	$0.0	$0.0	$3.9	$1.6	($1.4)	($2.5)	($4.3)	($2.6)

PREPARED BY MCGILL & ASSOCIATES February 27, 1990

Association of Community
Mental Health Centers of Kansas
835 S.W. Topeka Ave., Suite B/Topeka, Kansas 66612/913 234-4773
Paul M. Klotz, Executive Director

March 19, 1990

The Honorable August "Gus" Bogina, Jr.
Chairman, Senate Ways and Means Committee
State Capitol, Room 120-S
Topeka, KS 66612

Re: Substitute for HB-2586

Dear Senator Bogina:

The twelve Community Mental Health Centers serving the Osawatomie State Hospital catchment area support the mental health reform proposal currently before the Legislature, in the form of "Substitute for HB-2586". We are pleased the current plans call for beginning the reform effort in the Osawatomie region.

One major concern as we prepare for increased responsibility for serving the long term mentally ill, is the initial, one-time, expenses of developing resources necessary to serve these clients. Attached is a description of these expenses developed after careful study of our needs.

The expenses fall generally into three categories: (1) Alternative Community Residential Facilities, (2) Transportation, and (3) Other expenses (e.g. treatment and office space, equipment and supplies, client residential furnishings, training, etc.). Because the facility expense is the major start-up cost, some further explanation may be helpful.

Currently, there are only two group residential homes for the mentally ill in the entire Osawatomie State Hospital region. Collectively, the twelve Mental Health Centers in the region serve 1500-1600 long term mentally ill clients. Virtually all these clients have a history of state hospital treatment, and most have some risk of being re-hospitalized. The closing of state hospital beds will further challenge us to keep an even larger number of the most seriously disabled of these persons in the community.

While the vast majority can effectively be served in their homes or apartments with case management and other services, a small percentage require some type of 24-hour supervised care in the community before moving on to more independent living. Frequently, these are individuals just released from a state hospital. Group homes represent one of the most desirable and economical environments for persons requiring 24-hour supervision.

Although our analysis of one-time start-up expenses included only the Osawatomie State Hospital region, we assume the needs will be similar in the other two state hospital areas. It is our conclusion that funding of these initial costs is crucial to the success of Mental Health Reform.

Thank you for your support and consideration.

Ronald G. Denney, Executive Director
Four County Mental Health Center
Independence, Kansas

Linda B. Denniston, Director
Miami County Mental Health Center
Paola, Kansas

Helen Findley, Executive Director
Cowley County Mental Health Center
Winfield, Kansas

Ron Fisher, Executive Director
South Central MH Counseling Center
Eldorado, Kansas

Scott Jackson, Executive Director
Family Life Center, Inc.
Columbus, Kansas

John C. Jones, Administrative Dir.
Franklin County MH Clinic, Inc.
Ottawa, Kansas

Charles S. Kunce, Executive Director
Northeast Kansas MH & Guidance Ctr.
Leavenworth, Kansas

Jack W. Martin, Administrator
Labette Center for MH Services
Parsons, Kansas

Richard H. Pfeiffer, Administrator
Crawford County Mental Health Ctr.
Pittsburg, Kansas

Steven J. Solomon, Executive Dir.
Wyandot Mental Health Center, Inc.
Kansas City, Kansas

Paul Thomas, Administrator
Southeast Kansas Mental Health Ctr.
Humboldt, Kansas

David Wiebe, Executive Director
Johnson County Mental Health Ctr.
Mission, Kansas

ONE TIME START-UP EXPENSES RELATED TO MENTAL HEALTH REFORM
OSAWATOMIE STATE HOSPITAL REGION

INTRODUCTION

The one time start-up expenses identified below were developed following a series of meetings involving all twelve of the Mental Health Centers in the Osawatomie State Hospital catchment area. In addressing the need for start-up expenses, the following areas of need were examined with respect to the impact of mental health reform: (1) The need for additional supervised community residential resources to accommodate a reduction of up to 90 beds at OSH, (2) The need for additional vehicles to transport mentally ill clients to and from treatment programs, and (3) The need for additional facilities and equipment to accommodate the substantial increase in community programming called for in the mental health reform plan.

Recommendations in each of these three areas is as follows:

SUPERVISED COMMUNITY RESIDENTIAL FACILITIES

It is anticipated that four 10-bed group residential facilities will be required for those persons needing a 24-hour structured living environment. Two of these facilities would serve the urban northern part of the OSH catchment area, while the other two would serve the southern part of the OSH region. Supervised apartments are another necessary residential resource. The more modest expense for apartment start-up costs are included in the section titled OTHER START-UP COSTS.

1. Group Residential Facility (10 persons)

   Proposed Service Area:
   Franklin County MHC, Miami County MHC,
   Southeast Kansas MHC, Crawford County MHC,
   Family Life Center

   Target Population: Long Term Mentally Ill Adults

   Cost: $150,000

2. Group Residential Facility (10 persons)

   Proposed Service Area:
   Four County MHC, Labette Center for
   Mental Health Services, South Central MHC,
   Cowley County MHC

   Target Population: Long Term Mentally Ill Adults

   Cost: 150,000

3. Group Residential Facility (10 persons)

Proposed Service Area: Wyandot MHC, Northeast Kansas MHC

Target Population: Long Term Mentally Ill Adults

Cost: 150,000

4. Group Residential Facility (10 persons)

Proposed Service Area: Wyandot MHC, Northeast Kansas MHC, Johnson County MHC

Target Population: Long Term Mentally Ill Adults

Cost: 150,000

Total Facilities Expense: $600,000

TRANSPORTATION

It is anticipated that five vans will be needed to transport clients to and from treatment programs.

Cost: $19,000 each x 5 95,000

Total Vehicle Expense: $95,000

OTHER START-UP EXPENSES

The planned substantial expansion of community treatment programming in all twelve Mental Health Centers in the OSH catchment area will necessitate a number of additional one time start-up costs. These will include:

1. Acquisition/remodeling of additional Mental Health Center treatment space to accommodate increased clients and staff.

2. Acquisition of office furniture and equipment, and treatment supplies.

3. Start-up costs for supervised apartments, including basic furnishings, rental deposits, and utility deposits.

4. Training of MHC staff, law enforcement, hospital emergency rooms, etc. in gatekeeping techniques and procedures.

Because of the difficulty in accurately estimating the specific costs of these expenses for each Mental Health Center, it was determined to include an amount of $300,000 for these "other" expenses. These funds would be justified on a specific case by case basis as each Center develops its own individual program.

Total Other Start-up Costs:	$300,000

SUMMARY

Total - Facilities	$600,000
Total - Vehicles	95,000
Total - Other	300,000
Grand Total	$995,000

March 16, 1990

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, 915 S.W. Harrison, Topeka, Kansas 66612

(913) 296-3271

Mental Health &
Retardation Services
Fifth Floor
(913) 296-3471

April 10, 1990

The Honorable August Bogina, Jr.
The State Senate
State House, Room 120-S
Topeka, Kansas 66612

Dear Senator Bogina:

In preparation of your deliberation on HB 2586 on April 23, 1990, I am sending you the following materials for your consideration.

1. FY 1991 direct and indirect costs relative to HB 2586

2. SRS's position on HB 2586
   a. Background
   b. Significance of HB 2586 and reasons of SRS support
   c. Implementation of HB 2586

3. Financing Plan: Mental Health Services in Kansas

Thank you very much for your consideration.

Sincerely,

Al

Al Nemec
Commissioner

ALN:ML:ees
attachments

SWAM
April 23, 1990
Attachment 2

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MENTAL HEALTH AND RETARDATION SERVICES

M E M O R A N D U M

TO: Senator Bogina

DATE: April 3, 1990

FROM: Al Nemec
Commissioner

RE: HB 2586, FY 1991 Costs

In anticipation of the Senate Ways and Means Committee hearing scheduled for April 23, 1990, I am providing information in regard to direct and indirect costs (for FY 1991) associated with the implementation of HB 2586.

Direct Costs: The direct costs shown below relate specifically to Mental Health Reform, Phase I, in the Osawatomie State Hospital (OSH) catchment area:

1. $417,000 - Screening (Gatekeeping) is to be done in the OSH catchment area for a period of six months. Screening is the process of assessing the mental health service needs to determine whether an individual can be fully evaluated and/or treated in the community or whether he or she should be admitted to the state hospital for further evaluation and/or treatment.

2. $600,000 - Community Support Services Development is to be done in the OSH catchment area for a period of six months. This will allow OSH to reduce its census by 20 to 30 beds.

3. $??? - Start-up funds for mental health reform, limited to two years per catchment area.

TOTAL: $1,017,000 plus possible dollars for Start-up

Indirect Costs: The indirect costs shown below are not specific to Phase I, Mental Health Reform implementation, as these costs are related to statewide MH programming. Funding losses in items 1, 2, and 3; federal Mental Health Block Grant and GA/Medikan program reductions, would curtail services statewide and hamper Phase I Mental Health Reform efforts.

1. $265,202 - Restoration of Federal Mental Health Block Grant loss. A $265,202 reduction in the federal Mental Health Block Grant will result in disruption of services to the target population described in HB 2586.

2. $500,000 - Funds to be administered through Medical Programs, SRS to cover CMHC services to those clients (in target population) who are presently receiving services but who would not be covered as a result of anticipated GA/Medikan program reductions.

3. $400,000 - Community Mental Health Crisis Services Grants. These funds will be used to provide inpatient or other crisis residential services to certain mentally ill clients currently covered by the existing GA/Medikan programs, but who would most likely not meet new and more stringent eligibility requirements devised as cost cutting measures.

4. $207,586 - ICF/MH Programming. These funds would be used to employ staff to adequately administer ICF/MH programs by MH/RS. HB 2586 mandates the transfer of the administration of ICF/MH program from Adult Services, SRS, in an attempt to integrate various components of the mental health system under MH/RS.

TOTAL: $1,372,788

ALN:ML:ees

cc: Mr. Rick Kready
Ms. Laura Howard
Mr. Michael O'Keefe

Department of Social and Rehabilitation Services

House Bill 2586

1) History

2) Significance of HB 2586 and Support by the Department

3) Implementation of HB 2586

Al Nemec, Commissioner
Mental Health and Retardation Services
Department of Social and Rehabilitation Services
Telephone (913) 296-3773

April 9, 1990

HISTORY

For several years, the mental health system in Kansas has been the subject of numerous studies. These studies, including the report, "Toward An Agenda For Mental Health In Kansas" (December, 1987) by Charles Rapp, Ph.D. and James Hanson, the Legislative Performance Audit Report, entitled "Improving the System for Providing Mental Health Programs and Services in Kansas" (August, 1988), "The Kansas Plan for a Community Based Mental Health System" (September, 1989), and the report by the Governor's Task Force on Mental Health Reform (1989) all reached a number of conclusions. These conclusions included the following:

. . . . The system is fragmented.
. . . . The services within the system are not coordinated.
. . . . Approximately 80% - 85% of current funds are devoted to State psychiatric hospitals while individuals spend 90% - 95% of their time in the community.
. . . Individuals who receive services in the system sometimes are "lost between the cracks" because of the fragmentation and lack of coordination.
. . . . There is a lack of sufficient community-based services to meet the needs of those requiring mental health services who reside in their community.
. . . The costs of maintaining hospitals is escalating rapidly.
. . . .It will not be possible to contain the escalating costs of unless there is the development of an adequate community-based system of care.
. . . . These conclusions dramatically illustrate the need for **reform** of the mental health system.

In addition to the findings of all these studies and reports, Kansas, like every other state, is mandated by federal legislation, Public Law 99-660, to develop and implement a comprehensive, community-based mental health system.

SIGNIFICANCE OF HB 2586 AND SUPPORT BY THE DEPARTMENT

HB 2586, in essence, is a response to these studies and mandates. This proposed legislation allows for the **POSITIVE** reform of the mental health system.

HB 2586 has broad-based support because it establishes a coordinated system of care.

HB 2586 establishes the framework that will enable Kansas citizens to receive mental health services when and where they are needed.

HB 2586 proposes certain measures to unify State psychiatric hospitals and community mental health centers in ways that will result in a community-based mental health system.

HB 2586 permits the screening of <u>all</u> referrals to State psychiatric hospitals in a practical and systematic way.

HB 2586 results in the fewest changes to the existing law while, at the same time, it directs the public mental health system to deliver coordinated and efficient services.

HB 2586 allows the State to comply with the provisions of PL 99-660.

IMPLEMENTATION OF HB 2586

Mental Health and Retardation Services is confident that it can, in partnership with community mental health centers, other providers, families and consumers, implement this landmark legislation.

Our plan for implementation is contained in the **Financing Plan**, Revision II, dated February 23, 1990. It is our strong opinion that this financing plan is sound, practical, and workable. We believe it accomplishes a number of goals that our citizens deserve. These goals are as follows:

> Structural and financial reform of the mental health system consistent with the recommendations of the Governor's Task Force on Mental Health Reform and the provisions of PL 99-660.
> Incremental (phased) development of a community-based mental health system while maintaining the fiscal integrity of the State.
> Containment of escalating costs of maintaining State psychiatric hospitals.
> Reallocates scarce resources in a way that allows individuals currently employed in the system to maintain their jobs or move into new jobs in community programs.
> Individuals are served in the least restrictive and most normal setting possible.
> Allows for the maintenance of accreditation and certification of State psychiatric hospitals, thereby insuring quality of care and retention of federal financial participation.

REVISION II

FINANCING PLAN

MENTAL HEALTH SERVICES IN KANSAS

FEBRUARY 23, 1990

PREPARED BY: AL NEMEC, COMMISSIONER
MENTAL HEALTH AND RETARDATION SERVICES
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

INTRODUCTION. 4

SUMMARY 5

BACKGROUND. 5

ALTERNATIVE PROPOSAL. . . . . 5 & 6

DESIRED OUTCOMES. 6

FISCAL NOTE 6

PROGRAM DESCRIPTION . . . . . 7 & 8

CENSUS CAPACITY 9

GATEKEEPING . . . . . 10 & 11

SCREENING FUNDS DISTRIBUTION. . . . . 11 & 12

SUMMARY (GATEKEEPING/SCREENING) 13

COMMUNITY SUPPORT SERVICES - INTRODUCTION 14

CSS CENSUS REDUCTION STRATEGIES . . . . . 14 - 16

FISCAL NOTE (CSS) . . . . . 16 - 19

SUMMARY, CSS. 20

LONG-TERM PHASED IMPLEMENTATION 21

PHASED PROGRAM - OSH. . . . . 22 & 23

PHASED PROGRAM - TSH. . . . . 23 & 24

PHASED PROGRAM - LSH. . . . . 24 & 25

COST COMPARISON 26

RATIONALE - PHASED PROGRAM. 28

LEGISLATIVE REVISIONS . . . . . 28 & 29

FINANCING PLAN FOR CHILDREN AND ADOLESCENTS . . . . . 30 - 35

ATTACHMENTS 1 - 4 . . . . . 36 - 44

EXECUTIVE SUMMARY

THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES/MENTAL HEALTH AND RETARDATION SERVICES, IN PARTNERSHIP WITH COMMUNITY MENTAL HEALTH CENTERS, FAMILIES AND CONSUMERS, HAS DEVELOPED A PLAN DESIGNED TO ACHIEVE STRUCTURAL AND FINANCIAL REFORM OF THE MENTAL HEALTH SYSTEM CONSISTENT WITH RECOMMENDATIONS BY THE GOVERNOR'S TASK FORCE ON MENTAL HEALTH REFORM AND THE PROVISIONS OF FEDERAL LEGISLATION, PUBLIC LAW 99-660. THE PLAN IS A BLUEPRINT FOR THE PHASED DEVELOPMENT OF A COMMUNITY-BASED MENTAL HEALTH SYSTEM.

THIS SECTION IS A SUMMARY OF THE PLAN. THE PLAN DESCRIBES HOW THE ESCALATING COSTS OF STATE PSYCHIATRIC HOSPITALS ARE CONTAINED WHILE AT THE SAME TIME, RESOURCES ARE REALLOCATED TO COMMUNITY PROGRAMS, AND MOST IMPORTANTLY, INDIVIDUALS ARE SERVED IN THE LEAST RESTRICTIVE AND MOST NORMAL SETTING POSSIBLE. FURTHER, THE PLAN ALLOWS FOR THE MAINTENANCE OF ACCREDITATION AND CERTIFICATION OF THE STATE PSYCHIATRIC FACILITIES, THEREBY INSURING QUALITY OF CARE AND RETENTION OF FEDERAL FINANCIAL PARTICIPATION.

THE INITIAL PHASE OF THE PLAN INVOLVES TEMPORARY FUNDING FOR OSAWATOMIE TO RETAIN ACCREDITATION/CERTIFICATION. FUNDING FOR COMMUNITY PROGRAMS TO DEVELOP GATEKEEPING (SCREENING) AND COMMUNITY SUPPORT SERVICES IN THE OSAWATOMIE CATCHMENT AREA IS RECOMMENDED. AS THESE COMMUNITY PROGRAMS ARE DEVELOPED, OSAWATOMIE STATE HOSPITAL WILL BE ABLE TO CLOSE ONE UNIT, AND THE CENSUS CAPACITY WILL BE MAINTAINED AT THAT LEVEL. THE SAME PROCESS WILL CONTINUE AT OSAWATOMIE STATE HOSPITAL UNTIL 3 UNITS (2 ADULTS AND 1 ADOLESCENT) ARE PERMANENTLY CLOSED BY JUNE 30, 1993. SAVINGS REALIZED FROM THE CLOSURE OF TWO OF THE UNITS WILL BE REALLOCATED TO COMMUNITY PROGRAMS.

THE PROCESS OF COMMUNITY PROGRAM DEVELOPMENT AND HOSPITAL COST CONTAINMENT IS REPEATED IN A PRESCRIBED SCHEDULE IN THE TOPEKA STATE HOSPITAL AND LARNED STATE HOSPITAL CATCHMENT AREAS UNTIL ULTIMATELY, IN FY97, 9 UNITS, OR APPROXIMATELY 270 BEDS ARE PERMANENTLY CLOSED. OF THESE BEDS (90 IN EACH FACILITY), APPROXIMATELY 60 OF THEM ARE FOR CHILDREN AND ADOLESCENTS.

FISCAL NOTES ARE INCLUDED IN THE PLAN AS ARE STRATEGIES FOR THE DISTRIBUTION OF FUNDS. THE RATIONALE FOR A PHASED APPROACH IS EXPLAINED, AND THE LEGISLATION REQUIRED TO IMPLEMENT THE PLAN IS PRESENTED. THE ABILITY TO IMPLEMENT THE PLAN IS CONTINGENT UPON THE MAINTENANCE OF MEDIKAN AND GENERAL ASSISTANCE PROGRAMS AS THESE PROGRAMS HELP TO KEEP PEOPLE IN THE COMMUNITY SETTINGS.

INTRODUCTION

Kansas, like most other states, faces a serious difficulty in adequately financing its mental health system.

... Approximately 80% - 85% of current funds are devoted to State hospitals.

... Costs of maintaining/operating State hospitals escalate rapidly.

... Currently, there are 962 State hospital beds (excluding Security) that can serve 658 adults and 243 children and 61 substance abuse clients at any one time.

... There are an estimated 24,000 adults in Kansas with severe mental illness: approximately 8,000 of those 24,000 would need public mental health services at any one time, and there are an estimated 5,600 - 10,000 children/adolescents with severe emotional disabilities.

... Individuals with severe mental illness spend approximately 95% of their time in the community and only 5% of their time in a hospital.

... The technology is present to provide community-based services to most adults with severe mental illness and children and adolescents with severe emotional disabilities.

... Kansas, like every other state, is mandated by federal legislation to develop a community-based mental health system.

... Kansas must contain rising hospital costs, maintain individuals in the community, and achieve a more equitable distribution of funds between State hospitals and community programs.

The short-term financing plan for mental health services as proposed in the SRS/MH&RS "C" level budget for FY 91 continues to be a fiscally responsible method of mental health reform on an incremental basis. However, the current budget situation suggests that full funding of this proposal may not be possible this year.

With this situation in mind and because of the potential loss of certification at Osawatomie State Hospital (OSH), a contingency financing proposal is indicated. It should be emphasized that only preliminary discussions have occurred with State hospital and community mental health center (CMHC) representatives, other service providers, consumers and family members about this contingency proposal. As joint planning with all concerned parties continues, the plan will be subject to further revision, however, the basic concept of this plan has been approved unanimously by the Governor's Mental Health Services Planning Council.

SUMMARY

This discussion is a refinement and further development of the short-term contingency plan presented on January 18, 1990. At that time, it was proposed that $300,000 in new State General Funds be appropriated for Osawatomie State Hospital (OSH) for new temporary positions. This appropriation, for FY 91, would enable OSH to retain accreditation and certification. At the same time, the proposal indicated that $600,000 would be needed for a six month period to develop the necessary programs that would allow OSH to close 30 beds (one ward). Further, $417,000 was proposed for a six month period to develop necessary gatekeeping services in the community.

BACKGROUND

During surveys by JCAHO and HCFA in 1989, OSH was advised that, while accreditation and certification would be retained, these statuses could be lost if identified deficiencies were not corrected by the time of the next surveys scheduled in late spring and mid-summer, 1990, respectively.

The major deficiency cited was that of inadequate staffing. OSH indicates that an appropriation of approximately $600,000 to fund 28 new positions would provide sufficient resources to satisfy the contingencies.

The foregoing situation is an example of the manner in which the mental health system continues to invest its resources primarily in institutional settings. Namely, institutions require ever-increasing resources at ever-increasing costs to provide high standards of care. Failure to provide a high level of care in accordance with standards set by JCAHO and HCFA results in loss of accreditation and certification. The State is then unable to capture third party reimbursement and federal financial participation.

MH&RS ALTERNATIVE PROPOSAL

As the summary above suggested, MHRS proposes an alternative to an appropriation of $600,000 for the funding of 28 new positions at OSH. MHRS recommends partial funding over a 6 month period. This alternative would permit the hiring of temporary staff during that period of time.

At the same time, MH&RS recommends a six month appropriation for community programs that will enable the community programs to develop the services necessary to reduce bed utilization at OSH that would be the equivalent to an approximate 30 bed unit.

The ability to be the "gatekeeper" to the State hospital is essential for CMHCs if admissions, census, and growth of hospital programs are to be contained. Thus, the ability to screen all potential admissions by CMHCs is necessary if these agencies are to be effective gatekeepers. In order to develop this screening capability, MH&RS recommends a six month appropriation.

DESIRED OUTCOMES

... Maintenance of certification/accreditation

... Maintenance of high level of care

... Maintenance of federal financial participation

... Maintenance of ability to capture third party reimbursement

... Maintenance of integrity of hospital program

... No expansion of hospital programs

... Shifting of funds to community programs

... Improved ability to serve clients in the least restrictive environment

FISCAL NOTE

Temporary OSH positions - **$300,000:** when accreditation and certification secured, temporary staff would no longer be needed when a 30 bed unit is closed.

Community support services development - **$600,000:** this figure for six months is, as indicated earlier, the amount needed to develop necessary community mental health programs that would allow OSH to close one 20 to 30 bed units.

Gatekeeping (Screening) - **$417,000:** this figure for six months was calculated on the basis of **$2,500,000** estimated by CMHCs and MHRS to implement screening for all populations, statewide for one year; taking one half (six months) of that amount and then dividing by one third since the OSH catchment area comprises approximately one third of the State.

PROGRAM DESCRIPTION

This short-term program is one that will require a partnership between the CMHCs, other community providers, consumers, and family members and MH&RS (including OSH), one like that recommended by the Governor's Task Force on Mental Health Reform. That is, there must be cooperation and collaboration if this program is to succeed. The State, through MHRS, will provide the funds and monitoring mechanisms while the CMHCs will provide the needed services. To better understand the parameters of the program, it may be helpful to describe the OSH catchment area, the CMHCs in that area, and the services currently available.

The OSH catchment area consists of 22 counties on the eastern edge of the state from Atchison County south to the State of Oklahoma. These counties are divided into 12 community mental health center catchment areas, which provide an array of local mental health services to the communities in their districts. The total population served by the community mental health centers and OSH is estimated to be 933,600. The community mental health centers are located in heavily populated urban areas encompassing the Kansas side of metropolitan Kansas City, as well as the more rural areas of southeast Kansas.

Specifically, the following community mental health centers comprise the state funded community mental health service system in the OSH catchment area:

COMMUNITY MENTAL HEALTH CENTER	LOCAL OFFICES	COUNTIES SERVED	POPULATION
Cowley County MHC	Arkansas City Winfield	Cowley	37,000
Crawford County MHC	Pittsburg	Crawford	37,600
Family Life Center	Columbus Baxter Springs Galena	Cherokee	22,200
Four County	Independence Coffeyville Fredonia Neodesha	Chautauqua Elk Montgomery Wilson	61,200

Franklin County MH Clinic	Ottawa	Franklin	21,900
Johnson County MHC	Mission Olathe Merriam	Johnson	318,300
Labette Center for Mental Health Services	Parsons Oswego	Labette	25,400
Miami County MHC	Paola Louisburg Osawatomie	Miami	22,600
Northeast Kansas MHC	Leavenworth Atchison Oskaloosa Tonganoxie	Atchison Jefferson Leavenworth	94,500
South Central Mental Health Counseling Center	El Dorado Andover Augusta	Butler	48,000
Southeast Kansas MHC	Humboldt Chanute Fort Scott Garnett Mound City	Allen Anderson Bourbon Linn Neosho Woodson	70,800
Wyandot MHC	Kansas City Bonner Springs	Wyandotte	174,100
			933,600

All of the above centers provide the five basic services required for licensure. These include outpatient therapy, twenty-four hour emergency service, screening for state hospital admissions, services provided after discharge from state hospitals, and consultation/education. Some of the larger mental health centers are able to provide a broader array of more specialized services to their population.

Census capacity: As indicated previously, this short-term plan calls for the permanent closing of a 20 to 30 bed unit OSH. When those beds are closed by June 30, 1991, the permanent staff assigned to the closed ward would be distributed to other areas of the hospital. This distribution would allow staffing at a level sufficient to maintain accreditation/certification. In order to sustain this level of care however, it is absolutely imperative that the hospital census not exceed the number of beds reached when the unit is closed. This maximum census capacity is reasonably easy to maintain with respect to voluntary admissions, since by policy, voluntary admissions can be restricted. For involuntary admissions however, statutory modifications relative to the commitment law would be necessary.

GATEKEEPING

INTRODUCTION

The Governor's Task Force on Mental Health Reform recommended that community mental health centers (CMHC's) be designated as the "gatekeepers" to the public mental health system. Gatekeeping activities include screening, evaluation, crisis/emergency services and liaison/coordination functions. The purpose of these activities is to insure that individuals with mental illness receive the most appropriate services in the least restrictive environment. When possible, individuals are diverted from the most restrictive service levels, such as state hospitalization, or are discharged from these service levels expeditiously. However, diversion and early discharge are only possible if appropriate community support services are available.

SCREENING AS HB 2586 MANDATES

HB 2586 would mandate the screening portion of gatekeeping activities through language that states "that no person shall be admitted to a state psychiatric hospital without a written statement authorizing such admission from a qualified mental health professional (who is employed by a participating mental health center). In this context, screening is the process of assessing the mental health service needs to determine whether an individual can be fully evaluated and/or treated in the community or whether they should be presented to the state psychiatric hospital for further evaluation and/or treatment. Since this type of screening is most often done on an emergency/crisis basis, funding is needed for both screening and evaluation capacity and for crisis/emergency services. The existing screening and 24-hour emergency service capacity of the CMHC's is inadequate to provide these services for all state psychiatric hospital admissions. Currently about one third of all state hospital admissions are listed by hospitals as having been screened by a CMHC.

FISCAL NOTE

Mental Health and Retardation Services has recommended the appropriation of $2.5 million to implement screening/evaluation and 24-hour crisis/emergency services on a statewide basis. This amount would approximately double the amount of funds CMHC's are presently spending on screening and emergency services. Although hospital data shows only one third of admissions currently being screened by CMHC's, this figure underestimates the actual number of screenings since it only shows cases where the CMHC was the last point of contact prior to admission. In court committed admissions, the court would be shown as the referral source to the hospital; however, the CMHC may have, in fact, been involved in the admission decision and would have done a "screening". Therefore, in the absence of reliable data, it is reasonable to assume that at least half of the current admissions are being screened by CMHC's.

The $2.5 million recommended by MH&RS would allow CMHC's statewide to add additional staff to provide the availability of face-to-face emergency contact on a 24-hour basis. Some CMHC's may provide the service by contracting with other CMHC's or with other emergency personnel in their catchment area to form an "extended team" of screeners who could assure service availability throughout the catchment area. The program expectation for this service would be that 100% of all state psychiatric hospital admissions would be screened by a CMHC.

PHASED PROGRAM

As recommended in the contingency plan, the full screening/ emergency service could be phased in by funding one third of the statewide service for one state hospital catchment area at a time. Therefore, if the Osawatomie State Hospital area were chosen to begin this service, $417,000 would be allocated to the 12 CMHC's in the OSH catchment area for the first six months of the service. The $417,000 is half of the one third portion of $2.5 million. This would fund six months for one state hospital catchment area. The funds would be distributed to the CMHC's based on a formula to be determined by MH&RS and the CMHC's involved. The following sample distribution formula ~~that~~ would include their catchment area population and the number of state hospital admissions from their area currently.

SAMPLE SCREENING FUNDS DISTRIBUTION METHOD

The 12 CMHC's in the OSH area, their catchment area population and FY 89 admissions are as follows:

CMHC	Population	FY 89 Admissions
Northeast Kansas	94,500	82
Wyandot	174,100	182
Johnson County	318,300	150
Franklin County	21,900	16
Miami County	22,600	43
Southeast Kansas	70,800	61
South Central	48,000	28
Crawford County	37,600	28
Family Life Center	22,200	13
Labette Center	25,400	22
Four County	61,200	36
Cowley County	37,000	10
TOTAL	933,600	671

The chart below illustrates the amount of screening/emergency service funds that would be allocated to each CMHC for FY 91 and FY 92 using a distribution formula that gives a weight of 30 to catchment area population and a weight of 70 to FY 89 hospital admissions to OSH (excluding alcohol and drug admissions).

CMHC	FY 91 Allocation	FY 92 Allocation
Northeast Kansas	$ 47,538	$ 95,076
Wyandot	$102,582	$205,164
Johnson County	$106,752	$213,504
Franklin County	$ 11,259	$ 22,518
Miami County	$ 20,016	$ 40,032
Southeast Kansas	$ 36,279	$ 72,558
South Central	$ 17,931	$ 35,862
Crawford County	$ 16,680	$ 33,360
Family Life Center	$ 8,340	$ 16,680
Labette Center	$ 12,510	$ 25,020
Four County	$ 26,271	$ 52,542
Cowley County	$ 10,842	$ 21,684
TOTAL	$417,000	$834,000

SUMMARY

GATEKEEPING AND SCREENING

- Includes: screening, evaluation and 24-hour emergency/crisis services

- Purpose: to insure that individuals with mental illness receive the most appropriate services in the least restrictive environment

- HB 2586: mandate screening - "no person shall be admitted to a state psychiatric hospital without a written statement authorizing such admission from a qualified mental health professional (employed by a participating mental health center)

- Phased implementation: statewide cost estimated at $2.5 million. First phase - January, 1991 half of one third of the total would be allocated to the 12 CMHC's in the OSH catchment area for the first six months of the program. July, 1991 - one third of the statewide total ($834,000) would be allocated to CMHC's in OSH area for first full year of the program and each fiscal year thereafter. Phase two would start a full year's funding in the TSH area in July, 1992 and phase three would start funding in the LSH area.

- Total cost:

FY 91 -	$ 417,000
FY 92 -	$ 834,000
FY 93 -	$1,668,000
FY 94 -	$2,502,000
FY 95 -	$2,502,000

COMMUNITY SUPPORT SERVICES-ADULTS (INCLUDING HOUSING)

INTRODUCTION

The closing of one adult 20 to 30 bed unit at OSH would necessitate a substantial enhancement of present community support programs and services. To conceptualize the range of services necessary to accomplish this goal it is more useful, however, to address the reduction of state hospital bed days rather than individual beds. Addressing the reduction of state hospital bed days better illustrates the range of flexible services needed to decrease the demand for state hospital treatment. The elimination of one 30 bed unit would translate into a diversion of 10,950 bed days (30 beds x 365 days) of state hospital treatment to the community mental health system. The fundamental principle of community programming is to design services based on individual needs.

SAMPLE HOSPITAL CENSUS REDUCTION STRATEGIES

The actual programming will be done by CMHC's in consultation with MH&RS and will be based on the CMHC's individual needs assessment. The following is presented to illustrate some examples of the strategies that could be used to reduce state hospital beds. Other innovative program options will also be considered. MH&RS will offer technical assistance to any CMHC for help with needs assessment and program design. The elimination of the demand for state hospital bed days can be accomplished in at least three ways: 1) direct diversion, 2) early discharge, and 3) ongoing support.

1) **Direct Diversion:**

Direct diversion of imminent state psychiatric hospital admission requires an array of options which can be called upon in an attempt to intervene in a crisis and avoid hospitalization. If participating community mental health centers were designated as the single point of entry into the state hospitals, they would be the most logical agency to identify clients who could be diverted (through the gatekeeping/screening process) and coordinate the provision of crisis stabilization services. One of the most innovative and effective mechanisms for crisis stabilization involves mobile crisis stabilization teams to provide extended services on an outreach basis. Information from the field suggests that mobile crisis stabilization outreach services can be particularly effective in responding to crisis and in minimizing the need for hospitalization. Mobile crisis stabilization teams would go to the client and provide services in the setting in which the crisis is occurring - private homes, boarding homes, ICFs/MH, work settings, hospital emergency rooms, police stations, jails, human service agencies, and virtually anywhere else in the community where it is deemed safe and appropriate to meet the client. While this involves moving outside the usual space and time limitations of traditional mental health practice, effective

stabilization programming means that community mental health professionals must be capable, 24 hours a day, of going to the scene of an emergency.

The mobile crisis stabilization outreach team may stay with the client and significant others for as long as is necessary to intervene successfully in the crisis, initiating necessary treatment, resolving problems, providing high levels of support and making arrangements for ongoing services. A 30 to 60 day period for the crisis stabilization staff to work with an individual client should be sufficient to allow continuity from crisis intervention to resolution.

Although the mobile crisis stabilization team's primary objective would be to resolve the crisis in the natural environment, in some cases temporary separation is necessary for a client in crisis. Accordingly, innovative and flexible services which provide this option must be developed and enhanced. These options may include moving the client to a foster home, a crisis apartment, a crisis bed in a group setting (or ICF/MH) or a local hospital unit. The protective, supportive and supervised residential setting is used to assist the client to re-stabilize, to resolve problems and to access ongoing services.

2) **Early Discharge:**
The second strategy for eliminating the demand for state hospital bed days is to decrease the length of stay for patients by early discharge from the hospital. The most common barrier to early discharge cited by mental health professionals in Kansas is the lack of appropriate housing and support in the community. Local community support systems will need to increase access to a wide range of rehabilitative and supportive housing options for clients not in crisis. The choices should be broad enough to allow each client an opportunity to live in an atmosphere offering the degree of support necessary while also providing incentives and encouragement for clients to assume increasing responsibility for their lives. It is now apparent that community mental health agencies must assume a major role in helping clients meet their housing needs. The highest priority should be placed on helping clients secure mainstream or typical housing and helping them select, secure and be successful in a whole range of living situations.

Maximum flexibility should be allowed participating mental health centers in using available funds for housing and residential services. Flexibility is necessary to maximize available housing/residential and support options in a local catchment area and to facilitate the development of options to fill locally identified gaps.

3) **Ongoing Support:**
Finally, demand for state hospital beds can be reduced by "preventing" state hospital admissions through ongoing community support services. This could also be conceptualized as pre-crisis intervention. Ongoing support is accomplished through a comprehensive and coordinated community based mental health system which targets the most vulnerable individuals with severe and persistent mental illness. In a recent survey of Kansas' state psychiatric hospitals, almost 75% of the current patients were identified as "heavy users". Heavy users being identified as individuals who have either been hospitalized six months or more, or have had two or more admissions to the state hospital within the last three years. An organized network of caring and responsible people committed to assisting these vulnerable individuals meet their needs and develop their individual coping skills while they are in the community will help prevent future readmission by proactively resolving problems before they become full blown crises. This network is called a community support system. Besides the functions already discussed (24 hour crisis assistance and rehabilitative/supportive housing) a comprehensive community support system should also provide assistance in meeting basic human needs, psychosocial and vocational services, consultation and education, mental health care, protection of client rights and ongoing case management.

Selected elements and functions of a comprehensive community support system are present in all community mental health center catchment areas in Kansas. However, no area has the full array of services and/or capacity in their existing services necessary to meet the increased demands resulting from the closing of one adult 20 to 30 bed unit. Since local communities are in various stages of community support development each has their own unique barriers and gaps in the system. Therefore, funding to enhance local community support systems must be flexible and based on identified need.

FISCAL NOTE
The first phase of MH&RS' Long Range Financing Plan calls for the closing of one adult 20 to 30 bed unit at Osawatomie State Hospital. As indicated earlier this would necessitate the transfer of a maximum of 10,950 bed days of state hospital treatment to the community. It is proposed to accomplish this transfer through direct diversion, early discharge and prevention. The resulting fiscal note for the State of Kansas is analyzed below. Again, this fiscal note is based on the sample programs described ~~data available at this time~~ and is an estimate only.

I. Direct Diversion

A. Mobile Crisis Stabilization Teams - Fifteen F.T.E. positions will need to be funded by state general funds to staff approximately 5 - 7 crisis stabilization teams. These teams will be staffed by social workers,

psychiatric nurses, psychologists, and/or other professionals/paraprofessionals depending on local human resources and identified need. The average annual salary for these positions is estimated to be $30,000 for a total cost of $450,000/year ($30,000 x 15 F.T.E.s) and $225,000 for the initial six-month period.

B. $82,500 for the initial six-month period ($165,000/year) of flexible funding will need to be available to the crisis stabilization teams to purchase, develop or otherwise secure crisis residential beds in the community when temporary separation from the clients' natural environment is necessary. Options should include foster homes, crisis apartments, crisis beds in group settings and access to local hospital psychiatric units.

Direct diversion activities for the initial six-month period would cost $307,500 ($615,000/year) and would provide the capacity to divert approximately 35 (70/year) imminent admissions to Osawatomie State Hospital. On average, these individuals diverted from hospitalization would decrease demand on state psychiatric hospitalization by 4,258 (8,516/year) bed days.

II. Early Discharge

A. For the initial six-month period approximately $50,000 ($100,000/year) will be needed to provide the capacity to successfully discharge 7-8 (15/year) currently hospitalized patients into the community earlier than projected discharge. Funding at this level would provide the capacity to access the appropriate and desired mainstream housing for patients from the existing community housing stock and to provide the services and supports required to enable them to remain in the living situation they have chosen. Approximately, $17,500 ($35,000/year) should be available for rent subsidies, deposits and start-up costs for securing the housing and $32,500 ($65,000/year) should be available for providing the necessary support. Support would be primarily provided by case managers. Since these case managers will be working with the most demanding and immediate support needs, case manager to client ratios will have to be low. The recommended ratio for this proposed early discharge initiative is one F.T.E. case manager to every five clients for a total of 3 F.T.E. case managers during the adjustment period when they would need the most intensive service.

B. Rehabilitative Housing - Even with the capacity for appropriate community support to assist clients in living in mainstream housing, it is still anticipated that a successful early discharge strategy should provide the capacity for a more structured residential option.

Therefore, approximately $45,000 ($90,000/year) should be available to the community support program to accessmore structured rehabilitative housing options. These options include, but are not limited to, group homes, 5/40 bed resident care facilities and ICFs/MH. At an average cost of $50 per day this option would provide the capacity for the early discharge of five patients annually from the state hospital.

Through the enhanced supported and rehabilitative housing initiatives, the early discharge initiative has the capacity to serve an average of 10 (20/year) patients. The early discharge initiative should target the "heavy users" of state psychiatric hospital treatment to obtain the greatest impact on the demand for state hospital beds. The anticipated reduction in demand is 600 (1,200/year) bed days at Osawatomie State Hospital.

III. Ongoing Support - The impact of preventive admissions or "pre-crisis" intervention on state psychiatric hospitalization is probably the most difficult strategy to quantify. However, its importance in accomplishing the goal of eliminating a 20 to 30-bed unit at Osawatomie State Hospital cannot be overemphasized. Indeed, direct diversion and early discharge activities are necessarily time limited. Ongoing services for clients who have resolved the immediate crisis or made a successful transition to the community is necessary to maintain the individual in the community and allow him/her the opportunity to learn, grow and change with dignity.

A. Case management - an additional 10 case managers will be required to provide this core service for the Osawatomie catchment area. With an average annual salary of $21,000 per case manager, the fiscal note for this function is $105,000 for the initial six-month period and $210,000 annually.

B. Psychosocial Rehabilitation Services - An estimated $92,500 ($185,000/year) should be available for the development or enhancement of community psychosocial rehabilitation services. Psychosocial rehabilitation services is defined broadly and includes but is not limited to vocational/supportive employment services, drop-in centers, supported housing, consumer-run services, recreation services, compeer, self-help services, etc. Distribution of these funds should be flexible and based on locally identified needs and gaps in service.

Ongoing community support is estimated to have at least the impact of early discharge activities in reducing the demand for state hospital bed days. Therefore, it is conservatively estimated that 618 (1,235/year) state hospital bed days will be saved with the enhancement of the existing community support system.

IV. Total Fiscal Note

The total fiscal note for closing one 20 to 30 bed adult unit from State General Fund dollars is $600,000 for the initial six-month period and $1,200,000 annually thereafter.

SUMMARY - CSS

- Includes: Mobile crisis stabilization teams, rehabilitative and supported housing, case management, and psychosocial rehabilitation services.

- Purpose: To reduce the demand for state psychiatric hospital treatment by providing a comprehensive, coordinated, and flexible community support system which addresses the needs and desires of individuals with severe and persistent mental illness.

- H.B. 2586: "The secretary shall assist and coordinate the development by each mental health center of a community assessment of needs and a plan for the community system to provide community based mental health services for persons who reside in the service delivery area of the mental health center, including all targeted population members." "Targeted population means the population group designated by rules and regulations of the secretary as most in need of mental health services which are funded, in whole or in part, by state or other public funding sources, which group shall include, but not be limited to, adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care."

- **FISCAL NOTE:** $600,000 for the initial six month period. Funds would be allocated to local community mental health center catchment areas based on ~~(using~~ a distribution formula that would be developed by MH&RS and CMHC's. ~~gives a~~ The sample distribution formula below gives a weight of 30 to population and 70 to FY 89 state hospital bed days used) as follows:

CMHC	FY 91 Allocation
Northeast Kansas	$ 54,720
Wyandot	$162,420
Johnson County	$135,720
Franklin County	$ 14,400
Miami County	$ 36,660
Southeast Kansas	$ 46,020
South Central	$ 21,780
Crawford County	$ 29,040
Family Life Center	$ 11,040
Labette Center	$ 19,980
Four County	$ 45,060
Cowley County	$ 23,160
TOTAL	$600,000

LONG-TERM PHASED IMPLEMENTATION

The short-term alternative described so far (closing a 20 to 30 bed unit at OSH) is merely the beginning and part of system reform described in our long-term financing plan. As a beginning, it directs us toward a long-term solution of the difficulties in our current system.

Mental health reform must include both structural reform and financing reform.

Structural Reform: a single point of entry into the system. Currently, there are multiple points of entry. We propose that CMHCs become that single point of entry through the screening mechanism mentioned earlier.

Implementation of the screening mechanism means that all admissions to State Hospitals are screened by the CMHC. In effect, the CMHC becomes the "gatekeeper". Through screening, individuals are diverted to less restrictive settings when possible. Individuals receive services when and where they are needed.

Structural reform insures that an individual is not "lost" in the system. There is accountability. At the same time, community programs are strengthened, and a mechanism for controlling State hospital growth is developed.

Financing reform: the ability to achieve a more equitable distribution of funds between State hospitals and community programs. Reversing the current dilemma of spending more and more funds (in State Hospitals) while serving fewer and fewer individuals. Implementing the concept of dollars following the clients. Redistribution of scarce resources.

Financing reform includes: incentive financing and risk protection.

Incentive financing: a means of enhancing the development of community-based programs by shifting (reallocating) State hospital funds to communities according to contracts with each CMHC. Based on previous utilization of hospital bed days, each CMHC would determine how much they could reduce utilization of the hospital with the availability of strengthened/expanded community programs.

Risk protection: the ability to protect service providers against unforeseen circumstances particularly in a health care profession where in the delivery of mental health services, all eventualities cannot be predicted consistently. In this plan, CMHCs would be allocated a pre-determined number of bed days based on historical utilization. The CMHCs would be protected against unforeseen variables that might result in exceeding their "reserved" bed allocation by borrowing or purchasing reserved bed days from other centers without incurring undue financial risk.

PHASED PROGRAM - COST CONTAINMENT
OSAWATOMIE STATE HOSPITAL (OSH)

If the escalating costs of maintaining satisfactory State hospital programs are to be contained in a reasonable manner, the size of these facilities must be reduced, the resources realized through savings by downsizing reallocated, and as a result, community programs enhanced. No longer can State hospitals be used because there is "nothing else". The hospitals must be used because the clinical condition of any given client so warrants. ~~Long-term projected costs for total cost of mental health reform~~.

See attachment #1 for long-term projected costs for total cost of mental health reform.

MH&RS recommends a phased approach to mental health reform and cost containment. Specifically, this phased approach is as follows:

OSH closes one adult unit of 20 to 30 beds by June 30, 1991 - financing previously discussed.

OSH closes one adolescent unit of 20 to 30 beds by June 30, 1992. Financing: $834,000 appropriation to maintain screening services for one year (the previous appropriation of $417,000 was for six months)

$1,200,000 appropriation to maintain 90 adults in the community for one year-average length of stay in hospital is approximately 120 days; thus, each bed (30) "turns over" 3 times: 30 x 3 =90. $1,200,000 is double the $600,000 appropriation for 6 months in the preceding year. Another way of approaching hospital census reduction would be planning community programs according to bed utilization.

$1,200,000 to develop community services needed to sustain the adolescents in the community.

* Note - there are no anticipated savings in the first year because when the first adult unit is closed, existing permanent staff will be redistributed to other parts of the hospital to maintain certification.

OSH closes second adult unit of 20 to 30 beds by June 30, 1993. Financing: $834,000 to maintain screening

$1,200,000 to maintain the 90 individuals from closing of first 20 to 30 beds.

$1,200,000 to maintain the approximately 20 to 30 adolescents in the community from closure of 20 to 30 adolescent beds (average length of stay for adolescents is approximately one year, therefore beds do not "turn over").

LESS - $681,955 projected savings (approximately) from closing of adolescent unit.

Financing needs for FY 94 - OSH catchment area
$834,000 to maintain screening.

$1,200,000 to maintain original 90 adults in the community.

$1,200,000 to maintain 20 to 30 adolescents in the community.

$1,200,000 to maintain second group of 90 adults in the community.

LESS - $681,955 projected savings from closure of second unit.

LESS - $631,755 projected savings from closure of third unit.

PHASED PROGRAM - COST CONTAINMENT
TOPEKA STATE HOSPITAL (TSH)

TSH closes one, 20 to 30 bed unit (children/adolescents) by June 30, 1993. Financing: (FY 93) - $834,000 for screening for one year (1/3 of original $2.5 million for statewide screening -TSH catchment area comprises approximately 1/3 of State).

$1,200,000 to develop community services for adolescents in anticipation of closing adolescent unit (20 to 30 beds).

TSH closes one adult 20 to 30 bed unit by June 30, 1994.
Financing: $834,000 to maintain screening for one year.

$1,200,000 to maintain 20 to 30 adolescents in the community.

$1,200,000 for community support funds in anticipation of closing one, 20 to 30 bed unit for adults.

LESS - $900,000 projected savings from closure of 20 to 30 bed adolescent unit (approximate).

TSH closes one, 20 to 30 bed adult unit by June 30, 1995.
Financing: $834,000 to maintain screening for 1 year.

$1,200,000 to maintain original 20 to 30 adolescents in community.

$1,200,000 to maintain the first 90 adults in the community.

$1,200,000 for community support funds in anticipation of closing one adult unit.

LESS - $961,885 projected savings for closure of adolescent unit-actual savings may be less because of federal financial participation for children.

LESS - $878,753 projected savings for closure of first adult unit.

Financing Needs - FY 96

$834,000 to maintain screening for one year.

$1,200,000 to maintain original 20 to 30 adolescents in community.

$1,200,000 to maintain original 90 adults in community.

$1,200,000 to maintain second group of 90 adults in the community.

LESS - $961,885 projected savings for closure of adolescent unit.

LESS - $878,753 projected savings for closure of first adult unit.

LESS - $896,290 projected savings for closure of second adult unit.

PHASED PROGRAM - COST CONTAINMENT
LARNED STATE HOSPITAL (LSH)

LSH closes one, 20 to 30 bed unit for adults by June 30, 1994. Financing: $834,000 for screening for one year. (1/3 of original $2,500,000 for statewide screening).

$1,200,000 for community support funds in anticipation of closing first 20 to 30 bed adult unit.

LSH closes second 20 to 30 bed unit for adults by June 30, 1995. Financing: $834,000 to maintain screening for one year.

$1,200,000 to maintain original 90 adults in community.

$1,200,000 for community support funds in anticipation of closure of second unit for adults.

LESS - $999,963 projected savings (approximately) for closure of first 20 to 30 bed unit for adults.

LSH closes third 20 to 30 bed unit for adults by June 30, 1996. Financing: $834,000 to maintain screening for one year.

$1,200,000 to maintain first group of 90 adults in the community.

$1,200,000 to maintain second group of 90 adults in the community.

$1,200,000 for community support funds in anticipation of closure of third 20 to 30 bed unit for adults.

LESS - $999,963 projected savings for closure of first unit.

LESS - $999,963 projected savings for closure of second unit.

Financing needs FY 97 - $834,000 to maintain screening for one year.

$1,200,000 to maintain first group of 90 adults in the community.

$1,200,000 to maintain second group of 90 adults in the community.

$1,200,000 to maintain third group of adults in the community.

LESS - $999,963 projected savings from closure of first unit.

LESS - $694,463 projected savings of closure of second unit.

LESS - $804,112 projected savings from closure of third unit.

TOTAL ESTIMATED COST FOR PHASED PROGRAM

FY 91 OSH - $1,317,000	Total - $1,317,000
FY 92 OSH - $3,234,000	Total - $3,234,000
Fy 93 OSH - $2,552,045 TSH - $2,034,000	Total - $4,586,045
FY 94 OSH - $3,120,290 TSH - $2,593,362 LSH - $2,234,037	Total - $7,426,045
FY 95 OSH - $3,120,290 TSH - $2,593,362 LSH - $2,234,037	Total - $7,1947,689
FY 96 OSH - $3,120,290 TSH - $1,697,072 LSH - $2,739,574	Total - $7,556,936
FY 97 OSH - $3,120,072 TSH - $1,697,072 LSH - $1,935,462	Total - $6,752,824

COST COMPARISON

~~**Please see Attachment #2, Compare Future Costs of MH Hospitals With Census Reduction Plan.**~~

~~Attachments #2, #2A, and #2B dramatically illustrate the escalating costs of maintaining the current State psychiatric hospital system. It shows eventual cost savings created by the financing plan presented in this document. The plan achieves not only fiscal efficiency, but it also accomplishes an effective community-based mental health system.~~

~~The figures in Attachment #2 are based on historical inflation rates beginning in FY 1970. Specifically, it is estimated that the cost of maintaining the status quo for the three large State psychiatric hospitals will be **$111,551,358** in FY 1997. The cost of maintaining the same hospitals with a budget cap that includes a modest inflationary increase and State funded community programs to sustain the census reduction is estimated to be **$103,534,938** in FY 1997. A budget cap means no expansion of State psychiatric hospital programs and only a modest inflationary budget increase.~~

In revision I of the financing plan by MHRS, data was presented on Attachments #2, #2A, and #2B that illustrated the escalating costs on maintaining the current State psychiatric hospital system as compared to projected savings resulting from this financing plan. However, a recalculation of these projections suggests that a 5% inflation rate "cap" will not be realized for **all** three large hospitals until there is a census reduction in **all** three facilities and subsequent transfer of resources to community programs.

In other words, a cap can only be realized partially; in those hospitals where a census reduction occurs. The budget will continue to grow at the historical rate until the specified census reduction is achieved.

These revised cost projections are reflected in **NEW** Attachment #2, #2A and #2B. For example, on new Attachment #2, the grand total for all hospitals in FY 97, **if no new community programs are added**, will be (estimated) $111,094,142. With a reduction in census of approximately 270 beds and a corresponding expansion of community programs, the total cost (hospital plus community) is estimated to be $112,147,451.

Despite the revised projections, there are considerable benefits to be derived from this plan.

1. **Increased numbers of individuals residing in community settings.** We estimate that approximately 690 individuals, previously served in an institutional setting, would be served in community settings. This figure includes approximately 630 adults and 60 children. The specific number was calculated by taking the total number of beds reduced for adults (210) and multiplying by 3 (each adult bed "turns over" approximately 3 times per year) which

yields a total of 630 adults. The 630 adults are then combined with the 60 children/adolescent bed reduction (these beds "turn over" approximately once per year).

2. **Better quality of life.** The 690 individuals would live in more normal situations, and hence, their quality of life would be improved, assuming adequate community-based services. Furthermore, they would be contributing to their community by purchasing goods and services, maintaining jobs when appropriate, and achieving greater degrees of independence.

3. **Cost containment.** The incremental development of community-based services becomes possible at a modest cost with the reduction of hospital beds and implementation of an inflationary cap on hospital costs. This benefit is achieved while serving some of the heaviest users of the public mental health system.

4. **P. L. 99-660.** This plan is consistent with the provisions of P. L. 99-660 in terms of the development of a community-based system.

Rationale for a phased approach to mental health reform in Kansas

... Consistent with recommendations by the Governor's Task Force on Mental Health Reform.

... Encourages consumer and family involvement in planning process.

... Allows for the gradual, incremental development of a community-based system.

... Allows for planning in an orderly fashion.

... Allows for fiscal integrity of State funding particularly in times of economic difficulties.

... Allows for careful monitoring, review, and evaluation of phased programs.

... Allows for compliance with P. L. 99-660 in terms of developing a community-based system.

LEGISLATIVE REVISIONS NEEDED

In order to implement this plan, several revisions in the current proposed legislation, HB 2586, will be necessary.

1. Page 1, line 30, remove ", but not be limited to,".

2. Page 2, line 17, New Sec. 2. Insert (g)
Mental health reform phase program means the implementation of mental health reform in Kansas will be a three phase program with the first phase beginning July 1, 1990 and will cover the counties in the Osawatomie State Hospital catchment area and the full implementation of this phase will be completed by June 30, 1994. The second phase will cover the Topeka State Hospital catchment area beginning July 1, 1992, and will end by June 30, 1996. The third phase will cover the Larned State Hospital catchment area beginning July 1, 1993, and will end by June 30, 1997.

3. New language - Section 9, (c), Subject to and in accordance with the provisions of this act and appropriations acts, the secretary shall assist in the establishment of a phased program of mental health reform. Beginning with the Osawatomie State Hospital catchment area, the secretary will enter into contracts with participating mental health centers to reduce the size of Osawatomie State Hospital by one 20 to 30 bed unit for adults by June 30, 1991. By June 30, 1992, an additional 20 to 30 beds will be closed for adolescents. By June 30, 1993, an additional 20 to 30 adult beds will be closed.

The secretary also will enter into contracts with participating mental health centers to reduce the size of Topeka State Hospital by 20 to 30 adolescent beds by June 30, 1993; an additional 20 to 30 adult beds by June 30, 1994; and an additional 20 to 30 adult beds by June 30, 1995.

Further, the secretary will enter into contracts with participating mental health centers to reduce the size of Larned State Hospital by 20 to 30 adult beds in each of the Fiscal years ending June 30, 1994, June 30, 1995, and June 30, 1996.

4. Page 27, Line 30, New Sec. 27. Insert the following; No patient shall be admitted to a state psychiatric hospital pursuant to any of the provisions of the treatment act for mentally ill persons, including court ordered admissions, if the secretary has notified the supreme court of the state of Kansas and all district courts which have jurisdiction over all or part of the area served by the state psychiatric hospital, that the required program of the state psychiatric hospital has reached capacity. Following notification that a state psychiatric hospital program has reached its capacity, any district court, which has jurisdiction over all or part of the area served by such state psychiatric hospital and by any participating mental health center serving all or part of the same area, may request that patients be placed on a waiting list maintained by the state psychiatric hospital. As each vacancy at the state psychiatric hospital occurs, the district court and participating mental health center shall be notified, in the order of their previous requests for placing a patient on the waiting list, that a patient may be admitted to the state psychiatric hospital. As soon as the state psychiatric hospital is able to being admitting patients on a regular basis to a program for which notice has been given under this section, the state psychiatric hospital shall inform the supreme court and affected district courts that the moratorium on admissions is no longer necessary. The provisions of this section shall apply to those state psychiatric hospitals included in the Mental Health Reform Phased Program.

5. Additional new language in the proposed legislation will be needed to give CMHCs more authority concerning discharges from State hospitals and limit the liability of hospital staff for those discharges.

6. Appropriation - The ability to initiate the implementation of these revisions in the proposed legislation is dependent upon an initial appropriation during FY 91 in the amount of $1,317,000. The rationale for this amount is explained earlier.

DRAFT

REVISION II

FINANCING
OF KANSAS MENTAL HEALTH SERVICES
FOR CHILDREN AND ADOLESCENTS

JANUARY 30, 1990

NOTE - This plan, namely the pilot project section, is designed for use when Topeka State Hospital is scheduled to close a 20 to 30 bed adolescent unit by June 30, 1993. It can be used as a model for the closing of the adolescent unit at Osawatomie State Hospital by June 30, 1992. Revisions and modifications will be needed.

INTRODUCTION

Kansas, like most other states, is struggling to develop a comprehensive community-based system of mental health services for children and adolescents. The lack of a comprehensive array of community-based services makes it necessary to continue the use of State hospitalization, often because there is "nothing else". Not only is state hospitalization costly, or for that matter, any out-of-home placement, from a financial perspective, it is costly from a social economic perspective also. For example, it costs approximately $65,000 per year for state hospitalization of a child or adolescent. Further, estimates indicate that 50% to 75% of all children who are placed out of their own homes in state psychiatric hospitals become patients in psychiatric institutions as adults or become involved as offenders in the adult correctional system.

Children and adolescents who have mental health needs often are involved in several systems other than mental health. That is, they are involved in the educational system, can be involved in the correctional system and may be involved in the child welfare system. Thus, planning for mental health services must take into account these other systems, and interagency coordination is essential. When this coordination does not occur, the potential for fragmentation and duplication is great.

SHORT-TERM FINANCING PLAN

MHRS, in line with recommendations by the Governor's Task Force on Mental Health Reform, has indicated that the development of a system of mental health services should occur in an incremental and an orderly fashion. The "C" level budget request by MHRS for FY 91 reflects this incremental notion in that it permits the gradual expansion of core services on a statewide basis.

. . . Case management - to serve 150 children/adolescents and their families

. . . Home-based family services - expand from the present present coverage of four catchment areas to statewide coverage

. . . Respite care - expand from one metropolitan to three three metropolitan areas serving a total of 100 children

. . . Therapeutic foster care - expand to serve an additional 50 children

. . . School-based mental health liaison - development of five additional cooperative CMHC/local education agency programs

. . . Therapeutic pre-school - continuation funding of current program in Garden City

. . . $1,501,500

LONG-TERM FINANCING PLAN

In testimony provided to the Interim Committee on Ways and Means/Appropriations on October 30, 1989, MHRS indicated that approximately $28,000,000 is estimated to be needed to develop a comprehensive community-based system of care for children and adolescents in Kansas. This estimate was based on an estimate of 5,600 children and adolescents in Kansas with severe emotional disabilities at a cost of $5,000 per year. The 5600 was derived from national prevalence studies. It should be noted that other, earlier estimates indicated that there were approximately 10,000 children and adolescents with serious emotional disabilities. The $5,000 per year per child figure was based on estimates in the State of Maine. In Ventura County, California annual figures per child were approximately $2,351. This figure is somewhat misleading since only a small number of the identified population were served. Families of children and adolescents with severe emotional disabilities have stated emphatically that the $5,000 figure is under-estimated significantly. It is felt that a figure of $12,000 to $15,000 annually per child is more appropriate.

Regardless of the figure used per child per year, $28,000,000 would be a major step in developing and implementing a comprehensive, community-based system. The development of accurate projections for children and adolescents is a national problem and is complicated by a number of factors including the fact that children with severe emotional disabilities often are involved in several systems at the same time. A system for collecting accurate data simply has not been developed. MHRS has developed a proposed structure for such a system through interagency collaboration in a pilot site which could be expanded on a statewide basis. A copy of that proposal is attached.

In its overall long-term financing plan for mental health services for all populations, MHRS has included a plan for the gradual reduction of State psychiatric hospital beds. The money saved by closing of the beds would be re-allocated to community programs. The closing of 60 children/adolescent beds is included in that plan. A copy of the initial draft of the plan is enclosed.

SHORT-TERM FINANCING OPTION

HB 2577, currently HB 2586, contains a section (New Sec.11) calling for a contract for a pilot project for Medicaid eligible residents under the age of 21. In essence, this section would require the State to apply for a Medicaid Waiver from the Health Care Financing Administration (HCFA).

Recently, in an effort to explore the feasibility of implementing this section of the proposed legislation, MHRS participated in a meeting with staff from the HCFA regional office in Kansas City. HCFA staff indicated that the data required to submit a waiver application is difficult and time consuming to obtain. Further, that data must prove that the community-based services provided under the waiver are cost-effective. Namely, those services must cost less and be more effective than institutional beds.

The type of data needed to prove cost effectiveness includes the closing of institutional beds and making a determination about the cost of the community services required to maintain the individuals in the community who previously occupied those beds. A simple description of the needed services is not sufficient; it is necessary to be able to identify the degree of service. Failure to accurately project this data could result in underestimating the cost, thereby resulting in an inability to prove cost effectiveness and jeopardizing continuation of the waiver. Unfortunately, at this time, Kansas does not have the structure in place that would enable this data to be generated. The proposal for interagency collaboration previously mentioned would provide that structure and allow that data to be obtained.

Given the situation described above, it does not seem appropriate to have a provision in the law that ties service development to a **successful** Medicaid Waiver application. Rather, MHRS recommends that a Medicaid Waiver application remain a viable option assuming that the data obtained in the interagency collaboration project would support a potentially successful application.

MHRS strongly recommends that Kansas move forward in initiating community-based services for this population while, at the same time it begins to collect necessary information in a comprehensive way. MHRS proposes to achieve these goals through the interagency proposal previously mentioned as well as a pilot project.

The pilot project would be a relatively small venture, designed to demonstrate, as families consistently state and as current technology indicates, that children and adolescents with severe emotional difficulties can reside in their own homes, their own communities, and their own schools with adequate services and with adequate support to their families. MHRS believes that we can no longer continue to place children out of their own home on a large scale basis. As indicated, the cost socially and financially is too great. The pilot is discussed and proposed below.

We suggest that 20 to 30 children/adolescents currently hospitalized at Topeka State Hospital (TSH) be selected for the project. The number, 30, coincides with the number needed to close one unit, which would be an option the State could exercise if appropriate when the project reached the appropriate phase.

These 20 to 30 children, hopefully all from Shawnee County, would be evaluated in terms of what services they, and their families, would need for them to reside in the community. This evaluation would be conducted by an interagency team that would include at least one child/family advocate knowledgeable about services to this population. Other members would be determined by MHRS and might include representatives of CMHC's, TSH staff, SRS Area Office, local school district, etc. Clearly, interagency collaboration/ cooperation would be essential, and evaluation team membership would be dependent upon agency willingness to volunteer.

As individuals are evaluated and community-based services ar developed, these children/adolescents would be returned to their own homes when and where possible, their communities and their schools, and needed services would be implemented. We recognize that a return to one's natural home may not be possible; we are however, maintaining that a child should be returned to a family setting. We are not recommending that hospital settings or highly structured group homes be created because of their high cost socially and economically. We would anticipate that the 20 to 30 discharges would all occur during FY 93. As of January 23, 1990, there are 24 children/adolescents from Shawnee County in TSH. Since the number is less than 30, the other six children would be selected based upon their appropriateness for placement in Shawnee County.

FISCAL NOTE:
This fiscal note is based on data available to us at this time and is an estimate only. It is expected that projections will change over time as more accurate information is collected.

Out patient care (therapy) - felt to be an essential service estimated to be needed by all 20 to 30 children given their "heavy" use of the system. This service currently is available and is reimbursable by Medicaid.

Case management - a core service, estimated to be needed by all 20 to 30 children. Given their current level of care, caseload size should not exceed 10. To serve 20 to 30 children and their families with a caseload size of 10, 3 case managers needed at $20 to 30,000 each which is consistent with recommendations made by the Governor's Task Force on Mental Health Reform = **$90,000.** Case management is reimbursable by Medicaid, currently available only on limited basis, needs expansion by above.

Home-based family services (therapy) - a core service estimated to be needed by all 20 to 30 children given current level of care and the likelihood of significant adjustments, over time, that will have to be made within the families. To serve 20 to 30 children/families with a maximum caseload size of 7 (consistent with current draft standards) = 4.2 therapists at an approximate cost of $35,000 - high, mid-range (including fringe benefits plus 1/2 of one salary to account for vacancies, sick and annual leave,etc.) = **$164,500.** This service is Medicaid reimbursable. Service available for up to ten hours per week.

Crisis intervention - mobile services, available 24 hours per day, 365 days per year with back up medical/physician services, including **short-term** hospitalization. One social worker at $20 to 30,000 mid-range (including fringe benefits); one psychiatric nurse at $20 to 30,000 mid-range (including fringe benefits); one part-time psychiatrist at $66,600 (including fringe benefits calculated at 1/2 rate); $20,000 discretionary funds to purchase temporary emergency (crisis) services (ex. hire

temporary home aide during normal sleeping hours to maintain stabilization after crisis team has intervened); 1/2 of one salary to account for illness, vacation, etc. at $15,000. Note: it is assumed that the 20 to 30 children will be Medicaid eligible because of their current hospitalization status; therefore hospitalization (short-term) is available. However, those children who return to their own home may not retain eligibility if parental income exceeds eligibility requirements. Total = **$161,000.**

Therapeutic foster care - service currently is available and is Medicaid reimbursable. This service would need to be expanded.

Vocational services - assessment and training; one counselor at **$25,000** including fringe benefits.

Respite care - a crucial family support service estimated to be needed by the families (natural and foster) of all 30 children. Estimated cost at $10 per hour, 8 hours per week for 52 weeks for 30 families = **$124,800.** Training of respite care providers at **$10,500** including refresher courses and materials.

After school programs - a part-time service estimated to require 4 part-time staff at $10,000 each = **$40,000.**

Summer programs - day camp, recreation, therapeutic activities: estimated at $1,000 per child = **$30,000.**

Day Treatment - At varying times, at varying levels; some children may not need service at all, others for a short-term; others may need the service intensively for extended period. **$130,000.**

General support services - There are a number of support services needed by this population that are informal and may be needed by only a few of the 20 to 30 children or their families at any given time. These type of services may include transportation, special recreation needs, educational materials, big brother, big sister activities, etc. While some of these services may have no or minimal cost, there is a need to coordinate those types of activities that currently is being done only on a part-time basis = **$24,000.**

TOTAL COST OF PILOT PROJECT = $799,800

It is noted that the average cost for all of the above services, per child is $26,660 per year. This amount is nearly double the rate of $15,000 mentioned earlier. However, these are estimates subject to change with the collection of better data. It should be emphasized that $26,660 is less than **one half** of the approximate cost of hospitalization. Thus, a pilot project of this type avoids a cost of **$38,340** (65,000 less 26,660) per child.

LONG-TERM PROJECTED COSTS

FISCAL YEAR	OSAWATOMIE STATE HOSPITAL DISTRICT		TOPEKA STATE HOSPITAL DISTRICT		LARNED STATE HOSPITAL DISTRICT		FY MENTAL HEALTH COSTS	
FY 91	OSH/CMHC'S SCREENING	417,000	TSH/CMHC'S SCREENING	0	LSH/CMHC'S SCREENING	0	FY 91	
	MAINTENANCE	600,000	MAINTENANCE	0	MAINTENANCE	0		
	CMHC TOTAL	1,017,000	CMHC TOTAL	0	CMHC TOTAL	0	CMHC TOTAL	1,017,000
	OSH/SH TEMP STAFF COST	300,000					SH TOTAL	300,000
	GRAND TOTAL	1,317,000					GRAND TOTAL	1,317,000
FY 92	OSH/CMHC'S SCREENING	834,000	TSH/CMHC'S SCREENING	0	LSH/CMHC'S SCREENING	0	FY92	
	MAINTENANCE	2,400,000	MAINTENANCE	0	MAINTENANCE	0		
	CMHC TOTAL	3,234,000	CMHC TOTAL	0	CMHC TOTAL	0	CMHC TOTAL	3,234,000
	OSH/SH 1ST YR SAVINGS *	0					SH SAVINGS	0
	GRAND TOTAL	3,234,000					GRAND TOTAL	3,234,000

* NO SAVINGS REALIZED THE FIRST YEAR DUE TO MAINTAINING STAFF TO MEET ACCREDITATION AND CERTIFICATION STANDARDS

2-6-90

FY 93	OSH/CMHC'S		TSH/CMHC'S		LSH/CMHC'S		FY93
	SCREENING	834,000	SCREENING	834,000	SCREENING	0	
	MAINTENANCE	2,400,000	MAINTENANCE	1,200,000	MAINTENANCE	0	
	CMHC TOTAL	3,234,000	CMHC TOTAL	2,034,000	CMHC TOTAL	0	CMHC TOTAL 5,268,000
	OSH/SH						SH SAVINGS 681,955
	2ND YR SAVINGS	681,955					GRAND TOTAL 4,586,045
	GRAND TOTAL	2,552,045					
FY 94	OSH/CMHC'S		TSH/CMHC'S		LSH/CMHC'S		FY 94
	SCREENING	834,000	SCREENING	834,000	SCREENING	834,000	
	MAINTENANCE	3,600,000	MAINTENANCE	2,400,000	MAINTENANCE	1,200,000	
	CMHC TOTAL	4,434,000	CMHC TOTAL	3,234,000	CMHC TOTAL	2,034,000	CMHC TOTAL 9,702,000
	OSH/SH		TSH/SH				SH SAVINGS 2,275,595
	3RD YR SAVINGS	1,313,710	1ST YR SAVINGS	961,885			GRAND TOTAL 7,426,405
	GRAND TOTAL	3,120,290	GRAND TOTAL	2,272,115			

2.44

FY 95		
OSH/CMHC'S SCREENING	834,000	
MAINTENANCE	3,600,000	
CMHC TOTAL	4,434,000	
OSH/SH 4TH YR SAVINGS	1,313,710	
GRAND TOTAL	3,120,290	

TSH/CMHC'S SCREENING	834,000	
MAINTENANCE	3,600,000	
CMHC TOTAL	4,434,000	
TSH/SH 2ND YR SAVINGS	1,840,638	
GRAND TOTAL	2,593,362	

LSH/CMHC'S SCREENING	834,000	
MAINTENANCE	2,400,000	
CMHC TOTAL	3,234,000	
LSH/SH 1ST YR SAVINGS	999,963	
GRAND TOTAL	2,234,037	

FY 95	
CMHC TOTAL	12,102,000
SH SAVINGS	4,154,311
GRAND TOTAL	7,947,689

FY 96		
OSH/CMHC'S SCREENING	834,000	
MAINTENANCE	3,600,000	
CMHC TOTAL	4,434,000	
OSH/SH 5TH YR SAVINGS	1,313,710	
GRAND TOTAL	3,120,290	

TSH/CMHC'S SCREENING	834,000	
MAINTENANCE	3,600,000	
CMHC TOTAL	4,434,000	
TSH/SH 3RD YR SAVINGS	2,736,928	
GRAND TOTAL	1,697,072	

LSH/CMHC'S SCREENING	834,000	
MAINTENANCE	3,600,000	
CMHC TOTAL	4,434,000	
LSH/SH 2ND YR SAVINGS	1,694,426	
GRAND TOTAL	2,739,574	

FY 96	
CMHC TOTAL	13,302,000
SH SAVINGS	5,745,064
GRAND TOTAL	7,556,936

FY 97		
OSH/CMHC'S		
SCREENING		834,000
MAINTENANCE		3,600,000
CMHC TOTAL		4,434,000
OSH/SH		
6TH YR SAVINGS		1,313,710
GRAND TOTAL		3,120,290

TSH/CMHC'S	
SCREENING	834,000
MAINTENANCE	3,600,000
CMHC TOTAL	4,434,000
TSH/SH	
4TH YR SAVINGS	2,736,928
GRAND TOTAL	1,697,072

LSH/CMHC'S	
SCREENING	834,000
MAINTENANCE	3,600,000
CMHC TOTAL	4,434,000
LSH/SH	
3RD YR SAVINGS	2,498,538
GRAND TOTAL	1,935,462

FY 97	
CMHC TOTAL	13,302,000
SH SAVINGS	6,549,176
GRAND TOTAL	6,752,824

2-96

COMPARE FUTURE COSTS OF MH HOSPITALS WITH ADC REDUCTION PLAN (ALL FUNDS)

Fiscal<---- OSAWATOMIE STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$19,778,978		$20,078,978		
'91	$20,991,113	$0	$20,991,113	$1,067,850	$22,058,963
'92	$22,277,533	$0	$22,040,669	$3,565,485	$25,606,154
'93	$23,642,789	$797,932	$22,344,770	$5,132,909	$27,477,679
'94	$25,091,714	$1,613,983	$22,685,854	$5,389,555	$28,075,409
'95	$26,629,435	$1,694,682	$23,820,147	$5,659,032	$29,479,179
'96	$28,261,393	$1,779,417	$25,011,154	$5,941,984	$30,953,138
'97	$29,993,365	$1,868,387	$26,261,712	$6,239,083	$32,500,795

Fiscal<------ TOPEKA STATE HOSPITAL -------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$21,353,230		$21,353,230		
'91	$22,536,147	$0	$22,536,147	$0	$22,536,147
'92	$23,784,595	$0	$23,784,595	$0	$23,784,595
'93	$25,102,203	$0	$24,973,824	$2,354,609	$27,328,434
'94	$26,492,804	$1,181,229	$25,041,287	$3,930,947	$28,972,234
'95	$27,960,441	$2,373,386	$25,160,255	$5,659,032	$30,819,287
'96	$29,509,382	$3,705,551	$25,204,773	$5,941,984	$31,146,757
'97	$31,144,130	$3,890,828	$26,465,012	$6,239,083	$32,704,095

Fiscal<------ LARNED STATE HOSPITAL ------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$29,074,333		$29,074,333		
'91	$31,398,251	$0	$31,398,251	$0	$31,398,251
'92	$33,907,920	$0	$33,907,920	$0	$33,907,920
'93	$36,618,187	$0	$36,618,187	$0	$36,618,187
'94	$39,545,087	$0	$38,449,097	$2,472,340	$40,921,436
'95	$42,705,934	$1,388,512	$38,983,039	$4,127,495	$43,110,534
'96	$46,119,429	$2,470,459	$39,919,670	$5,941,984	$45,861,654
'97	$49,805,765	$3,824,989	$40,684,646	$6,239,083	$46,923,729

Fiscal<------ GRAND TOTAL ALL HOSPITALS----->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$70,206,541	$0	$70,506,541	$0	$70,506,541
'91	$74,925,511	$0	$74,925,511	$1,067,850	$75,993,361
'92	$79,970,047	$0	$79,733,183	$3,565,485	$83,298,668
'93	$85,363,180	$797,932	$83,936,782	$7,487,519	$91,424,300
'94	$91,129,605	$2,795,212	$86,176,238	$11,792,842	$97,969,079
'95	$97,295,810	$5,456,581	$87,963,441	$15,445,559	$103,409,001
'96	$103,890,204	$7,955,426	$90,135,597	$17,825,952	$107,961,549
'97	$110,943,259	$9,584,205	$93,411,369	$18,717,250	$112,128,619

OSH Status Quo Inflation Rate: 6.1%
TSH Status Quo Inflation Rate: 5.5%
LSH Status Quo Inflation Rate: 8.0%

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COMPARE FUTURE COSTS OF MH HOSPITALS WITH ADC REDUCTION PLAN (SGF)

Fiscal<---- OSAWATOMIE STATE HOSPITAL ------>

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$13,845,285		$14,145,285		
'91	$14,704,316	$0	$14,704,316	$1,067,850	$15,772,166
'92	$15,616,647	$0	$15,439,532	$3,565,485	$19,005,017
'93	$16,585,582	$558,953	$15,652,556	$5,132,909	$20,785,465
'94	$17,614,636	$1,130,598	$15,891,486	$5,389,555	$21,281,041
'95	$18,707,537	$1,187,128	$16,686,060	$5,659,032	$22,345,093
'96	$19,868,247	$1,246,485	$17,520,363	$5,941,984	$23,462,347
'97	$21,100,974	$1,308,809	$18,396,381	$6,239,083	$24,635,465

Fiscal<------ TOPEKA STATE HOSPITAL -------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$14,947,261		$14,947,261		
'91	$15,775,303	$0	$15,775,303	$0	$15,775,303
'92	$16,649,216	$0	$16,649,216	$0	$16,649,216
'93	$17,571,542	$0	$17,481,677	$2,354,609	$19,836,286
'94	$18,544,963	$826,860	$17,528,901	$3,930,947	$21,459,848
'95	$19,572,309	$1,661,371	$17,612,179	$5,659,032	$23,271,211
'96	$20,656,567	$2,593,885	$17,643,341	$5,941,984	$23,585,325
'97	$21,800,891	$2,723,580	$18,525,508	$6,239,083	$24,764,591

Fiscal<------ LARNED STATE HOSPITAL ------->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$20,352,033		$20,352,033		
'91	$21,978,775	$0	$21,978,775	$0	$21,978,775
'92	$23,735,544	$0	$23,735,544	$0	$23,735,544
'93	$25,632,731	$0	$25,632,731	$0	$25,632,731
'94	$27,681,561	$0	$26,914,367	$2,472,340	$29,386,707
'95	$29,894,154	$971,958	$27,288,127	$4,127,495	$31,415,622
'96	$32,283,600	$1,729,321	$27,943,769	$5,941,984	$33,885,753
'97	$34,864,035	$2,677,493	$28,479,252	$6,239,083	$34,718,335

Fiscal<------ GRAND TOTAL ALL HOSPITALS----->

Year	Status-Quo	SAVINGS	Reduce ADC	CMHC's	TOTAL
'90	$49,144,579	$0	$49,444,579	$0	$49,444,579
'91	$52,458,395	$0	$52,458,395	$1,067,850	$53,526,245
'92	$56,001,407	$0	$55,824,292	$3,565,485	$59,389,777
'93	$59,789,856	$558,953	$58,766,964	$7,487,519	$66,254,482
'94	$63,841,160	$1,957,458	$60,334,754	$11,792,842	$72,127,596
'95	$68,174,000	$3,820,457	$61,586,366	$15,445,559	$77,031,926
'96	$72,808,414	$5,569,691	$63,107,473	$17,825,952	$80,933,426
'97	$77,765,900	$6,709,881	$65,401,142	$18,717,250	$84,118,391

OSH Status Quo Inflation Rate: 6.2%
TSH Status Quo Inflation Rate: 5.5%
LSH Status Quo Inflation Rate: 8.0%

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STATE HOSPITAL CENSUS AND EXPENDITURE: PATTERNS AND PROJECTIONS

Fiscal	LSH		OSH		TSH		Total	
Year	census	expenditures	census	expenditures	census	expenditures	census	expenditures
'70	630	$5,783,626	507	$5,672,047	729	$6,882,175	1866	$18,337,848
'71	671	$6,446,955	393	$5,709,757	637	$7,198,780	1701	$19,355,492
'72	698	$6,708,606	432	$5,687,352	494	$7,090,097	1624	$19,486,055
'73	688	$7,070,845	454	$5,787,503	408	$7,058,278	1550	$19,916,626
'74	665	$7,567,296	405	$6,697,365	376	$7,403,078	1446	$21,667,739
'75	539	$8,086,352	369	$7,804,675	375	$7,840,692	1283	$23,731,719
'76	460	$9,497,426	355	$8,968,610	353	$8,668,195	1168	$27,134,231
'77	393	$9,966,125	349	$8,018,430	334	$9,403,480	1076	$27,388,035
'78	427	$10,945,805	363	$8,679,832	343	$10,507,258	1133	$30,132,895
'79	414	$12,490,173	359	$9,521,584	318	$11,199,319	1091	$33,211,076
'80	400	$13,405,998	350	$10,339,044	302	$12,058,547	1052	$35,803,589
'81	427	$14,942,263	369	$11,680,997	316	$13,638,681	1112	$40,261,941
'82	436	$16,143,290	382	$12,499,500	329	$14,651,620	1147	$43,294,410
'83	404	$16,037,693	354	$12,829,250	346	$14,037,176	1104	$42,904,119
'84	420	$17,531,074	356	$13,415,424	353	$15,124,264	1129	$46,070,762
'85	452	$20,237,087	338	$14,935,928	360	$16,493,526	1150	$51,666,541
'86	488	$21,046,748	336	$15,139,546	348	$16,615,701	1172	$52,801,995
'87	483	$21,938,321	368	$15,890,615	335	$17,059,127	1186	$54,888,063
'88	459	$23,199,360	340	$16,483,778	324	$17,831,452	1123	$57,514,590
'89	451	$26,432,207	339	$18,780,831	304	$20,626,561	1094	$65,839,599
'90		$29,074,333		$19,778,978		$21,353,230		$70,206,541
'91		$31,398,251		$20,991,113		$22,536,147		$74,925,511
'92		$33,907,920		$22,277,533		$23,784,595		$79,970,047
'93		$36,618,187		$23,642,789		$25,102,203		$85,363,180
'94		$39,545,087		$25,091,714		$26,492,804		$91,129,605
'95		$42,705,934		$26,629,435		$27,960,441		$97,295,810
'96		$46,119,429		$28,261,393		$29,509,382		$103,890,204
'97		$49,805,765		$29,993,365		$31,144,130		$110,943,259

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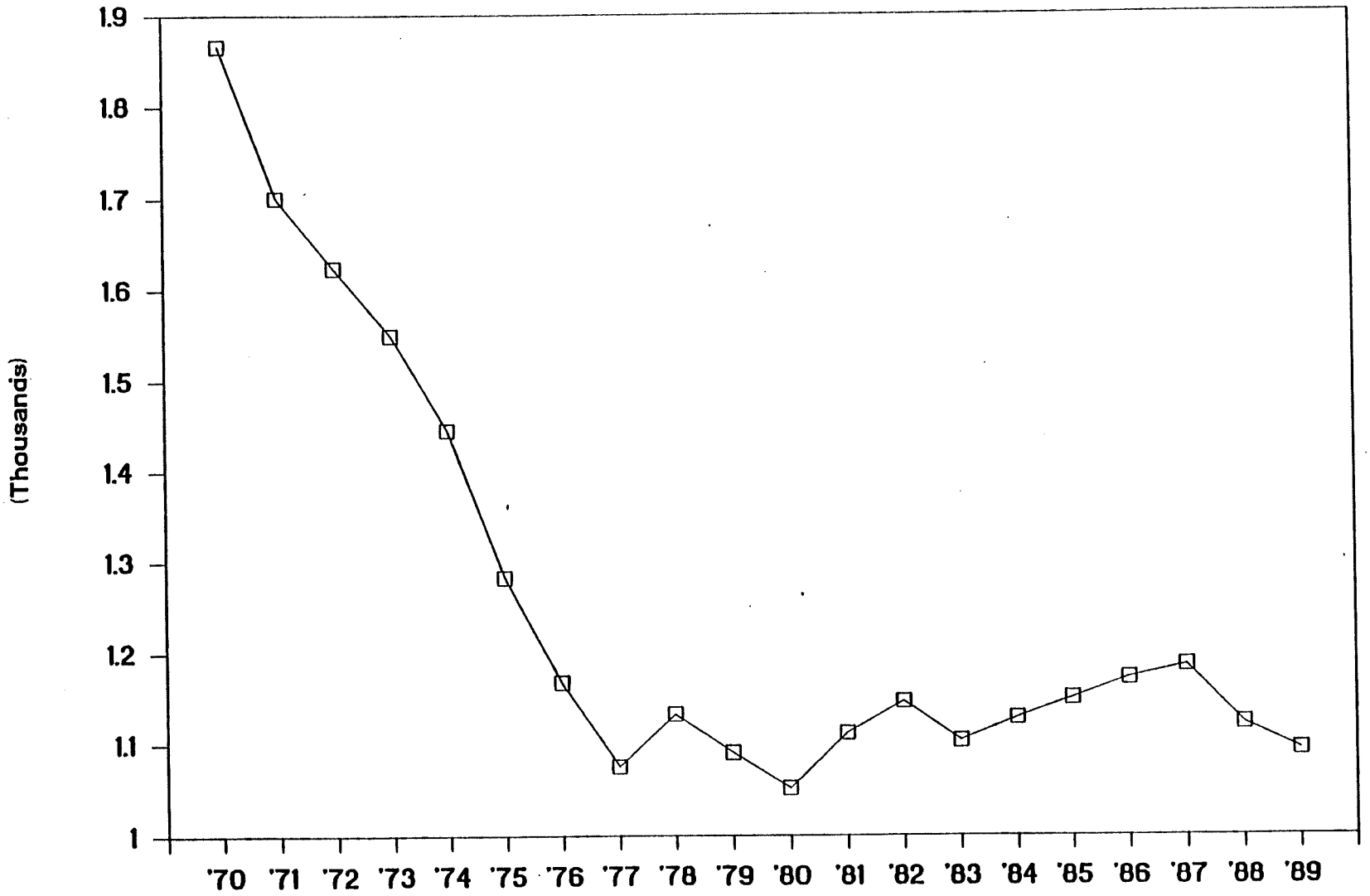
ALL MH HOSPITAL AVERAGE DAILY CENSUS
FY 1970 - FY 1989



MH Hospital Average Daily Census
From FY 1970 to FY 1989

	LSH	OSH	TSH	Total
'70	630	507	729	1866
'71	671	393	637	1701
'72	698	432	494	1624
'73	688	454	408	1550
'74	665	405	376	1446
'75	539	369	375	1283
'76	460	355	353	1168
'77	393	349	334	1076
'78	427	363	343	1133
'79	414	359	318	1091
'80	400	350	302	1052
'81	427	369	316	1112
'82	436	382	329	1147
'83	404	354	346	1104
'84	420	356	353	1129
'85	452	338	360	1150
'86	488	336	348	1172
'87	483	368	335	1186
'88	459	340	324	1123

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MENTAL HEALTH AND RETARDATION SERVICES

ASSOCIATION OF COMMUNITY MENTAL HEALTH CENTERS OF KANSAS

FINANCING MENTAL HEALTH REFORM SUB. FOR HB 2586

NEED			SRS	CENTERS
1.	$417,000. (In GBA)	Screening Gatekeeping	Yes	Yes
		$289,557. --Fed. Grant $727,443. --SGF $1,017,000.		
2.	$600,000. (In GBA)	Community Support Services	Yes	Yes
3.	$500,000. (New) (SGF)	Start-up funds	Limited	Yes
4.	$400,000. (Existing MediKan)	Community Mental Health Crisis Service Grants	Yes	Yes
5.	$265,202. (Existing) (Fed. Grant)	Maintain the Status Quo in Community Support Programs	Yes	Yes
6.	$207,586.	ICF/MH Programming Staff to Administer Program	Yes	Limited

NOTE: The Al Nemec memo to Senator Bogina lists $500,000. to be administrated through Medical Programs. The Centers also support this amount. However, this is money agreed to by both the House and the Senate to replace the loss of the MediKan Program. This funding only indirectly relates to Mental Health Reform.

SWAM
April 23, 1990
Attachment 3

SENATE COMMITTEE ON WAYS AND MEANS
APRIL 23, 1990
TESTIMONY ON HOUSE BILL 2586
JOHN C. PETERSON
KANSAS ASSOCIATION OF PROFESSIONAL PSYCHOLOGISTS

Mr. Chairman, Members of the Committee, House Bill 2586, called the Mental Health Reform Act, has substantial fiscal ramifications for the State. As now written it is to be implemented in stages, perhaps to determine how well the program is working, perhaps to determine whether the State can afford the full cost reflected by its fiscal note, or perhaps to determine what the real cost will be. In any event we would recommend that a Legislative Post Audit study be included as an annual part of this legislation during the next 3-4 years of its implementation. Quite frankly we have concerns about turning over a gatekeeping function to anyone who can be a direct provider to those same individuals. If we are going to head in that direction, at least we should have the benefit of a Post Audit analysis of how effectively this program is working. Perhaps we can learn whether the gatekeepers have kept patients out of state institutions and utilized already existing local community resources or whether they have used this gatekeeping function to feather their own fiscal nests.

Our second concern from a fiscal standpoint is that HB 2586 mandates that the State contract with a particular party to provide gatekeeping services. Yet that party is not required to provide those services. SRS is given no flexi-

SWAM
April 23, 1990
Attachment 4

bility in utilizing or negotiating with other providers. Attached to this testimony is an amendment to page 15, line 16, which would give SRS that flexibility. They wouldn't have to use it, they probably wouldn't, but the mere possibility could save the State a lot of money at the bargaining table.

Our third concern deals with the costs of duplicative services for certain individuals. Most persons who enter state hospitals do so through court committments, or as "walk in" voluntary patients. A local gatekeeper is certainly appropriate in those cases. Only a small fraction of state hospital patients are at the time of their admission being treated by psychiatrists or psychologists. However for that patient to have to be sent to and receive an additional evaluation from a mental health center both unnecessarily increases costs and causes unnecessary delay and duplication. The attached amendment to page 15, line 27, would allow a treating physician or psychologist to be considered a qualified mental health professional.

Thank you for this opportunity to testify.

As Amended by Senate Committee

[As Amended by House Committee of the Whole]

Session of 1990

Substitute for HOUSE BILL No. 2586

By Committee on Appropriations

3-7

AN ACT concerning community mental health services; providing for assessments of need and the adoption of plans to provide such services; prescribing certain powers, duties and functions in relation thereto; establishing the governor's mental health services planning council; amending K.S.A. 19-4002, 19-4002a, 19-4002b, 59-2905, 65-211 and 65-213 and K.S.A. 1989 Supp. 59-2901, 59-2902, 59-2907, 59-2908, 59-2909, 59-2912, 59-2914, 59-2914a, 59-2916, 59-2917, 59-2918, 59-2918a, 59-2924, 65-4434 and 65-5603 and repealing the existing sections; also repealing K.S.A. 75-3302d and 75-3302e.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. Sections 1 through ~~11~~ *12* and amendments thereto shall be known and may be cited as the mental health reform act.

New Sec. 2. As used in sections 1 through ~~11~~ *12* and amendments thereto:

(a) "Targeted population" means the population group designated by rules and regulations of the secretary as most in need of mental health services which are funded, in whole or in part, by state or other public funding sources, which group shall include adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care.

(b) "Community based mental health services" includes, but is not limited to, evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education, consultation, treatment and rehabilitation services, twenty-four-hour emergency services, and any facilities required therefor, which are provided within one or more local communities in order to provide a continuum of care and support services to enable mentally ill persons, including targeted population members, to function outside

3-7

Proposed amendments:

Kansas Psychological Association

and the

Kansas Association of Professional Psychologists

March 26, 1990

(q) "Treatment facility" means any mental health center or clinic, psychiatric unit of a medical care facility, psychologist, physician or other institution or individual authorized or licensed by law to provide either inpatient or outpatient treatment to any patient.

(r) "Voluntary patient" means a person who is receiving treatment at a treatment facility other than by order of any court.

(s) The terms defined in K.S.A. 59-3002 and amendments thereto shall have the meanings provided by that section.

(t) "Mental health center" means any community mental health center organized pursuant to the provisions of K.S.A. 19-4001 through 19-4015, and amendments thereto, or mental health clinic organized pursuant to the provisions of K.S.A. 65-211 through 65-215, and amendments thereto, and licensed in accordance with the provisions of K.S.A. 75-3307b and amendments thereto.

(u) "Participating mental health center" means a mental health center which has entered into a contract with the secretary of social and rehabilitation services to provide court ordered evaluation and treatment services pursuant to the treatment act for mentally ill persons.

or other treatment facility

(v) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility and Topeka state hospital.

(w) "Qualified mental health professional" means (1) a physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist, respectively, under a contract with a participating mental health center; or (2) a registered masters level psychologist or a licensed specialist ~~clinical~~ social worker or licensed master social worker or a registered nurse who has a specialty in psychiatric nursing who is employed by a participating mental health center and who is acting under the ~~supervision~~ direction of a physician.

or who is currently treating or evaluating the voluntary or proposed patient

or psychologist

(x) "Registered masters level psychologist" means a person registered as a registered masters level psychologist by the behavioral sciences regulatory board under K.S.A. 1989 Supp. 74-5361 through 74-5373 and amendments thereto.

(y) "Licensed specialist ~~clinical~~ social worker" means a person licensed in ~~the~~ ~~clinical~~ a social work practice specialty by the behavioral sciences regulatory board under K.S.A. 1989 Supp. 65-6301 through 65-6318 and amendments thereto.

(z) "Licensed master social worker" means a person licensed as a master social worker by the behavioral sciences regulatory board under K.S.A. 1989 Supp. 65-6301 through 65-6318 and amendments thereto.

As Amended by Senate Committee

[As Amended by House Committee of the Whole]

Session of 1990

Substitute for HOUSE BILL No. 2586

By Committee on Appropriations

3-7

AN ACT concerning community mental health services; providing for assessments of need and the adoption of plans to provide such services; prescribing certain powers, duties and functions in relation thereto; establishing the governor's mental health services planning council; amending K.S.A. 19-4002, 19-4002a, 19-4002b, 59-2905, 65-211 and 65-213 and K.S.A. 1989 Supp. 59-2901, 59-2902, 59-2907, 59-2908, 59-2909, 59-2912, 59-2914, 59-2914a, 59-2916, 59-2917, 59-2918, 59-2918a, 59-2924, 65-4434 and 65-5603 and repealing the existing sections; also repealing K.S.A. 75-3302d and 75-3302e.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. Sections 1 through ~~11~~ *12* and amendments thereto shall be known and may be cited as the mental health reform act.

New Sec. 2. As used in sections 1 through ~~11~~ *12* and amendments thereto:

(a) "Targeted population" means the population group designated by rules and regulations of the secretary as most in need of mental health services which are funded, in whole or in part, by state or other public funding sources, which group shall include adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care.

(b) "Community based mental health services" includes, but is not limited to, evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education, consultation, treatment and rehabilitation services, twenty-four-hour emergency services, and any facilities required therefor, which are provided within one or more local communities in order to provide a continuum of care and support services to enable mentally ill persons, including targeted population members, to function outside

SWAM
April 23, 1990
Attachment 5

budget submitted to the secretary by the mental health center;

(q) to establish state policies for the disbursement of federal funds within the state and for state administration of federal programs providing services or other assistance to persons who have mental illness consistent with relevant federal law, rules and regulations, policies and procedures;

(r) to adopt rules and regulations to ensure the protection of persons receiving mental health services, which shall include an appeal procedure at the state and local levels;

(s) to establish procedures and systems to evaluate the results and outcomes pursuant to section 10 and amendments thereto and as otherwise provided for under this act; and

(t) to adopt such rules and regulations as may be necessary to administer the provisions of sections 1 through [11] and amendments thereto *which are consistent with appropriations available for the administration of such provisions*. [12

New Sec. 4. (a) On or before October 1, 1991, and in accordance with rules and regulations adopted under section 3 and amendments thereto, the secretary shall develop and adopt a state assessment of needs and a plan to develop and operate a state system to provide mental health services for persons who are residents of Kansas, including all targeted population members designated by rules and regulations adopted by the secretary. The plan for the state system shall include coordinating and assisting in the provision of community based mental health services in the service delivery areas of mental health centers, including the services provided by state psychiatric hospitals and the provision of state financial assistance. On or before March 1, 1992, the secretary shall adopt a state plan for an integrated system to coordinate and assist in the provision of community based mental health services within Kansas. The assessment of needs and plan for the state shall be reviewed and updated by the secretary on an annual basis.

(b) The secretary shall assist and coordinate the development by each mental health center of a community assessment of needs and a plan for the community system to provide community based mental health services for persons who reside in the service delivery area of the mental health center, including all targeted population members. The secretary shall review and approve, or return, with recommendations for revision and resubmittal, all such assessments of needs and plans in accordance with criteria prescribed by rules and regulations adopted under section 3 and amendments thereto. If necessary services for a service delivery area cannot be provided by the mental health center or in order to ensure that a continuum of

services will be provided in a service delivery area, the secretary may require the provision of services for a service delivery area through ~~the combination of the operations of two or more mental health centers or through~~ contracts between two or more mental health centers.

(c) Each mental health center shall annually review and update such assessment of needs and plan for the service delivery area. If the assessment of needs or the plan for the community system to provide community based mental health services are not in compliance with the criteria prescribed by rules and regulations under section 3 and amendments thereto, the secretary shall withhold all or part of the state financial assistance provided to the mental health center.

(d) On or before October 1, 1991, [each mental health center shall submit [an annual] coordinated services plan addressing the service needs of the targeted population to the secretary of social and rehabilitation services for review and approval. The annual coordinated services plan shall be developed according to the standards established by rules and regulations adopted by the secretary of social and rehabilitation services.

[and annually on or before such date thereafter, a

New Sec. 5. (a) There is hereby established the governor's mental health services planning council. The council shall consist of ~~27~~ *28* members appointed by the governor, of which not more than 13 members shall be state officers or employees or providers of mental health services. The members shall be appointed by the governor so that the composition of the council is in compliance with the requirements of public law 99-660 and supplementary federal acts and in accordance with the following:

(1) Eight members shall be representatives of state agencies;

(2) one member shall be a representative of private mental health service providers;

(3) one member shall be a person licensed to practice medicine and surgery;

~~(3)~~ *(4)* two members shall be members of governing boards of mental health centers;

~~(4)~~ *(5)* two members shall be executive directors of mental health centers; and

~~(5)~~ *(6)* fourteen members shall be members of the general public and a majority of such members shall be consumers of mental health services and family members of mentally ill persons.

(b) The governor shall designate the chairperson of the governor's mental health services planning council. Each member of the governor's mental health services planning council shall be appointed

New Sec. 7. On or before March 1, 1991, the secretary shall transfer those powers, duties, functions of adult services, which are part of ~~the home and community based services program or~~ the adult services community and day living program, or similar programs, and which provide mental health services to persons, including persons residing in intermediate care facilities that provide mental health services, to mental health and retardation services.

New Sec. 8. (a) On or before October 1, 1991, and in accordance with rules and regulations adopted by the secretary each mental health center shall prepare and adopt a community assessment of needs and a plan to provide community based mental health services for persons who are residents of the service delivery area of the mental health center and shall submit such assessment of needs and plan to the secretary for approval. Among other provisions, such plan shall include the provision of services to all targeted population members who apply therefor.

(b) Each mental health center shall conduct [periodic] reviews of [annual] the community assessment of needs for the service delivery area and shall report at least annually to the secretary the results of such reviews and any amendments to the community assessment of needs or the plan to provide community based mental health services which are adopted. The amendments to such plan shall be subject to approval by the secretary in accordance with criteria prescribed by rules and regulations adopted by the secretary.

(c) Prior to October 1, 1991, the secretary shall adopt rules and regulations prescribing guidelines for the conduct of community assessments of need, for the development and operation of systems to provide community based mental health services within the service delivery area of the mental health center, and for periodic reporting to the secretary on the operations under such systems in accordance with this act.

New Sec. 9. (a) Each mental health center may provide community based mental health services under the system established in accordance with this act and approved by the secretary either by directly providing such services or by providing such services through contracts with service providers, including other mental health centers, or both directly and through contracts with such service providers.

(b) Subject to and in accordance with the provisions of this act and appropriations acts, the secretary shall assist in the establishment and development of community based mental health services in each county by providing counties and mental health centers with technical assistance and financial assistance.

erning board for Sedgwick.

(b) If the board of county commissioners elects to serve as the governing board pursuant to this section, the board of county commissioners shall appoint a mental health and mental retardation advisory board of not less than seven members. Members of the advisory board shall serve at the pleasure of the board of county commissioners. Membership of the advisory board *shall include consumers of mental health services and family members of mentally ill persons and*, as nearly as possible, shall be representative of public health, medical profession, the judiciary, public welfare, hospitals and mental health organizations and education, rehabilitation, labor, business and civic groups.

(c) The board of county commissioners, as the mental health or mental retardation governing board, shall seek the recommendations of the mental health and mental retardation advisory board prior to adopting the annual plan and budget for county mental health and retardation programs.

Sec. ~~14~~ *15*. On January 1, 1991, K.S.A. 19-4002b is hereby amended to read as follows: 19-4002b. (a) In lieu of appointing a governing board as provided by K.S.A. 19-4002 and amendments thereto, the board of county commissioners of Johnson county may serve as the community mental health or mental retardation governing board for Johnson county.

(b) If the board of county commissioners elects to serve as the governing board pursuant to this section, the board of county commissioners shall appoint a mental health and mental retardation advisory board of not less than seven members. Members of the advisory board shall serve at the pleasure of the board of county commissioners. Membership of the advisory board *shall include consumers of mental health services and family members of mentally ill persons and*, as nearly as possible, shall be representative of public health, medical profession, the judiciary, public welfare, hospitals and mental health organizations and education, rehabilitation, labor, business and civic groups.

(c) The board of county commissioners, as the mental health or mental retardation governing board, shall seek the recommendations of the mental health and mental retardation advisory board prior to adopting the annual plan and budget for county mental health and retardation programs.

Sec. ~~15~~ *16*. On January 1, 1991, K.S.A. 1989 Supp. 59-2901 is hereby amended to read as follows: 59-2901. ~~This~~ act *The provisions of K.S.A. 59-2901 through 59-2941 and amendments thereto and K.S.A. 1989 Supp. 59-2943 and sections 29 and 30 and amendments* section

COMMENTS AND AN OVERVIEW OF KANSAS MENTAL HEALTH SERVICES AND HOUSE BILL NO. 2586

Presented By
Bill Simons

Mental Health Services Consumer and
Coordinator of PROJECT ACCEPTANCE
A Self-Help Mental Health Consumer Organization
P.O. Box 187
Lawrence, KS 66044
913-841-9257

SWAM
April 23, 1990
Attachment 6

The brevity of time allowed to respond to this piece of legislation makes it impossible to respond adequately to the number of concerns that mental health consumers have regarding not only this bill, but also the gross inadequacies of the mental health treament system that is presently in place and that will, in many ways, remain in place only in a different form, if this legislation passes.

I represent one of the few mental health consumer organizations that you will hear from that is truly consumer-initiated and consumer run and that is not attached to or an adjunct to some public or privately run professional treatment program. I, myself, am on psychiatric Social Security disability and have been for the past five years. I have been unable to hold a full-time job for over ten years and my record of hospitalizations date back to 1965. Project Acceptance, which I represent today, has served over 90 participants since we opened our Drop-In Center last September. Approximately half of this number are served by our local CMHC while the other half is not.

During the course of these hearings you will hear from many groups and organizations--most of them represent either public or private providers and governmental agencies such as SRS. They all have strong vested interests in the final outcome of this legislation because it will affect either their power or control of the system or it will affect their financial clout or their ability to make neat statistical reports to satisfy legislators and to meet reporting criteria to receive federal dollars. These people are politicians, providers, and state government managers and I understand their desire to do the best they can with what is offered, to fight for what little there is, to offer compromises that rob Peter (state hospital) to pay Paul (CMHC's). I believe that most of them are sincere and trying to do the best for us

(consumers) that they can with what little they are given. Thank God, we the consumers are not under such pressures and constraints. We don't have to answer to "political realities", we merely have to tell you that there is a tremendous gap between what is needed and what is proposed.

A pig painted green is still a pig, and a rearranged grossly under funded mental health system is still a grossly inadequate mental health treatment system.

My friends, the facts are that last year Kansas was ranked 42nd in the nation in the level of mental health care and if that were not sad enough, we were also reported as "still moving backwards". This is more than embarrassing, it is a moral outrage. No legislator need fear being voted out of office by a powerful mental health consumer voting block but sometimes, as John F. Kennedy pointed out in his book, Profiles in Courage, there comes a time when politicians must rise above the political arena and address that which is morally unconscionable and make it right! Money does not fix everything and, if not properly applied, may not fix anything. But that is no answer because inadequate funding is a game of pretense almost more insulting to the consumer than no funding at all.

Some of the specific concerns regarding this legislation are as follows:

1. We will always need a quality State hospital system because there will always be those who need hospitalization. Yet, in spite of past and present decertification concerns, we hear that a community-based mental health system will be funded as we reduce hospital beds and budgets. Whether present size or smaller, our State hospital system is a consumer detention system based on heavy sedative drug use rather than a quality care and treatment system. Where will the funds come from to upgrade this deplorable system?

2. The mental health "reform" legislation is really mental health management reform, not treatment reform. There should be some way to provide local CMHC's and the State SRS with mental health patient data without violating the consumer's right of choice, and the consumer's concern with confidentiality.

3. The definition of "mental health professional" must be expanded to include private certified and licensed mental health practitioners who are not attached to a CMHC. The "gatekeeper" concept is a "management" tool, not a treatment enhancer. If a medical doctor can refer his/her cancer patient to a State facility such as the K.U. Medical Center without a bureaucratic middleman (gatekeeper), why should not a qualified private mental health practitioner and his/her patient not have the same option which guarantees the consumer choice and confidentiality. If a consumer was wealthy they could simply go through their private practitioner to a private provider such as the Menninger Foundation. Thus, this bill falls on the consumer who is poor--it is income discriminatory.

If this legislation were to pass, it should contain strong guarantees of adequate appeal procedures for consumers, the right to second opinions from a licensed or certified mental health professional of the consumer's choice and hopefully an independent body or person to serve as an omsbudsman. The gatekeeping concept locked into this legislation by the definition of "qualified mental health professional" permeates the whole bill and thus the whole system from screening, to hearings, to transfers, to discharges, etc.

In spite of this list of deep concerns, Project Acceptance applauds the efforts of SRS personnel, legislators, family members and others who have worked so hard to try to bring some meaningful change to the present deplorably inadequate system. We concur that change is necessary. If the concerns listed are adequately addressed and if resources, that's money, are provided for a truly adequate community based support system that includes such needs as adequate housing (supervised for those who need it), transportation needs, employment opportunities, and skyrocketing medical costs, especially medication, then we would enthusiastically support such a bill. Thank you for your kind consideration of our concerns.

TO: SENATOR GUS BOGINA
CHAIRMAN, WAYS & MEANS
STATE OF KANSAS SENATE

FROM: PENNY SUE JOHNSON, PRESIDENT
THE KANSAS COALITION, INC.

REF: Mental Health Reform legislation(HB 2586, 2577, 2578, & 2579 and substitutes)

Dear Mr. Chairman and Committee;

Again it seems we as Kansans are faced with reviewing a poorly written, and conceived bill(s). Mental Health Services and contractee' such as CMHC have had their chance to prove themselves and throwing money at an industry which only seeks to further medical problems for our citizens seems to be frankly quite outrageous and it is this administrators recommendation to "kill" this legislation and stop spending our tax money on a system whom does not believe in its people and only again seeks to line the pockets of providers and offer no relative services to Kansans who legally and lawfully for the most part are no more "mentally ill" than you or I. Advocates have tried since the mid 70' to educate SRS and its affilates and simply they refuse to be humane in their delivery of care.

Finally, It would not be wise to allow this bill to go through unless you mean to tie thousands of Kansans up in the courts and consumers are aware now that social workers and psychiatrist are no smarter or more competent than the consumer themselves, nor are group homes and more nursing home necessary given the technology of todays learning and educational methods of even dealing with indigent citizens and getting them back on the way to work and school. Now when we examine the facts the insurance scam and the rein of terror of mental health industry has dumped on all of us then perhaps many legislators will join the community in standing against this piece of trash legilation that will only cause more harm, conflict, institutional violence, and involuntary servitude. Earlier I submitted limits to the first three sections of the original HB 2586 with comments and recommendations. The legal battles were so pervasive not to mention the constitutional disregard for even Kansas' constitution I threw the bill in the corner of my desk trying to forget that it had ever been drafted in a country which is based on majority, community, and some sense of respect for diversity of choice, and the fear to realize I was reading Iron Curtain material left me very concerned about leadership at all levels and having been involved at both a national and state level since 1983 and serving on two SRS Advisory Councils related to "mental health" indeed this leader is frightened by the implications of such suggested legislation. No way not on my tax dime. The more appropriate response is work, opportunity, and setting people up in a non-medical housing situation is the top level expertise of this nation. This bill was written for CMHC' and again a drug related industry of experimentation out of control with no accountability.

Thousands of Kansans are counting on our legislators to stand strong and say no to this piece of legislation which was brought to you to line a few pockets and imprision and victimize a Kansan who simply needs a little praise, opportunity, and a chance to restart. Looking forward to seeing everyone on the 23rd.

Penny Sue Johnson 4/17/90

Your loyal advocate and adminstrator

SWAM
April 23, 1990
Attachment 7

STATE OF KANSAS

DEPARTMENT OF CORRECTIONS
OFFICE OF THE SECRETARY
Landon State Office Building
900 S.W. Jackson—Suite 400-N
Topeka, Kansas 66612-1284
(913) 296-3317

Mike Hayden
Governor

Steven J. Davies, Ph.D.
Secretary

To: SENATE WAYS AND MEANS COMMITTEE

Re: SENATE BILL 787

K.S.A. 75-52,116 currently authorizes the Department of Corrections to provide inmate labor to work for any state agency, federal agency, city, county, school district, or non-profit organization organized for charitable purposes. The statute provides a restriction on such labor by specifying that it can only result in "minimal negative impact on the private sector work force."

When providing inmate labor to requesting entities, the Department of Corrections has applied a so called "but for" test. Simply stated, the point of this test is that if the work would not be done but for the use of inmate labor, the labor could be provided. However, if the entity had funds available to complete the project, inmate labor would not be provided.

The philosophy behind the department's policy is that work programs are of rehabilitative benefit to inmates. While the department wants inmates to work, it does not desire to take job opportunities away from citizens who have committed no crimes and are available and willing to work. However, if a governmental entity has no funds available to complete a project or to hire someone to do the work, inmates may be provided rather than have the project go undone. In such instances, the use of inmate labor is to the public's advantage.

The department's policy regarding inmate labor has for the most part worked well over the past several years. However, questions have recently been raised regarding the interpretation of the restriction that inmate labor not have more than a "minimal negative impact on the private sector workforce."

This phrase can mean different things to different people. The Department of Corrections does not desire to get involved in such interpretations regarding each project for which inmate labor is

SWAM
April 23, 1990
Attachment 8

requested. Rather, straight forward guidelines regarding which projects qualify for inmate labor are preferred.

The amendments proposed in S.B. 787 provide guidelines which appear to be reasonable but are not subject to varying interpretations. The provisions of the proposed amendments lend themselves to a checklist format which can be submitted to the requesting entity in order to determine if the project qualifies for the use of inmate labor. If the entity certifies that the use of inmates will comply with the limitations set forth in the statute, inmates will be provided. Fiscal and personnel records of the requesting agency can be reviewed to determine if the agency's certification was appropriate.

S.B. 787 appears to be an appropriate solution to achieve the objectives of providing work to inmates as a rehabilitative tool, respecting the employment of the private sector workforce, and benefitting the general public by completing projects of a worthwhile nature.

The Department of Corrections supports S.B. 787.

1990 HB 2867
(Governor's Spending Lid Proposal)

-- The Governor's proposal requires that the budget be based upon the concensus revenue estimate prepared jointly by the Director of Legislative Research and the Director of the Budget. Revised revenue estimates during the Legislative Session would be prepared by joint memorandum on the 85th legislative day.

-- The Governor proposes that a State Operating Reserve Fund be established on July 1, 1990, and an amount equal to five percent of FY 1991 expenditures be transferred to that fund from the State General Fund.

-- The Director of the Budget would have the authority to require transfers be made from the Cash Operating Reserve Fund to the State General Fund as necessary during a given fiscal year to meet the obligations of the State General Fund during the course of the year. Monies remaining in the Cash Operating Reserve Fund would be lapsed at the end of the fiscal year.

-- Each fiscal year subsequent to FY 1991 a transfer of five percent would be made to the Cash Operating Reserve Fund at the beginning of the fiscal year. In addition, the Governor recommends State General Fund balances of an additional 2.5 percent in FY 1992 and 5.0 percent in FY 1993.

-- No appropriation bill could take effect without passage of an Omnibus Reconciliation Bill. If appropriation bills during a session would appropriate amounts that would reduce balances below 5.0 percent of estimated expenditures, the Omnibus Reconciliation Bill would be used to adjust appropriation bills to meet the balance requirement.

-- The State General Fund balance could contain an additional 2.0 percent for a total of 7.0 percent above the limit. Amounts above 7.0 percent would be transferred to a Capital Improvement Reserve Fund to be utilized in subsequent fiscal years for capital improvements.

-- Use of balances above the level of the Cash Operating Reserve Fund to finance budgets during a fiscal year could be accomplished only by a 2/3 vote of each house.

SWAM
April 23, 1990
Attachment 9

Proposed Spending Limit Bills

	1971 SB 105	1971 HB 1170	1972 SB 675	1973 SB 87	1974 SB 793	1975 SB 213	1975 HB 2240	1978 SB 566	1979 SB 25	1979 SB 39	1979 HB 2090	1979 HB 2623
State General Fund Revenues estimated by Extraordinary Committee?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Estimates Based On Consensus Revenue Estimate?	No	No	No	No	No	No	No	No	No	No	No	No
Minimum Balance to be Maintained.	No	No	No	No	No	No	No	8%	8%	8%	8% current 8.56% budget	8%
Spending Ceiling to Limit Increases in Expenditures?	Receipts equal expend.	Receipts equal expend.	Receipts equal expend.	Receipts equal expend.	Receipts equal expend.	Receipts equal expend.	Receipts equal expend.	7%	7%	7%	7%	7%
Capital Improvement Fund for Excess Balance?	No	No	No	No	No	No	No	No	No	No	No	No
"Rainy Day" Fund Established?	No	No	No	No	No	No	No	No	No	No	No	No
Consensus Revenue Group Established by Statute?	No	No	No	No	No	No	No	No	No	No	No	No
Able to Exceed Spending Lid with 2/3 vote of Legislature?	No	No	No	No	No	No	No	No	No	No	No	No
Expenditures in Governor's Budget Must Not Exceed Existing Revenues.	No	No	No	No	No	No	No	No	No	No	No	No

Proposed Spending Limit Bills

	1983 HB 2275	1985 HB 2175	1985 SB 216	1985 SB 217	1985 SB 254	1987 SB 198	1987 SB 224	1987 HB 2310	1990 SB 518	1990 HB 2867	1990 HB 2900
State General Fund Revenues estimated by Extraordinary Committee?	No	No	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No
Estimates Based On Consensus Revenue Estimate?	Yes	Yes	No	No	No	No	No	Yes	No	Yes	No
Minimum Balance to be Maintained.	No	No	No	7%	10%	10%	7%	No	7%	5%*	5%
Spending Ceiling to Limit Increases in Expenditures?	No	No	Yes	Based on CPI increase	Receipts equal expend.	Receipts equal expend.	7% Increase	No	Based on CPI increse	No	No
Capital Improvement Fund for Excess Balance?	No	No	No	No	Yes	Yes	No	No	No	Yes	No
"Rainy Day" Fund Established?	No	No	No	No	Yes	Yes	No	No	No	Yes	No
Consensus Revenue Group Established by Statute?	Yes	Yes	No	No	No	No	No	No	No	No	No
Able to Exceed Spending Lid with 2/3 vote of Legislature?	NA	NA	Yes	No	No	No	Yes	NA	No	Yes	No
Expenditures in Governor's Budget Must Not Exceed Existing Revenues.	Yes	Yes	No	No	No	No	No	Yes	NA	NA	NA

**The Governor recommends additional State General Fund balances of 2.5 percent in FY1992 and 5.0 percent in FY1993.*

Division of Budget 16-Feb-90

SUBCOMMITTEE REPORT

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HOUSE BILL NOS. 2867 AND 2900

As instructed, your Subcommittee has reviewed the provisions of House Bill Nos. 2867 and 2900. We recommend certain amendments be made to the bills and the bills as amended be recommended for passage.

House Bill No. 2867, as introduced, would carry out the Governor's recommendation for a "State Spending Lid" which is discussed on page 13 of Volume 1 of The Governor's Report on the Budget for fiscal year 1991. In essence, this legislation is directed at the legislative appropriations process and sets an eventual target for end-of-year General Fund balances which are effectively equal to 10 percent of authorized expenditures and demand transfers (expressed in the bill as a basic 5 percent for cash flow purposes plus an additional increment). Expenditure measures which would reduce the estimated ending balance for a fiscal year below the target would require the affirmative votes of two-thirds of the members of each house. As introduced the bill sets the targeted balance at 5 percent for FY 1991, 7.5 percent for FY 1992, and 10 percent for FY 1993 and thereafter.

While endorsing this basic concept of H.B. 2867, the Subcommittee recommends adoption of the following amendments:

1. The absence of any reference to the Governor's budget report should be corrected by requiring that the Governor's budget recommendations adhere to the same targeted General Fund balances that would apply to the legislative appropriations process.

2. The bill should be amended to provide a longer phasing-in of the eventual General Fund target balance of 10 percent; i.e., commencing for FY 1992, the targeted balance should be 6 percent, and the target should increase by increments of 1 percent until the target is an effective 10 percent for FY 1996.

3. Concerning the revenue side of the equation, H.B. 2867 places reliance upon the consensus estimates of the Director of the Budget and the Director of the Legislative Research Department as originally arrived at and as subsequently amended, including amendments for subsequent enactments of revenue measures; and the Subcommittee recommends that the initial Fall consensus and Spring revision thereof take place on or before December 4 and April 4, respectively.

4. As introduced, H.B. 2867 establishes a State Capital Improvements Reserve Fund to be credited with General Fund resources in excess of a stated percentage; and the Subcommittee recommends that this provision be deleted.

5. Inasmuch as H.B. 2867 imposes substantial changes to the present appropriations process, it is recommended that the Committee on Appropriations request the Legislative Coordinating Council to charge an interim Committee with the task of recommending procedural revisions which may be necessary or desirable. The Subcommittee does not believe it is practical to implement H.B. 2867 this Session and therefore suggests that its provisions first be made applicable to FY 1992.

The Subcommittee believes that H.B. 2900 with amendments is an important fiscal management measure and is likewise favorably recommended. H.B. 2900 authorizes the Governor to issue an executive order or orders with the approval of the State Finance Council to reduce, prorata, General Fund appropriations and demand transfers in the event that estimated General Fund balances would fall below a stated ending balance of 5 percent of expenditures and demand transfers for the fiscal year. The Subcommittee recommends that amendments be made to H.B. 2900 to clarify that, with regard to demand transfers, any changes therein which would result from revised revenue estimates should be taken into account before the Director of the Budget certifies a percentage reduction to the Governor for his consideration as to the necessity of issuing an executive order of prorata reduction.

Representative Robert Vancrum

Representative Max Moomaw

Representative George Teagarden

90-391

MEMORANDUM

Kansas Legislative Research Department

Room 545-N – Statehouse
Topeka, Kansas 66612-1586
(913) 296-3181

April 10, 1990

Re: Proposed State Spending Lid Bill

House Bill No. 2867

As Passed by the House

This bill establishes targeted ending balances in the State General Fund effectively equal to 6 percent of expenditures and demand transfers for FY 1992, 7 percent for FY 1993, 8 percent for FY 1994, 9 percent for FY 1995, and 10 percent for FY 1996 and thereafter. Technically, the targeted balances are expressed as 5 percent for cash flow purposes (in a new Cash Reserve Operating Fund beginning at the start of FY 1992) plus stated increments of 1 percent per year from FY 1992 through FY 1996.

Two tables are attached to this memo to illustrate how H.B. 2867 would work in FYs 1992 and 1993 based on various assumptions. There are three different projections in each table.

Table I Assumptions

Receipts. For FYs 1990 and 1991, receipts are as estimated by the Consensus Estimating Group as of April 4, 1990, plus minor legislative adjustments approved in bills passed and sent to the Governor before the wrap-up session. For FYs 1992 and 1993, it was assumed that receipts would increase each year by 2.6 percent (the same as estimated for FY 1991) in Projection A, by 3.5 percent in Projection B, and by 4.5 percent in Projection C.

Expenditures. It is assumed that expenditures in FY 1990 will be an amount that would result in an ending balance of $241.3 million, or 10 percent of expenditures. For FY 1991, the assumption is that expenditures would result in an ending balance of $123.1 million, or 5 percent of expenditures. For FYs 1992 and 1993, expenditures are simply calculated amounts which are by-products of the beginning balances, revenue projections, and targeted ending balances.

Table II Assumptions

This table is the same as Table I except that for FY 1991 it is assumed that expenditures would be an amount resulting in an ending balance of $100 million, or 4 percent of expenditures.

SWAM
April 23, 1990
Attachment 10

It will be noted that for FY 1992 the beginning balance in the General Fund would be a negative number if 5 percent of expenditures in that year were transferred to the Cash Reserve Operating fund on July 1, 1991, as the bill now requires. That is a technical problem which could be remedied by an amendment to the bill.

90-425/rwr

TABLE I

PROJECTIONS – STATE GENERAL FUND AND CASH OPERATING RESERVE FUND*

In Millions

	FY 1990	FY 1991	Increase	FY 1992	Increase	FY 1993	Increase
A. Beginning Balance							
General Fund	$ 371.4	$ 241.3		$ 3.9 (7-1-91)		$ 21.1 (7-1-92)	
Cash Oper. Res. Fund	–	–		119.2 (7-1-91)		122.0 (7-1-92)	
% of Expend.	–	–		5.0%		5.0%	
Receipts							
Consensus Est.	2,283.0	2,343.4	2.6%	2,404.3	2.6%	2,466.8	2.6%
Legis. Adj.	0.3	0.7		–		–	
Total	2,283.3	2,344.1		2,404.3		2,466.8	
Expenditures							
Excl. Circuit Breaker	2,402.6	2,462.3	2.5%	2,384.0	(3.2)%	2,439.2	2.3%
Homeowners' CB	10.8	–	(100.0)	0.3	–	–	(100.0)
Total	2,413.4	2,462.3	2.0%	2,384.3	(3.2)%	2,439.2	2.3%
Ending Balance							
General Fund	241.3	123.1 (6-30-91)		143.1 (6-30-92)		170.7 (6-30-93)	
% of Expend.	10.0%	5.0%		6.0%		7.0%	
Cash Oper. Res. Fund	–	–		0.0		0.0	
B. Beginning Balance							
General Fund	$ 371.4	$ 241.3		$ 2.9 (7-1-91)		$ 20.3 (7-1-92)	
Cash Oper. Res. Fund	–	–		120.2 (7-1-91)		124.0 (7-1-92)	
% of Expend.	–	–		5.0%		5.0%	
Receipts							
Consensus Est.	2,283.0	2,343.4	2.6%	2,425.4	3.5%	2,510.3	3.5%
Legis. Adj.	0.3	0.7		–		–	
Total	2,283.3	2,344.1		2,425.4		2,510.3	
Expenditures							
Excl. Circuit Breaker	2,402.6	2,462.3	2.5%	2,403.9	(2.4)%	2,480.9	3.2%
Homeowners' CB	10.8	–	(100.0)	0.3	–	–	(100.0)
Total	2,413.4	2,462.3	2.0%	2,404.2	(2.4)%	2,480.9	3.2%
Ending Balance							
General Fund	241.3	123.1 (6-30-91)		144.3 (6-30-92)		173.7 (6-30-93)	
% of Expend.	10.0%	5.0%		6.0%		7.0%	
Cash Oper. Res. Fund	–	–		0.0		0.0	

	FY 1990	FY 1991		Increase	FY 1992		Increase	FY 1993		Increase
C. Beginning Balance										
General Fund	$ 371.4	$ 241.3			$ 1.8	(7-1-91)		$ 19.2	(7-1-92)	
Cash Oper. Res. Fund	–	–			121.3	(7-1-91)		126.4	(7-1-92)	
% of Expend.	–	–			5.0%			5.0%		
Receipts										
Consensus Est.	2,283.0	2,343.4		2.6%	2,448.9		4.5%	2,559.1		4.5%
Legis. Adj.	0.3	0.7			–			–		
Total	2,283.3	2,344.1			2,448.9			2,559.1		
Expenditures										
Excl. Circuit Breaker	2,402.6	2,462.3		2.5%	2,426.1		(1.5)%	2,527.8		4.2%
Homeowners' CB	10.8	–		(100.0)	0.3		–	–		(100.0)
Total	2,413.4	2,462.3		2.0%	2,426.4		(1.5)%	2,527.8		4.2%
Ending Balance										
General Fund	241.3	123.1	(6-30-91)		145.6	(6-30-92)		176.9	(6-30-93)	
% of Expend.	10.0%	5.0%			6.0%			7.0%		
Cash Oper. Res. Fund	–	–			0.0			0.0		

* Based on 1990 H.B. 2867 as passed by the House.

90-425-I/RWR

TABLE II

PROJECTIONS – STATE GENERAL FUND AND CASH OPERATING RESERVE FUND*

In Millions

	FY 1990	FY 1991	Increase	FY 1992	Increase	FY 1993	Increase
A. Beginning Balance							
General Fund	$ 371.4	$ 241.3		$ (18.1) (7-1-91)		$ 19.9 (7-1-92)	
Cash Oper. Res. Fund	–	–		118.1 (7-1-91)		121.9 (7-1-92)	
% of Expend.	–	–		5.0%		5.0%	
Receipts							
Consensus Est.	2,283.0	2,343.4	2.6%	2,404.3	2.6%	2,466.8	2.6%
Legis. Adj.	0.3	0.7		–		–	
Total	2,283.3	2,344.1		2,404.3		2,466.8	
Expenditures							
Excl. Circuit Breaker	2,402.6	2,485.4	3.4%	2,362.2	(5.0)%	2,437.9	3.2%
Homeowners' CB	10.8	–	(100.0)	0.3	–	–	(100.0)
Total	2,413.4	2,485.4	3.0%	2,362.5	(4.9)%	2,437.9	3.2%
Ending Balance							
General Fund	241.3	100.0 (6-30-91)		141.8 (6-30-92)		170.7 (6-30-93)	
% of Expend.	10.0%	4.0%		6.0%		7.0%	
Cash Oper. Res. Fund	–	–		0.0		0.0	
B. Beginning Balance							
General Fund	$ 371.4	$ 241.3		$ (19.1) (7-1-91)		$ 18.9 (7-1-92)	
Cash Oper. Res. Fund	–	–		119.1 (7-1-91)		124.0 (7-1-92)	
% of Expend.	–	–		5.0%		5.0%	
Receipts							
Consensus Est.	2,283.0	2,343.4	2.6%	2,425.4	3.5%	2,510.3	3.5%
Legis. Adj.	0.3	0.7		–		–	
Total	2,283.3	2,344.1		2,425.4		2,510.3	
Expenditures							
Excl. Circuit Breaker	2,402.6	2,485.4	3.4%	2,382.2	(4.2)%	2,479.6	4.1%
Homeowners' CB	10.8	–	(100.0)	0.3	–	–	(100.0)
Total	2,413.4	2,485.4	3.0%	2,382.5	(4.1)%	2,479.6	4.1%
Ending Balance							
General Fund	241.3	100.0 (6-30-91)		142.9 (6-30-92)		173.6 (6-30-93)	
% of Expend.	10.0%	4.0%		6.0%		7.0%	
Cash Oper. Res. Fund	–	–		0.0		0.0	

	FY 1990	FY 1991		Increase	FY 1992		Increase	FY 1993		Increase
C. Beginning Balance										
General Fund	$ 371.4	$ 241.3			$ (20.2)	(7-1-91)		$ 18.0	(7-1-92)	
Cash Oper. Res. Fund	–	–			120.2	(7-1-91)		126.3	(7-1-92)	
% of Expend.	–	–			5.0%			5.0%		
Receipts										
Consensus Est.	2,283.0	2,343.4		2.6%	2,448.9		4.5%	2,559.1		4.5%
Legis. Adj.	0.3	0.7			–			–		
Total	2,283.3	2,344.1			2,448.9			2,559.1		
Expenditures										
Excl. Circuit Breaker	2,402.6	2,485.4		3.4%	2,404.3		(3.3)%	2,526.5		5.1%
Homeowners' CB	10.8	–		(100.0)	0.3		–	–		(100.0)
Total	2,413.4	2,485.4		3.0%	2,404.6		(3.3)%	2,526.5		5.1%
Ending Balance										
General Fund	241.3	100.0	(6-30-91)		144.3	(6-30-92)		176.9	(6-30-93)	
% of Expend.	10.0%	4.0%			6.0%			7.0%		
Cash Oper. Res. Fund	–	–			0.0			0.0		

* Based on 1990 H.B. 2867 as passed by the House.

90-425-I/RWR

Joint Testimony on HB 2867
before the
Senate Committee on Ways and Means
by
James Hays, Research Director
Kansas Association of School Boards

for
Kansas Association of School Boards
Kansas-National Education Association
United School Administrators
Unified School District No. 512 (Shawnee Mission)
Unified School District No. 259 (Wichita)
Unified School District No. 229 (Blue Valley)
Unified School District No. 501 (Topeka)
Schools for Quality Education
Schools for Equal Education in Kansas

Mr Chairman and members of the Committee, we appreciate the opportunity to testify today on behalf of the above listed school districts and organizations.

We oppose HB 2867. It is unworkable; even if it could be made to work we believe it represents bad public policy for the State of Kansas. We urge you as the Legislature, and the Governor, to use the process described in current law and your own sense of responsible public policy to govern your fiscal behavior, rather than resorting to artificial barriers such as a "spending lid" and a "rainy day fund".

HB 2867 would require that all appropriations bills be made effective upon the passage of an "omnibus reconciliation spending limit bill". This final bill would require that certain increasing levels of

SWAM
April 23, 1990
Attachment 11

ending balances be achieved in the State General Fund, based upon estimated total expenditures for the ensuing fiscal year. As such, it would essentially require that the entire budget be enacted in one bill, at the end of the session, in what would surely become a "crisis atmosphere." Deliberations, testimony, professional staff analysis, agency requests, Governor's recommendations and any semblance of thoughtful consideration of spending priorities would all go for naught if, at the end of the session, the total authorized spending exceeded the limits imposed by this bill. As representatives of local boards of education and professional educators in this state, we do not relish the prospect of attempting to discuss rationally the funding needs of public education knowing full well that the entire issue will be rejoined at the eleventh hour on some later date. And we can easily foresee a process whereby funds for public schools would be held "hostage" until the necessary votes were secured to enact this "omnibus reconciliation bill."

HB 2867 would also formalize the "consensus revenue estimating group" in that it would require spending to be based upon agreements between the Director of the Budget and the Director of Legislative Research. We believe that the only reason that our state has been able to retain a non-partisan approach to estimating revenues is due precisely to the informal nature of the group. With the absolute limits imposed by this bill (and therefore the entire state budget) at stake, it is easy to foresee a breakdown of the revenue estimating process and a routine system of the Governor having his revenue estimate and the majority leadership in the Legislature having theirs. We do not believe that politicizing the process of economic forecasting can possi-

bly make it more accurate, or can possibly result in a budgetary process which is more rational and democratic than that provided by current law.

Finally, we are hard pressed to understand the need for a "rainy day" fund, such as that provided by HB 2867. The Governor, as executive officer of the State, has the tools of current law (such as the issuance of certificates of indebtedness) at his disposal to manage the day-to-day expenditures in such a way as to preserve fiscal health. Sometimes, we acknowledge, those tools would require tough political decisions but, as is often said, "...if you can't stand the heat, get out of the kitchen." By FY 1996, as envisioned by this bill, a 5% ending balance and an additional 5% "rainy day fund" could easily exceed $300 or $400 million. We do not believe that this degree of overtaxation of Kansans will be generally perceived as necessary, if it is justified only on the basis of the Legislature and the Governor being unable to exercise fiscal restraint in arriving at a budget.

We appreciate having the opportunity to participate in this debate on such a fundamental issue of public policy and we would gladly answer any questions from the committee.

to ensure that misinterpretations are avoided which could hamstring bond issues.

*The reference to "...total taxable tangible property in the state" is unclear. Is reference being made to the total statewide valuation of real and personal property or to the total statewide assessed valuation of real and personal property? The differences between the two are substantial.

*Reference is also made to "...bonds the principal of and interest upon which are payable from revenues of the state..." This language is also unclear in its meaning. Does it mean the bond principal and the debt service or only the bond principal? Also, I am advised that there are questions as to how defeased bonds are to be treated under this section.

Mr. Chairman and members of the Committee, we see numerous problems with Section 5 of House Bill 2867, as amended. We also have concerns that the language in Section 5 could adversely affect the future issuance of highway bonds to the extent that investment banking firms would hesitate to underwrite our highway bonds. Additionally, the 7.8% cap could limit the issuance of highway bonds to a level below the amount authorized by the 1989 Legislature. For these reasons we respectfully ask that in your deliberations on House Bill 2867, consideration be given to striking Section 5 from the bill.

Thank you. This concludes my prepared remarks. I am available for questions.

KDFA
KANSAS
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M E M O R A N D U M

TO: Senate Ways and Mean Committee

FROM: Allen Bell, President
Kansas Development Finance Authority

SUBJECT: Testimony in Opposition to House Bill No. 2867

House Bill 2867 was amended by the House Committee of the Whole to include the provisions of House Bill 2887, which would limit the amount of bonds issued or authorized by or on behalf of all state agencies except the Board of Regents, to an amount equal to 7.8% of the value of all tangible taxable property in the state. House Bill 2887 never received a hearing in the House of Representatives, so this is the only opportunity to give testimony on this proposed legislation.

My personal recommendation is that the bill should not pass with the aforementioned amendments; and if it passes it should be vetoed by the Governor. The bill is technically flawed in two ways. First, it is not precise enough about the basis for calculating the limitation on bonds issued or authorized; however, I understand the intent was to use assessed valuation as the basis. Second, if assessed valuation is the basis for calculating the limitation, then we are already in violation of the proposed statute by approximately $40 million.

The current assessed value of tangible taxable property in the state is $125.35 billion; 7.8% of which is $1.10 billion. There is approximately $233 million principal amount of bonds currently outstanding that would be affected by this legislation. There is another $19 million bonds authorized that will be issued before the end of FY 1990, and $890 million highway bonds that will be issued after FY 1990, for a total of outstanding and authorized bonds of $1.14 billion. As a practical matter, no new bond issues could be authorized by the legislature without raising the "debt ceiling", and the issuance of the last of the highway bonds might be delayed until currently outstanding principal has been paid-off.

The sponsors of House Bill 2887 obviously believe that the State of Kansas is making too great a use of long term financing for capital improvement projects. I could not disagree more.

SWAM
Attachment 13
April 23, 1990

First of all, one should distinguish between the sources of repayment of bonds in assessing whether there is an over-reliance problem. Of the $1.14 billion in authorized or outstanding revenue bonds effected by this bill, almost $1.02 billion are highway or freeway bonds supported primarily by transportation user revenues. Only $81 million in revenue bonds are totally paid from state general fund appropriations. When it comes to general revenue supported bonds, Kansas ranks as one of the very least users of long term bonds for long term capital improvements.

State government has a responsibility to the taxpayers of this state, and to their children and grandchildren, to take good care of state-owned physical assets. In some cases this means the construction or acquisition of new assets to replace old; in other cases it means renovation and rehabilitation of existing assets. The state also has a responsibility to do the best it can with the limited resources available. And in the 1990s this means a reasoned and judicial use of long term bond financing.

Blind adherence to the old "pay-as-you-go" doctrine at the expense of our state's infrastructure is, in my opinion, irresponsible, both to the present generation because current taxpayers are required to pay for assets that will be used beyond their lifetimes, and to future generations because the deterioration of the public infrastructure will accumulate until massive capital outlays, and massive debt, cannot be avoided.

The checks and balances inherent in our political system should provide ample safeguards against over-reliance on bond financing of capital projects. The legislature already has it in its power to control the state's use of bond financing, without a self-imposed limit. The fact that it has recently approved some significant bond financings shows that the political consensus favors this approach.