Approved: April 27, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairperson David Adkins at 4:15 p.m. on March 29, 2000 in Room 514-S of the Capitol.

All members were present except: Representative Allen - excused
Representative Shultz - excused

Committee staff present: Alan Conroy, Kansas Legislative Research Department
Stuart Little, Kansas Legislative Research Department
Robert Waller, Kansas Legislative Research Department
Paul West, Kansas Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Dave Stallings, Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee: None

Others attending:

Chairman Adkins opened the meeting to consideration of **SB 391**.

SB 391 - State buildings and facilities, capital improvements, building code interpretations and variances

Representative Kline, Public Safety Budget Committee, explained that this bill was requested by the Division of Architecture. The state has no state building code. This bill would authorize the Secretary of Administration and the Director of Architectural Services to make decisions which code on a particular project should be in effect except for matters relating to fire safety. Committee questions and discussion followed.

Representative Kline made a motion, seconded by Representative Pottorff, to pass **SB 391** out favorably. Motion carried.

Bill Introductions

Representative Neufeld made a motion, seconded by Representative Hermes, to introduce two bills: one concerning natural gas authorizing certain refunds and reimbursements and the second concerning hepatitis B immunizations. Motion carried.

The Chairman recognized Representative McKechnie who mentioned that he had copies distributed of the Performance Audit Report, Reviewing the Implementation of the Mental Health Reform Act issued by the Legislative Division of Post Audit in March 2000 (Attachment 1). Representative McKechnie brought to the Committee's attention that there are some disturbing issues in the audit and hopes that the Committee can turn its attention to this at some time in the future. The Chairman mentioned that it is the Chair's intention after consulting with the ranking minority member and the vice chairman to appoint a subcommittee to review this further and bring back to the full committee any recommendations or actions.

The Chairman recognized Representative Kline who mentioned that there is another bill he would like to have discussed with the Committee. The Joint Committee on State Building Construction had recommended a funding mechanism to bring the National Guard Armories up-to-date, **SB 592**, that the Senate has passed. The Chairman mentioned that he may seek additional information from the Adjutant General.

The Chairman referred **SB 660** to the General Government and Human Resources Budget Committee chaired by Representative Pottorff which authorizes over $40 million in bonds for renovation and improvements to the State Capitol for recommendations to the full Committee.

Chairman Adkins mentioned that it is his intent, based on the information distributed earlier on the Prevention Initiative, to begin the process of putting into legislation some of those ideas with the idea that they may provide a framework for further distribution of the Children's Initiative Funds.

The meeting was adjourned at 4:35 p.m. The next meeting is scheduled for April 5, 2000.

HOUSE APPROPRIATIONS COMMITTEE
GUEST LIST

DATE March 29, 2000

NAME	REPRESENTING
Kelly Tinnes	Ks. Public Health Assn.
Mike Hutfles	Ks. Gov't Consulting
BILL Brady	Ks Gov't Consulting
Diane Duffy	SRS
Laura Howard	SRS
Robert E Kahrs	KLOGA

PERFORMANCE AUDIT REPORT

Reviewing the Implementation of the Mental Health Reform Act

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
March 2000

1975 PERFORMANCE 25 YEARS AUDITING 2000

00-08

House Appropriations
3-29-00
Attachment 1

Legislative Post Audit Committee
Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about $8 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

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

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

Audits are performed at the direction of the Legislative Post Audit Committee. Legislators or committees should make their requests for performance audits through the Chairman or any other member of the Committee. Copies of all completed performance audits are available from the Division's office.

LEGISLATIVE POST AUDIT COMMITTEE

Senator Lana Oleen, Chair
Senator Anthony Hensley
Senator Pat Ranson
Senator Chris Steineger
Senator Ben Vidricksen

Representative Kenny Wilk, Vice-Chair
Representative Richard Alldritt
Representative John Ballou
Representative Lynn Jenkins
Representative Ed McKechnie

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Barbara J. Hinton, Legislative Post Auditor

LEGISLATURE OF KANSAS

LEGISLATIVE DIVISION OF POST AUDIT

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March 24, 2000

To: Members, Legislative Post Audit Committee

Senator Lana Oleen, Chair	Representative Kenny Wilk, Vice-Chair
Senator Anthony Hensley	Representative Richard Alldritt
Senator Pat Ranson	Representative John Ballou
Senator Chris Steineger	Representative Lynn Jenkins
Senator Ben Vidricksen	Representative Ed McKechnie

This report contains the findings, conclusions, and recommendations from our completed performance audit, *Reviewing the Implementation of the Mental Health Reform Act*.

The report includes several recommendations for improving the Department of Social and Rehabilitation's overall process of planning for the needs of the mentally ill, for improving its annual State plan, and for monitoring mental health programs and services. Specifically, we recommend that the capabilities of the AIMS computer system be expanded to allow it to gather and compare information about the number, cost, and types of services provided to all clients served by mental health centers. Until the Department has this information, we recommend that the Department begin to look at funding formulas based on population, clients served, or other measures that might result in more equitable distribution of mental health moneys.

Finally, we recommend that the Department ensure that all mental health centers are following the same criteria when deciding which clients should be screened for State hospitalization. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY
LEGISLATIVE DIVISION OF POST AUDIT

Question 1: Has the Department of Social and Rehabilitation Services Fulfilled it Statutory Duties Related to Implementing the Mental Health Reform Act?

State Law gives the Secretary broad authority and responsibility related to services for the mentally ill. *The Mental Health Reform Act spells out 21 specific responsibilities for the Secretary in the areas of: planning and coordinating mental health services; establishing rules, regulations, and standards; assisting communities and mental health centers; monitoring and evaluating mental health services programs; and funding services.*

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Overall, the Department has taken actions to implement the requirements of the Mental Health Reform Act, but it needs to strengthen its oversight in a number of areas. *The areas that need strengthening include:*

. . . . page 8

Planning: The Department's State plan doesn't include long-term goals, specific actions steps, and a clear prioritization of needs or goals. Also, the Department didn't conduct a complete annual needs assessment in 1999 as required by State law.

Adopting Rules, Regulations, and Standards: Current regulations don't include a local and State-level appeals process as required by State law. The Department also doesn't have standardized definitions for mental health services–such definitions would be helpful in identifying gaps in services. In addition, the Department doesn't hold all mental health centers to the same performance standards, and some performance standards are set at very low levels.

. . . . page 9

Assisting Communities and Mental Health Centers: The Department has hired only 8 of 12 quality enhancement staff–leaving western Kansas without much assistance. In general, the Department was slow to implement this type of assistance, given that the Mental Health Reform Act has been in place for 10 years.

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Question 3: Does the Current System for Funding Mental Health Services Ensure That Money For Services Follows the Clients?

The distribution of grant funding was the key issue in a conflict between two mental health centers in Sedgwick county. *During 1999, a dispute arose between COMCARE (the participating mental health center in Sedgwick County) and the Wichita Child Guidance Center, one of its affiliates. Historically, COMCARE provided most services to adults while the Guidance Center was the primary service provider for children. When mental health reform was passed, Sedgwick County began receiving annual grants that now total about $3.8 million to establish community services for those clients who were at risk of hospitalization. According to the Guidance Center, about a third of this new funding was to be used to establish community services for children. Department officials directed COMCARE to use this new source of funding to develop community services for children in the targeted population. However, the Guidance Center continued to provide services to the majority of children in Sedgwick County–including a significant number of children in the targeted population. The Guidance Center contends it was entitled to a portion of the additional moneys COMCARE was given. This situation is complicated by the fact that the two entities have operated under a 1985 contract that wasn't well-written. Also, one of the original entities that signed the contract no longer exists, and statutes the contract was based on have been repealed.*

. . . page 33

Some community mental health centers have significant cash reserves, while others have little cash on hand to protect them against budget cuts or funding shortfalls. *We compared cash balances at all mental health centers to the United Way's standard for non-profit organizations, which suggests keeping cash equal to at least 3 months of expenditures on hand. In all, 11 centers exceeded that standard, 6 of which had reserves equal to 5 or more months of expenditures. At the other end of the scale were 6 centers whose cash on hand equaled less than one month's expenditures.*

. . . page 37

Kansas could significantly increase the amount of Federal Medicaid funding available for mental health services. *Under the Medicaid program, the federal government pays 60% of the cost of providing eligible mental health services, and the State matches the federal portion with the remaining 40%. The State currently only draws down about $25 million a year in federal Medicaid money, even though it commits enough money to mental health programs to match about $73 million in federal funding. Kansas could bring more federal dollars into its mental health program at relatively little additional cost to the State by raising its Medicaid reimbursement rates. Those rates haven't been raised in years, and are among the lowest of the 50 states.*

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This audit was conducted by Laurel Murdie, Scott Frank, Katrin Osterhaus, and Kate Watson. Leo Hafner was the audit manager. If you need any additional information about the audit's findings, please contact Laurel Murdie at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

Reviewing the Implementation of the Mental Health Reform Act

The 1990 Legislature passed the Mental Health Reform Act. The Act provided for closing some of the State's psychiatric hospital beds in phases and setting up a system of community mental health services for those who needed them. Those community services were intended to help mentally ill persons to function outside of inpatient facilities to the extent of their capabilities. Community mental health services include a wide variety of services. Just a few examples are evaluation and diagnosis, case management, inpatient and outpatient services, prescription management, 24-hour emergency services, assistance in securing employment, housing services, and other support services.

The Secretary of Social and Rehabilitation Services has overall responsibility for developing a State plan to provide mental health services in the community. Individual community mental health centers are responsible for conducting annual needs assessments and providing mental health services (either themselves or through contracts with other service providers) to clients in their service areas.

Recently, legislators raised questions about whether funding for mental health services is following the clients and making its way to the actual providers of services. Specific concerns also have been expressed that in some cases the mental health centers may have a conflict of interest when it comes to providing moneys to contracted providers, and that State funds intended to match federal moneys aren't actually being paid to the service providers. Finally, legislators are interested in knowing whether clients are getting the services they need in the community, and whether the Department has fulfilled its responsibilities related to implementing the Mental Health Reform Act.

This performance audit was approved to answer the following three questions.

1. **Has the Department of Social and Rehabilitation Services fulfilled its statutory duties related to implementing the Mental Health Reform Act?**

2. **Are appropriate services being provided in the community to those in need of mental health services?**

3. **Does the current system for funding mental health services ensure that money for services follows the clients?**

A copy of the scope statement approved by the Legislative Post Audit Committee is contained in Appendix A. For reporting purposes, we changed the order of questions 2 and 3.

To answer these questions, we reviewed statutes, regulations, the community mental health centers' contracts with the Department, and other documents. We also interviewed Department officials, as well as a number of community mental health center executive directors, and officials with the Mental Health Consortium, the Association of Community Mental Health Centers of Kansas, and the Governor's Mental Health Planning Council. In addition, we surveyed all participating community mental health centers, the affiliated mental health centers, and a sample of case managers. We also visited community mental health centers in Hays, Kansas City, Paola, Topeka, and Wichita. At 3 of these, we reviewed a sample of client files to determine whether State hospital screenings were completed, and whether diversion services were initiated. We also reviewed collections policies and practices at 3 centers.

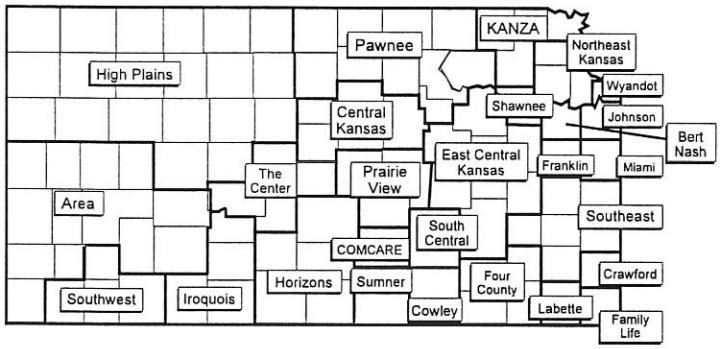
In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office, except that in the time available for this audit we weren't able to verify the accuracy of financial and client data submitted by the mental health centers. Although we have no reason to suspect major inaccuracies in the data, any such inaccuracies could affect information presented in this report about cash balances at mental health centers and amounts of funding received per client. Our findings begin on page 6 after a brief overview of the Mental Health Reform Act.

Overview of the Mental Health Reform Act

In 1990, the Legislature passed the Mental Health Reform Act. The Act was intended to increase community mental health services and decrease the use of State hospital beds by requiring people to be screened before being admitted to a State hospital and by providing funding for community mental health services to reduce the rate of hospitalization. It provided for the phased closing of up to 90 beds each at the Osawatomie, Larned, and Topeka State Hospital. Later, the 1996 Legislature authorized the closure of the Topeka State Hospital.

The system for delivering mental health services currently consists of 27 mental health centers that are designated as "participating" mental health centers by law, and 2 "affiliated" mental health centers. Each of the participating mental health centers operates within the Osawatomie catchment area in eastern Kansas or the Larned catchment area in western Kansas, and each serves an area ranging in size from 1 to 20 counties. The two affiliated mental health centers are located in Shawnee and Sedgwick county. The accompanying map shows the areas served by each of the 27 participating mental health centers.

Service Areas of the 27 Participating Mental Health Centers



Area Mental Health Garden City
Bert Nash Community Mental Health Center, Lawrence
The Center for Counseling and Consultation, Great Bend
Central Kansas Mental Health Center, Salina
COMCARE, Wichita
Community Mental Health Center of Crawford County, Pittsburg
Cowley County Mental Health Center, Arkansas City
Family Consultation Services, Wichita [1]
Family Life Center, Columbus
Family Service & Guidance Center, Topeka [1]
Four County Mental Health Center, Independence
Franklin County Mental Health Center, Ottawa
High Plains Mental Health Center, Hays
Horizons Mental Health Center, Hutchinson
Iroquois Center for Human Development, Greensburg
Johnson County Mental Health Center, Mission
KANZA Mental Health & Guidance Center, Inc., Hiawatha
Labette Center for Mental Health Services, Parsons
Mental Health Center of East Central Kansas, Emporia
Miami County Mental Health Center, Paola
Northeast Kansas MH & Guidance Center, Leavenworth
Pawnee Mental Health Services, Manhattan
Prairie View Inc., Newton
Shawnee Community Mental Health Center, Topeka
South Central Mental Health Center, Eldorado
Southeast Kansas Mental Health Center, Humbolt
Southwest Guidance Center, Liberal
Sumner County Mental Health Center, Wellington
Wyandot Mental Health Center, Inc. Kansas City

[1] These centers are affiliated mental health centers.

The "participating" mental health centers are responsible for making sure that mental health services are available in the areas they serve. These centers also perform a gatekeeping function using specialized staff to "screen"

persons who are at the risk of State hospitalization. The purpose of the screening is to ensure that clients who need hospitalization get it, and those that don't need hospitalization get services in the least restrictive environment. Definitions of the types of services mental health centers provide are in Appendix B. Participating centers are entitled to a variety of State and federal funds, including State Aid, mental health reform grants, and State hospital closure grants. They are also allowed to bill Medicaid for the services that they provide to low income clients who qualify.

The "affiliated" mental health centers are centers that existed at the time the Mental Health Reform Act was passed that weren't designated as participating community mental health centers. They were allowed to retain their community mental health center status as long as they maintain an affiliation agreement with one of the participating mental health centers. Affiliated mental health centers also provide a variety of services to clients in their service area, but aren't responsible for screening clients for admission to State hospitals. They don't receive any direct funding from the State, but are able to bill Medicaid for services to low income clients. Until recently, there was a third affiliated mental health center. However, its affiliation agreement was terminated when it became involved in a dispute with the designated mental health center in Sedgwick county. This dispute is discussed in more detail beginning on page 33 of this report.

The Act gave the Secretary of Social and Rehabilitation Services overall responsibility for developing and monitoring a State plan to provide mental health services in the community. The specific responsibilities of the Secretary are discussed in detail under question 1 of this report. The Secretary has placed responsibility for mental health programs within Mental Health and Substance Abuse Treatment and Recovery, a section within the Department's Division of Health Care Policy. Currently, the Department has 28 employees directly involved in the oversight of mental health and substance abuse programs. During fiscal year 2000 the Department will provide about $65 million in grant funding to the mental health centers. In addition, the Centers are able to access about $25 million in Medicaid funds from the federal government. Other sources of funding for mental health centers include such things

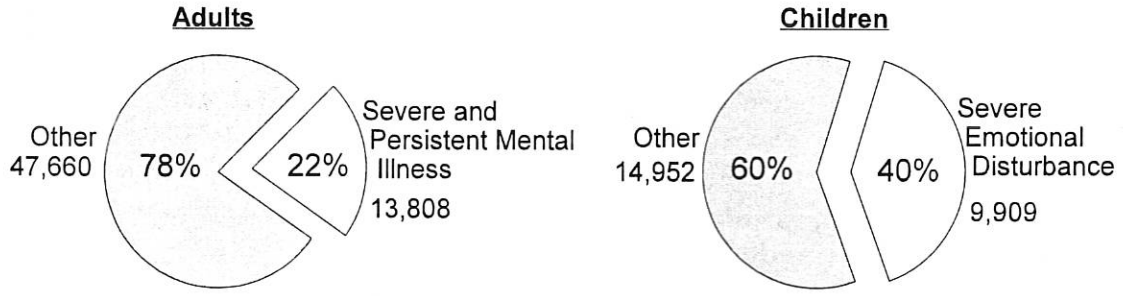
Kansas Spends Less Than Most States to Oversee its Mental Health Programs

A recent study by the National Association of State Mental Health Program Directors Research Institute shows that for fiscal year 1997, Kansas spent an average of 58 cents per capita on administrative expenses for mental health programs. The study ranked Kansas 38th in the nation. The national average was $1.82 per capita. By contrast, Missouri spent $4.13 per capita on administration which ranked 4th in the nation.

as local property taxes, fees charged to private-pay clients, insurance reimbursements, and private donations.

State regulations require mental health centers to provide necessary mental health services to <u>all</u> clients regardless of their ability to pay, but the main emphasis is on the targeted population. The targeted population includes those who are most at risk of being hospitalized–adults with severe and persistent mental illness and children with a severe emotional disturbance. During the past seven years, the number of adults served in the targeted population has nearly doubled from 7,775 to 13,808. The number of children served in the targeted population has increased during that same period from about 6,000 to 9,909. The targeted population represents about one-quarter of the clients served by mental health centers, as shown in the chart below.

Number of Clients Served Statewide
Fiscal Year 1999



Source: LPA analysis based on SRS FY 1999 Implementation Report

The Act also establishes the Governor's Mental Health Planning Council. This Council is composed of 25 members, made up of State agency officials, mental health officials, consumers of mental health services, and family members of clients. More information about the Council and its activities is shown in a profile box on page 10.

Question 1: Has the Department of Social and Rehabilitation Services Fulfilled Its Statutory Duties Relating to Implementing the Mental Health Reform Act?

The Mental Health Reform Act gives the Secretary broad authority and responsibility for providing mental health services for the mentally ill. Overall, the Department has taken actions to implement the requirements of the Act, but it needs to strengthen its oversight in a number of areas. For instance, the Department could improve its planning efforts by developing long-term goals, clearly defining steps to achieve its short-term goals, and conducting a complete annual needs assessment as required by law. In the area of adopting rules, regulations, or standards, the Department hasn't implemented a local and State level appeals process–although required to by law. In addition, the Department doesn't have standardized service definitions, and doesn't hold all mental health centers to the same performance criteria. In the area of assisting communities and mental health centers to provide services to the mentally ill, the Department has hired only 8 of 12 planned quality enhancement staff leaving western Kansas without much assistance. Finally, although the Department has set up systems to monitor and evaluate programs, it doesn't directly monitor whether clients are getting the services they need, and whether those services are cost-effective. These and other findings are described in more detail in the sections that follow.

State Law Gives the Secretary Broad Authority and Responsibility Related to Services for the Mentally Ill

One of the main goals of the Mental Health Reform Act is to reduce the number of people being treated in State psychiatric hospitals, and to provide effective treatment for them in their own communities. To help achieve this goal, the Act spells out 21 specific powers and duties for the Secretary of Social and Rehabilitation Services. We grouped these duties into 5 categories and provided some examples of each in the section below:

- **Planning and Coordinating.** The Department is required to conduct an annual assessment of the needs of Kansans with mental illness, develop a comprehensive plan to meet their needs, provide for the most appropriate services in the least-restrictive manner, and ensure that each mental health center provides specialized programs to care for the people in the "targeted" population, and others who are at-risk of being institutionalized.

- **Establishing Rules, Regulations, and Standards.** The Department is required to adopt rules and regulations to ensure that mentally ill people aren't inappropriately denied services and have access to an appeals process at the State and local level, and to establish standards for community mental health programs and services.

- **Assisting Communities and Mental Health Centers.** The Department is required to provide technical assistance and services to mental health centers or local groups to develop community programs, and to ensure that they are provided in the least-restrictive environment and are of high quality.

- **Monitoring and Evaluating Programs.** The Department is required to evaluate and coordinate all programs, services, and facilities for mentally ill people, and to monitor State-funded programs to ensure that they comply with or meet established standards or outcomes.

- **Funding Services.** The Department is required to establish and implement policies and procedures so that State funds follow people from State facilities into community programs, and for disbursing federal funding.

Overall, the Department Has Taken Actions To Implement the Requirements of the Mental Health Reform Act, But It Needs To Strengthen Its Oversight In a Number of Areas

In each of the five areas noted above, we conducted both a general review of the Department's actions to determine whether it had addressed the requirements in the law, and a more in-depth review of a sample of activities to determine whether they appeared to be appropriate and effective, given the statutory mandate.

In general, we found that the Department has taken steps to address each of the statutory requirements. However, the Department's oversight of mental health services should be strengthened in a number of areas. Here's a summary of our main findings:

- Planning needs to be more long-term oriented, goals need to be prioritized, and the State Plan for mental health services needs to have specific action steps for achieving the stated goals. In addition, the Department didn't do a complete annual needs assessment in 1999 as required by State law.

- Rules, regulations, and standards appear to be fairly comprehensive, except they don't provide for a local and State-level appeals process, and all mental health centers aren't held to the same standards.

- The Department has made reasonable efforts to help local communities and mental health centers establish and provide

services, but it has been slow to do so, and it hasn't yet hired quality enhancement staff to provide such assistance in the western part of the State.

- The Department doesn't have the information needed to effectively monitor and evaluate mental health programs. For example, the Department doesn't directly monitor whether clients are getting the services recommended, and how cost-effective those services are.

These findings are discussed in more detail in the sections that follow. Our findings related to funding issues–the fifth broad area of responsibility for the Department–are discussed in Question 3 of this report.

Findings Related to Planning

We reviewed the State Plan, needs assessments, and other associated documents the Department has prepared for the State's mental health system. These documents contain a lot of good information about mental health services in Kansas.

Based on our review, we think the Department should be commended for a number of things. In particular, we noted that the Department's State Plan identifies specific needs in the mental health system, and establishes specific goals for the system to meet.

We also noted a number of areas where the Department could make improvements in its planning efforts. Our findings are summarized below:

- **The State Plan lacks a long-term view of the State's mental health system and a vision of how it should look in the future.** While it's important to have an annual plan, a system this large and complex also should have long-term goals.

- **The Plan doesn't clearly prioritize the Department's goals or the needs of adults and children served by the State's mental health system.** Such prioritization is important when there are multiple needs and limited funding available. Based on our reading of the Plan, all goals appear to be co-equal, and there's no way to determine which have the highest priority and which would be dropped or postponed should funding not be available.

- **The Plan doesn't provide clearly defined steps that will be taken to achieve its stated goals.** For example, one section of the plan discusses services for certain groups that traditionally lack services, such as the Asian population in southwest Kansas. The Plan states that "planning for improvements in services is supported by outreach programs that identify and offer services to populations that are underserved." But there are no specific steps that would

tell how these services will be provided, such as the creation of specific outreach programs that will serve southwest Kansas or increased staffing or funding in those areas.

- **Some of the measures in the Plan aren't relevant to the goals they're supposed to measure.** For example, one goal is that "individuals in special populations will have access to mental health services that are provided in a manner which preserves human dignity and assures continuity and high quality, cost-effective care." The Department measures this by counting the number of people in rural areas who receive mental health services at a community mental health center–a measure which doesn't address quality or cost-effectiveness.

- **In some cases, the Plan sets goals that appear to call for decreased levels of achievement.** For example, the FY 2000 Plan shows that 7,784 adults in the targeted population in rural areas were served in fiscal year 1998, but the goal for fiscal year 2000 is only 6,655.

- **The required annual needs assessment wasn't completed in 1999, and the 1998 assessment was based on inconsistent and incomplete information.** Department officials told us they didn't do a complete needs assessment for fiscal year 1999 because the centers were too busy working on a new computerized information system. The most recent assessment available is from 1998, and is based on data from calendar year 1997. In addition, the centers hadn't always provided complete information on the Department's survey. For example, only 25 of the (then) 30 centers provided information about what additional resources they needed to serve their clients. Also, some centers didn't quantify the cost of the additional resources they'd need to provide services. Finally, we had a difficult time finding any relationship between the 1998 needs assessment and any additional requests for funding made by the Department.

Findings Related to Adopting Rules, Regulations, and Standards

Generally, the Department has implemented sound rules and regulations to implement the Mental Health Reform Act. Those regulations govern a wide variety of areas, including such things as service delivery standards and protection for clients. In addition, the Department has included performance standards in each mental health center's contract. However, we identified the need for improvement in the following areas:

- **The current regulations don't include an appeals process at the State and local level as required by State law.** The centers we visited had only a complaints process in place. An appeals process at both the local and State level is important for clients who disagree with an action or decision made by the center. The Department is in the process of revising its regulations to allow clients to appeal a center's decision to the Department, but we saw no mention of an appeal process for the local level.

The Governor's Mental Health Services Planning Council Hasn't Been Very Active Because of Low Attendance

The Governor's Mental Health Services Council is composed of 25 members, including nine State agency representatives (including the Commissioner of Mental Health and Developmental Disabilities), one psychiatrist, two directors of community mental health centers, and 13 members from the community, including consumers and family members of adults and children.

By law, the main duties of the Council include to annually monitor, review, and evaluate the allocation and adequacy of mental health services within the State and to report to the Governor and members of the legislature and make recommendations as necessary. Other duties include:

- Perform other reviews and evaluations as requested by the Secretary
- Consult with and advise the Governor periodically about the operations of state hospitals and community mental health centers
- Consult with the Secretary regarding policies about managing and operating State hospitals and community mental health centers
- Serve as an advocate for the targeted population as well as other consumers with mental illness.

By law, the Council is supposed to hold quarterly meetings, but agency and council member officials have stated that that hasn't happened in the past 12 months. In addition, the Council hasn't produced any reports to monitor or review the mental health system, and hasn't made any reports to the Governor or members of the Legislature since 1997. The Chairperson of the Council explained that it's a challenge to produce reports when the Council meets so infrequently and it's very difficult to get all the members from all over the State together for one day.

- **The Department hasn't developed standardized definitions for mental health services.** For example, at one mental health center, crisis stabilization services can be as formal as admission to a local hospital's psychiatric unit, while at another center it could mean only an increase in the client's current services. Having standardized service definitions can help ensure that everyone is talking about the same thing in assessing client needs and identifying gaps in services.

- **The Department hasn't set uniform performance standards for all mental health centers.** By contract, mental health centers are required to achieve certain goals or standards. For example, in exchange for State funding, centers must make sure that a certain percentage of adults in the targeted population are living independently and that they are competitively employed. However, not all centers are required to meet the same percentage goals. Having uniform goals can help ensure that more consistent services are being provided across the State. Department officials told us these goal levels were based largely on each center's historic performance, and that it would be unrealistic to have uniform goals because centers are funded unequally.

- **Some Department performance standards have been set at very low levels.** In addition to performance standards in centers' contracts, the Department tracks performance standards or "indicators" at the State level. For example, one indicator requires that only 60% of adults in the targeted population be involved in their treatment planning. However, State regulations require that all clients be involved in planning their treatment.

Findings Related to Assisting Communities and Mental Health Centers

The Mental Health Reform Act requires that the Department provide consultation and assistance in developing local and area services for the mentally ill. The Department periodically offers training seminars to mental health center staff and others in the mental health community. However, "quality enhancement coordinators," are primarily responsible for providing assistance to mental health centers. In general, these coordinators are

supposed to handle complaints, act as a liaison between the Department and centers, and monitor the centers' performance.

The only weaknesses we identified in this area were:

- **Only 8 of the 12 planned quality enhancement staff have been hired, leaving western Kansas without much assistance.** Department staff told us that some staff assigned to cover eastern Kansas also try to assist centers in western Kansas–but this coverage is inadequate.

- **In general, the Department has been slow to make this type of assistance available to mental health centers.** The Division only started to hire quality enhancement staff less than two years ago, but the Mental Health Reform Act has been in place for 10 years.

Findings Related to Monitoring and Evaluating Programs

The Department does a number of things to monitor and evaluate mental health services and programs, including biannual licensing visits at all mental health centers. During these visits, Department staff review the centers' policies, pull a sample of client files to determine whether assessments and treatment plans are developed timely, and check staffing qualifications. In addition to licensing visits, the Department contracts with the University of Kansas School of Social Welfare to track outcomes for children and adults in the targeted population, and in 1999 the Department also contracted with the University to conduct consumer satisfaction surveys. Finally, as part of its State Plan, the Department tracks State-level performance indicators. In 1999, the Department tracked 23 such indicators. We discuss those indicators in more detail in Question 2, and the Department's outcomes for Fiscal Year 1999 are listed in Appendix C.

In reviewing the work done by the Department in this area, we identified the following weaknesses:

- **The Department doesn't directly monitor whether clients get the recommended services.** Instead, the Department monitors general outcomes for clients in the targeted population–such as whether adult clients are employed and whether they are living independently. Department officials told us that if these outcomes are achieved, then clients are getting the appropriate services. However, that may not always be the case.

- **The Department doesn't determine whether the services actually provided are cost-effective.** Some goals in the Department's State Plan call for centers to provide cost-effective services. The Department doesn't gather information about specific services provided to clients and the cost of those services. Without

such information, the Department can't determine whether the centers are using State moneys in the most cost-effective way.

- **The Department and the mental health centers may be duplicating their efforts in surveying mental health clients about how satisfied they are with the services they receive.** The Department has contracted with the University of Kansas School of Social Welfare to survey a portion of clients in the targeted population. The centers also do a client survey. Both surveys are designed to assess clients' satisfaction with services. Because the Department doesn't review the centers' survey results, there could be duplication of efforts.

- **The Department doesn't monitor the State hospital screening process, and we found that some centers don't use the same criteria to determine when clients should be screened for State Hospitalization.** Mental health centers are responsible for screening individuals to determine whether they need to be hospitalized or can be treated in the community. Although the Department has set basic criteria for when a person should be screened for State hospitalization, it does nothing to determine whether those criteria are followed. The problem is that two clients with identical conditions can seek treatment at different mental health centers, and one may be screened and admitted to a State hospital while the other might not be screened at all. For example, we found that one mental health center generally only does State hospital screenings for people who have had a mental health petition filed with the court system–other mental health centers initiate the screening process with or without a petition.

- **The current definition of the "targeted" population isn't uniformly applied by centers.** Department officials and officials from the Kansas University School of Social Welfare have told us that under the current definitions, some centers may include clients with less severe mental illnesses as being in the targeted population. This would allow those centers to report better outcome averages when compared to centers that apply the definition more strictly. If the Department ever bases funding allocations on performance and outcome measures, it needs to make sure that definitions are applied uniformly across the State. Department officials have told us they are aware of the problem and are working to remedy it. The profile box on the next page shows the current definitions for the targeted population.

Recently, the Department Has Worked With The Mental Health Consortium To Develop a Computer System That Will Provide Some, But Not All, Information Needed To Manage Mental Health Services

As mentioned in previous sections of this Question, there are a number of areas where the Department lacks good information with which to monitor and evaluate mental health services. The Department doesn't have current and accurate client counts, nor information about the services recommended and provided to clients, nor information about the cost of those services. The absence of good information hinders the Department's ability to determine whether clients get services at all, whether clients get

the services they need, whether there are any gaps in services, and whether or not services are provided in a cost-effective manner.

Current Definitions for the Targeted Population

By law, the targeted population includes certain adults and children with mental illness, as well as any person at risk of requiring institutional care for mental illness. The targeted population for adults is defined as adults with severe and persistent mental illness (SPMI). This means adults must meet the following two criteria:

1. Clients must have a severe disability resulting from mental illness evidenced by *either* of the following:
   - having been hospitalized for psychiatric care and treatment previously
   - experiencing at least one episode of disability which requires continuous, structured, supportive residential care, other than in-patient hospitalization, lasting for at least two months
2. Clients must have impaired functioning evidenced by *two* of the following:
   - being unemployed, employed only in a sheltered setting, or having markedly limited work skills and a poor work history
   - requiring public financial assistance for out-of hospital maintenance and being unable to get such assistance without help
   - showing severe inability to establish or maintain a personal social support system
   - needing help in basic living skills
   - exhibiting inappropriate social behavior which results in a demand for intervention by either the mental health or judicial systems

Children in the targeted population include those children or adolescents with severe emotional disabilities or disorders (SED). This means children must meet the following criteria:

1. Children must be under age of 18 (or under the age of 21 having continuously received services prior to turning 18 years of age that need to be continued for maximum therapeutic benefit)
2. Children must have severe behavioral, emotional or social disabilities evidenced by having experienced some of the following:
   - disruptions in academic or developmental progress, or in family or interpersonal relationships to the point that the child has been placed, or is at risk for out-of home placement
   - episodes of behavioral, emotional or social disability
   - behavioral, emotional or social disabilities that cannot be attributed solely to physical sensory or intellectual deficits
   - frequently requires intensive, well coordinated, supportive services developed by an inter-disciplinary team involving mental health professionals.

Recently, Department officials acknowledged the need for this type of information. In the Department's most recent business plan, officials state that the "factors [contributing to uneven services and performance] include a lack of clarity in defining the targeted populations, a lack of financial incentives to improve, and the lack of a database on which to base policy decisions."

Since 1997, the Department has worked with the Mental Health Consortium to develop a computer system that will provide some of the information the Department needs. The Consortium is a not-for-profit organization that serves as a contractual and administrative agent for the community mental health centers.

To date, the Consortium has received several grants totaling about $823,000 to design, and maintain the Automated Information Management System (AIMS). Both Department and Consortium officials told us they expect all mental health centers to be submitting the required data through the new computer system by July 1, 2000.

The table below shows the types of information that currently are unavailable to the Department and indicates whether AIMS will provide that information.

Information the AIMS Computer System Will or Won't Provide

Statistics we expected the Department to have	Will AIMS provide the information?	Limitations
Overall client counts and demographic information	Yes	None
Types of services recommended per client	No	This information is not captured by the AIMS computer system
Types of services provided per client	Partially	Collected for targeted population, not for other clients
Amount of services provided per client	Partially	Collected for targeted population, not for other clients
Service cost per client	No	Most funding is currently not tied to individuals or services and therefore cannot be tracked.
Outcome data for clients	Partially	Only collected for the targeted population with a case manager over length of treatment, not for other clients

Source: Interviews with SRS officials

CONCLUSION

The Department generally has taken actions to implement policies, procedures and programs aimed at implementing the various provisions of the Mental Health Reform Act. However, it needs to look at the mental health system over more than just a one-year horizon and improve its efforts to identify needs, prioritize them, and come up with specific steps to meet the needs of the mentally ill in Kansas. The Department's planning, monitoring, and evaluation of mental health programs have been hampered by a lack of complete and reliable information about what services are being provided, who is getting them, and what those services cost. Without this type of information, the Department can't effectively manage the program to identify who the cost-effective service providers are, develop incentives for mental health centers to be more cost effective, or direct funding

to where it is most needed. Within the past several years the Department has recognized the need for this type of information and has worked with the Mental Health Consortium to develop a new computer information system. Although this system will provide much improved information about mental health services, it still won't capture some critical information such as costs.

RECOMMENDATIONS

1. To improve the overall process of planning for the needs of the mentally ill and to comply with the provisions of the Act, the Department should ensure that mental health centers conduct an annual assessment of needs as required.

2. To improve its annual State Plan for mental health services, the Department should do the following:

   a. prioritize the goals in the Plan so that it's clear which ones are the most critical and which can be postponed in the event of funding shortfalls.

   b. list specific, concrete steps that will be taken to achieve each goal in the Plan.

   c. re-evaluate the target levels for some of the goals to ensure that they are challenging yet achievable.

   d. ensure that the stated standards for measuring achievement of the goals are appropriate to measure whether the stated goal has been accomplished.

3. To ensure that appropriate long-range plans are developed to meet the needs of the mentally ill in Kansas, the Department should work with the Governor's Mental Health Services Planning Council to identify long-term goals and initiatives that should be accomplished in the area of mental health, and develop specific steps and funding plans to meet those goals.

4. To comply with the provisions of K.S.A. 39-1603(r), the Department needs to ensure that an appeals process is established at the State and local level.

5. To help ensure a uniform level of mental health services throughout the State, the Department should:

a. develop uniform definitions for the various types of mental health services.

b. enact uniform performance standards for all mental health centers to meet that are both challenging and achievable.

6. To ensure that mental health centers in western Kansas receive the same level of assistance as centers in eastern Kansas, the Department should take steps to fill the four vacant quality enhancement coordinator positions as soon as possible.

7. To improve the efforts it has made to monitor programs and services for the mentally ill, the Department should:

   a. ensure that mental health centers properly follow the definitions of the target population.

   b. ensure that the data it needs to measure certain outcomes such as the number of clients receiving "State-funded" services, is actually available.

8. To eliminate duplication of cost and effort, the Department should work with the Mental Health Consortium to develop a single customer satisfaction survey that fulfills the needs of both parties.

Question 2: Are Appropriate Services Being Provided in the Community For Those Who Need Mental Health Services?

According to the Department's own data, mental health centers haven't been meeting goals related to providing services to clients. For a sample of clients whose cases we reviewed, qualified mental health professionals conducted the screenings, and the mental health centers generally provided the immediate services needed to prevent hospitalization. However, more than one-third of the case managers we surveyed said their clients weren't getting all the services they need. They cited a lack of certain services–such as respite and attendant care for children and residential programs and transportation services for adults. Most often, they attributed the lack of services to a lack of funding or qualified staff. Mental health center officials cited shortages of some of the same types of services. In addition, satisfaction surveys conducted by the mental health centers show that clients were least satisfied with being able to get help in an emergency at night or on the weekend. Finally, on average nearly two-thirds of the case managers rated the quality of available services as good or very good. These and related findings are discussed in the sections that follow.

Results from the Department's Review of Outcome Measures Indicate That Some Clients May Not Be Getting All the Services They Need

As noted in Question 1, the Department doesn't specifically review case files to determine whether mental health clients get the services they need. Instead, it tracks 23 "performance indicators" to indirectly measure whether clients in the targeted population are getting mental health services from the centers.

We analyzed the Department's reported results for a total of 20 relevant indicators that address such things as whether adults in the targeted population are living independently, and whether children in the targeted population are attending school regularly—outcomes you might expect to occur if people are getting the services they need to function in the community.

Statewide, Department data show that goals for only 12 of 20 performance indicators–or 60%–were met in fiscal year 1999. The goals that were met included such things as reducing clients' average length of stay at State hospitals, and providing case management services to homeless clients.

The goals the Department and the mental health centers missed are listed in the table on the next page. The fact that so many

goals weren't met suggests that clients may not be getting all the services they need.

Performance Indicators Not Met by the Department Or the Mental Health Centers In Fiscal Year 1999

Goals for Performance Indicators FY 1999	Actual Performance
100% of all adults in the targeted population will get case management services	49%
6,655 rural adults in the targeted population will receive State-funded mental health services	4,243
1,100 adults in the targeted population who receive services will get supported employment services	829
960 adults in the targeted population who receive services will get supported housing services	832
58% of the children in the targeted population will receive State-funded services	18%
6,600 rural children in the targeted population will receive State-funded mental health services	3,733
No more than 6% of the people discharged from a State hospital will be readmitted within 30 days	7%
32% of adults in the targeted population will receive State-funded services	27%

Table prepared by LPA, based on information contained in the FY 1999 Block Grant Implementation Report/State Plan. All 23 performance indicators and the outcomes for Fiscal Year 1999 are listed in Appendix C.

For some goals, the Department may have used inaccurate data in calculating its performance, and other goals can't be measured. In looking at the Department's outcomes in more detail, we found the following problems:

- Some outcomes may be based on inaccurate data: We tried to verify the data the Department used to determine that 49% of all adults in the targeted population actually received case management. Our calculations using the more accurate data, showed that only 34% received case management.

- The Department purports to measure some things that cannot be measured accurately with current data. In all, 11 of the 20 performance indicators purport to measure whether clients are receiving "State-funded" services. Officials from mental health centers and Department officials both told us they can't readily identify which clients receive State-funded services. Department officials told us they assume a client is receiving State-funded services if he or she is part of the targeted population.

For a Sample of Clients Whose Cases We Reviewed, the Mental Health Centers Generally Provided the Immediate Services Needed to Prevent Hospitalization

Within the time available for this audit, we couldn't do a comprehensive file review for a broad sample of mental health clients to determine whether mental health centers were providing all the services needed. Instead, we selected a sample of 85 clients who had been screened for possible hospitalization during fiscal year 1999 by 3 different mental health centers. The centers we visited were COMCARE in Wichita, High Plains Mental Health Center in Hays, and Wyandot Mental Health Center in Kansas City.

For these 85 mentally ill clients, we reviewed documentation related to their "screenings." Screenings are face-to-face interviews center staff conduct to help determine whether the clients' needs are severe enough to require State hospitalization, or whether those needs can be effectively met through community-based services. We focused our review on whether those screenings were conducted by qualified people, and on whether those people had accessed and reviewed all relevant information about the client when the screening was being done.

The screenings for our sample clients all had been done by qualified mental health professionals as required, but not by a psychiatrist or someone with a medical background. By law, the credentials for a qualified mental health professional can range from a psychiatrist or psychologist to a licensed specialist social worker, or to a licensed master's level social worker. For the 85 clients in our sample, 37 of their screenings had been conducted by a master's-level social worker, 29 were done by a master's-level psychologist, and 19 were done by a licensed specialist clinical social worker. All the screenings in our sample were completed by only one person, although center officials told us the screeners do seek additional advice when needed.

Compared with 5 other states we contacted (Missouri, Nebraska, Oklahoma, Iowa, and New Hampshire), Kansas seems to use lower-level qualified mental health professionals (for example, social workers instead of psychiatrists) to conduct screenings. In addition, we found that 4 of the 5 states either use a "team" assessment or the client is assessed twice–by different staff.

The screenings for our sample clients appeared to be fairly thorough, but clients and family members may not always know they can disagree or appeal decisions made by mental health center staff. Without witnessing the actual screening, it's difficult to determine how thorough the centers' procedures were, but here's what we were able to tell from the documentation in the clients' files:

- **It appeared that the people doing the screening obtained existing records about the client when those records were available.** In addition, the average recorded time spent interviewing clients was about 2 hours, and all forms generally were completely filled out. The exceptions we noted were one case where the client was involuntarily admitted to a State hospital but the criteria for involuntary admission weren't checked off, and one case where the section of the screening form dealing with the client's support systems (whether he or she has a home, family, friends, etc.) wasn't filled out.

- **None of the files showed evidence that a client or family member had objected to the results of the screening–but that could be because they didn't know they could object.** When we asked several mental health officials whether clients or family members knew they could disagree or "appeal" a screening treatment decision, center officials told us they have a "complaint" procedure in place. However, State law requires an appeals process to be in place at both the local and State level and no such process is in place.

Emergency or crisis services generally were set up for the clients who were diverted from a State hospital, but many clients didn't follow through with appointments. Of the 85 client files we looked at, 43 were admitted to a State hospital and 42 were diverted to services in the community. The types of community services recommended for these 42 clients generally included crisis stabilization services, case management, or outpatient therapy.

When we looked to see whether those services had been provided, we found evidence that 70% of the clients at least started attending the services recommended for them. In those cases where the client hadn't started the services, it usually was because he or she had moved from the area or refused treatment.

More Than One-Third of the Case Managers We Surveyed Said Their Clients Weren't Getting All the Services They Need

We surveyed a sample of 462 mental health case managers from all over the State and received 250 responses, for an overall response rate of 54%. Generally, case managers are assigned to coordinate services for clients during treatment for their mental health problems. In addition, a case manager may help the client find a job or housing, or develop a personal financial budget.

In our survey, we asked case managers about whether their clients were receiving needed services and about the quality and availability of services for children and adults in their areas. Less than two-thirds of those who responded said their clients got all the services they needed, but more than one-third said they didn't.

Case managers noted that a number of services weren't available for adults or children. The table on the next page lists the top five services case managers reported as not being available for children and adult clients.

When case managers gave specific reasons why a particular type of service wasn't available, it usually was because of a lack of funding or qualified staff. Some of their specific comments about shortages of services are provided in the profile box on page 22.

Even in areas where these services were available, clients sometimes couldn't access them immediately. Some case managers reported that clients sometimes had to wait anywhere from 2 weeks to 5 months to get these services. That information also is shown in the accompanying table. Finally, we didn't see any particular patterns to the service shortages (for example shortages of services in rural areas).

Summary of Case Manager's Opinions On Availability of Services

Children's services citing as having a shortage	% case managers citing a shortage (1)	Average length of wait (2)
Respite Care	38%	1 months
Attendant Care	26%	2 months
In-home Family Therapy	22%	24 days
Partial Hospitalization	18%	14 days
Medication Management	17%	1 month

Adult services cited as having a shortage	% case managers citing a shortage (1)	Average length of wait (2)
Residential Programs	40%	3 months
Transportation	34%	not quantified
Respite Care	32%	16 day
Attendant Care	26%	5 months
Medication Management	11%	18 days

Source: LPA survey responses of case managers.

1. These percentages represent only those case managers who responded to this question.
2. This category only includes information from those case managers who chose to quantify the length of wait.

Mental health center officials reported some of the same types of services as not being available. We also surveyed all 27 participating mental health centers and the 2 current mental health center affiliates. All centers returned the surveys. The services they cited most frequently as unavailable included the following:

- attendant care
- respite care
- medication management
- transportation services
- case management
- crisis stabilization

In addition, center officials who offered comments told us that these services are an integral part of helping clients avoid State hospitalization.

Center officials most often blamed low Medicaid reimbursement rates for shortages of a number of services, including psychiatry services, as well as medication management, and respite and attendant care for all clients. We've summarized some of their specific comments about this problem in the profile boxes on the next page. We discuss Medicaid funding and reimbursement rates in more detail in Question 3.

Case Managers Cite a Lack of Funding As One Reason for Shortages of Mental Health Services

Attendant Care
"Many clients in our system could benefit from attendant care. It could keep clients out of hospitals, State hospitals, and nursing homes. Due to lack of funding programs can't take on attendant care without taking a loss."

"Attendant care is a must if our mental health system is to continue with keeping clients out of hospitals (local) or State hospitals. If funding continues to be cut, mental health centers will continue to see increases in hospitalizations and staff turnovers will also increase."

Respite care
"Respite care [is] greatly needed to give consumers' families a break from stressors. It could decrease hospitalizations. Just knowing they could get relief would decrease anxiety."

"Respite care is Wyandotte County's greatest need. Now we have none. The only option is hospitalization which isn't necessarily appropriate. Let's get respite care! Please!"

Transportation
"Most of our clients lack transportation and availability of activities outside their homes. I work in a lot of rural areas where there are not as many services. It is hard to always maintain care because of lack of workers in rural areas. Most of the services we offer are good but there is a lack of staff. The pay is often low compared to other jobs in the area."

"For adults and children transportation is often a real barrier for services."

Residential
"One of the biggest difficulties I have encountered is trying to find a residential program for a consumer who is unable to live alone. It's difficult to find because frankly there are hardly any programs like this in Kansas. On the other hand, Missouri has more than enough residential programs."

"Group home placement locally is severely limited to only State hospital diversions. Dual diagnosis programs for mentally ill and developmentally disabled clients are severely limited, particularly inpatient treatment and residential treatment."

Center Officials Blame Inadequate Medicaid Reimbursement Rates For Shortages of Some Mental Health Services

Psychiatry Services
"We need funding to underwrite care and child psychiatry."

"Length of wait for adults is often 4-8 weeks due to limited funding and poor rates of reimbursement."

"The expense of psychiatry for children and adults is not covered by fees or contracts."

Attendant Care
"Reimbursement rates for this service are so low that we have difficulty recruiting appropriately qualified staff. This appears to be a Statewide problem."

"The reimbursement rates are very low and do not cover the cost of the service when it is billable to Medicaid."

"The reimbursement rate has not been adequate to fund full time positions, we have been reliant on part time contract employees."

"This service is absolutely essential in order to help individuals with serious illness stay out of the hospital. . . We also cannot maintain staff in this service because we can't offer salaries that are demanded in this community. We train staff and they go work for another health care entity that offers a salary that is more."

Case Management
"Reimbursement rate is below expected cost. Uniform delivery across 20 counties is difficult with geographic distance."

"We have no funding to provide case management to our Crisis Stabilization Center - which is essential to follow-up on diversion plans."

Medication Management
"Medication Management continues to always be a high priority. Psychiatry services have to be significantly subsidized by the Center since reimbursement rates do not cover the cost of the service."

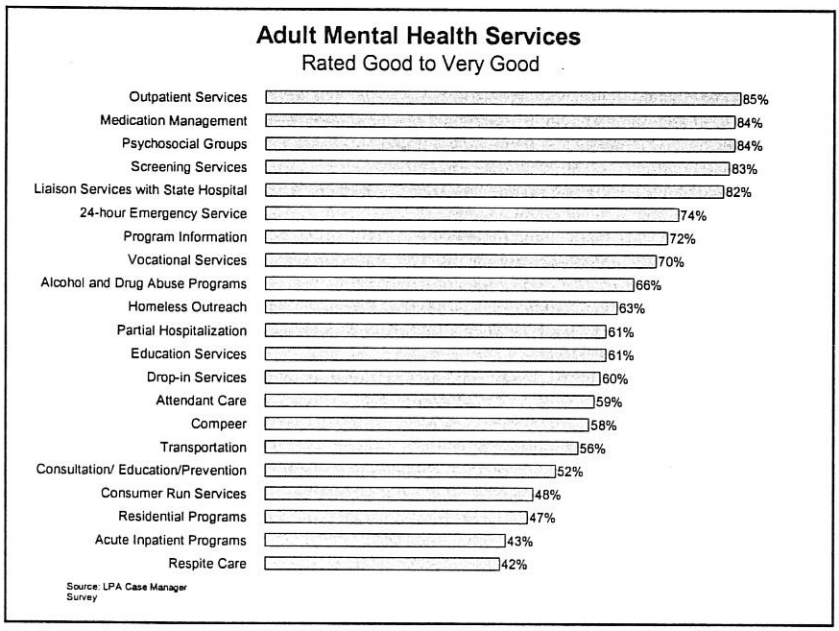
"Current Medicaid reimbursement is too low. Also, with frozen general funds, we are unable to attract enough workers. Medicaid only pays a portion."

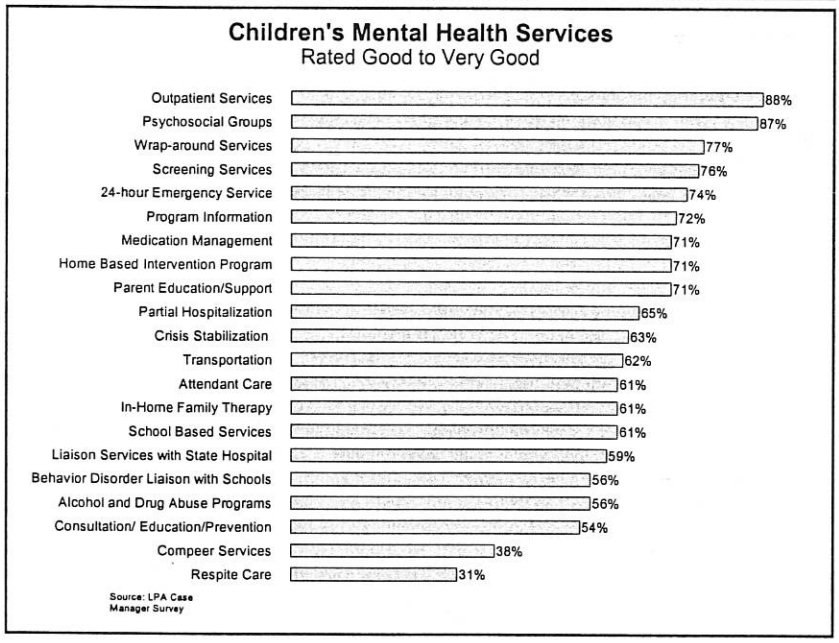
Respite Care
"There is no funding source for this service except through the Medicaid waiver for children in the targeted population. Medicaid and other third party insurance does not reimburse for respite care."

On Average, Nearly Two-Thirds of the Case Managers Rated the Quality of Available Mental Health Services As Good or Very Good

We asked case managers to rate the overall quality of 21 different services for children and adults. On average, 64% of them rated the services as "good" or "very good." The following tables show the percentage of responding case managers who rated children and adult mental health services either good or very good.

As the tables show, outpatient, medication management, psychosocial groups, and screening services for both children and adults were rated as good to very good by 76-88% of responding case managers. However, few case managers rated respite care services good or very good.





Client satisfaction surveys conducted by the mental health centers show clients were least satisfied with being able to get help in an emergency at night or on the weekend, and most satisfied with the professionalism of service providers. State regulations require all mental health centers to have ongoing quality assurance programs that include a method to assess client satisfaction. To do this, the centers have contracted with the Mental Health Consortium to develop and analyze quarterly client satisfaction surveys.

Although these surveys don't ask clients about specific services, they do address general service issues like access and overall client satisfaction. For calendar year 1999, the Consortium analyzed more than 11,700 surveys. One word of caution about these survey results—the choices on the survey are somewhat biased toward positive responses. The survey includes three positive choices and only two negative choices for each question.

The Department just recently contracted with the University of Kansas to conduct its own client satisfaction survey. These surveys are designed to measure consumer satisfaction with services provided by mental health centers. They are targeted to adults with severe and persistent mental illness and children with severe emotional disturbances.

Consumers are asked to respond to questions about their access to services, consumer choices and rights, staff performance, and consumer outcomes. Survey results will be provided to each mental health center, to consumers who participate in the survey, and to the Department.

At the time this report was written, only the results for children's services were available. They showed consumers were most satisfied with family therapy and case management services. However, almost one-fourth of those surveyed weren't satisfied with crisis services, which must be available immediately for clients who need them. This response rate which suggests these respondents didn't receive the crisis services they needed when they needed them.

CONCLUSION

Without access to good information about whether clients are getting the services recommended for them, it's difficult to know for sure whether they are getting the services they need in the community. Based on the Department's performance indicators and on our survey of case managers, it appears Kansas has fallen short of providing the needed services for its mentally ill population. The capacity to provide services such as respite care, attendant care, and transportation will need to be increased Statewide if the needs of the mentally ill are going to be fully met.

RECOMMENDATIONS

1. To ensure that clients aren't inappropriately diverted away from needed services, the Department should ensure that all mental health centers are following the same criteria to decide when and which clients should be screened for possible hospitalization.

2. To ensure that clients are getting the services they need in the community the Department should:

   a. either expand the capability through the AIMS computer system to allow it to gather and compare information about services recommended and received or, on a spot

check basis, review client files to determine whether the clients received the recommended services.

b. as part of a longer-range planning process, develop and fund programs specifically designed to increase the availability of services that case managers and mental health centers have cited as being in short supply such as respite care, attendant care, and transportation.

Question 3: Does the Current System for Funding Mental Health Services Ensure That Money for Services Follows the Clients?

Under mental health reform, State funding for treating the mentally ill has shifted from hospitals to the communities. About one-third of the State and Federal money provided for community services is linked to specific services and does follow the clients. Nearly two-thirds of the money is distributed in the form of grants and isn't necessarily linked to client numbers or needs, which results in an unequal distribution of moneys among mental health centers. Things that have contributed to this unequal distribution of money include the use of historical distribution formulas, failure to consider existing funding streams when adding new funding, and the lack of good information upon which to make effective funding decisions. Some mental health centers have significant cash balances while other have little cash to protect them against budget cuts or funding shortfalls. Funding for the mental health centers could be increased at no cost to the State by raising reimbursement rates to take advantage of federal dollars that are already available. Additional moneys also might be generated if centers strengthened their efforts to collect money from private-pay patients or patients' insurance companies. These and related findings are discussed in more detail in the sections that follow.

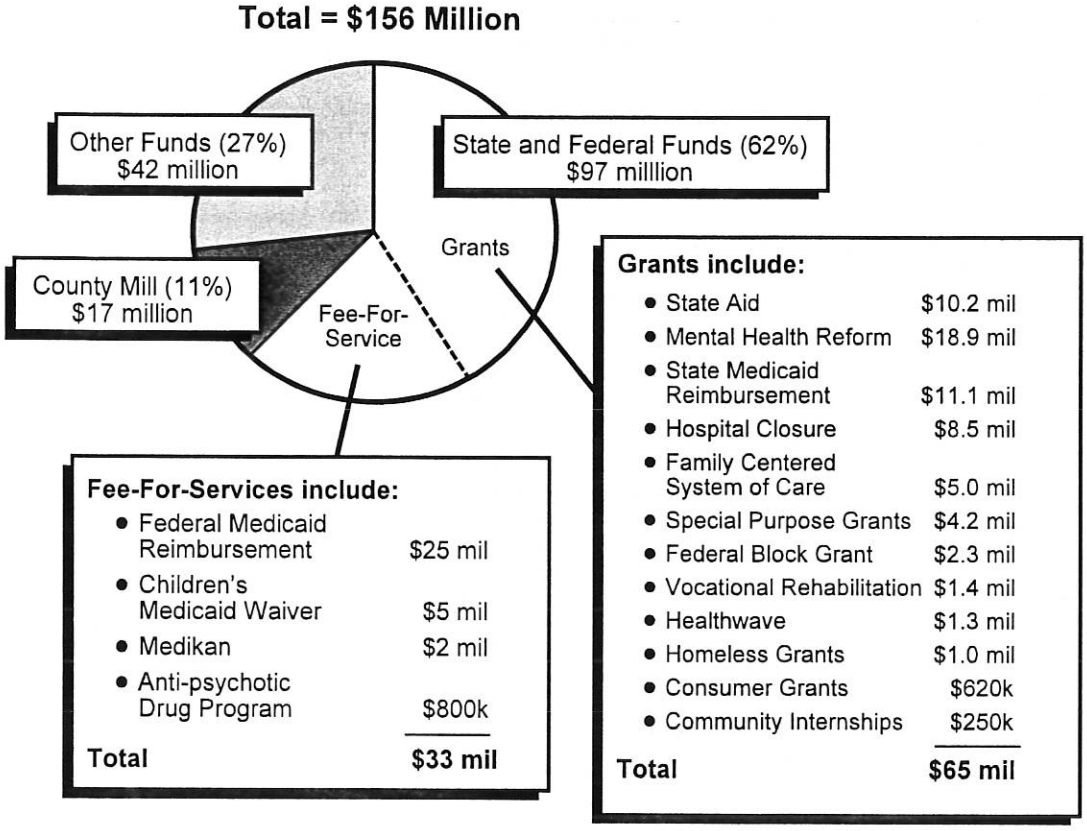
About Two-Thirds of the Funding for Community Mental Health Centers Comes from State and Federal Funds Provided Through the State

As the pie chart on the next page shows, mental health centers receive funds from many sources, including grants from the State and federal government, reimbursements from Medicaid for services provided to clients, local tax revenues, donations, and private fees from clients and private insurers. For fiscal year 2000, mental health centers are projecting that they will receive $156 million in total revenues. The chart shows that about 62% of the total funding the centers will receive is State and federal funding appropriated through the State.

As Called for Under Mental Health Reform, Funding Provided Through the State for Treating the Mentally Ill Has Shifted from State Hospitals to the Communities

When the Legislature passed the Mental Health Reform Act in 1990, the intent was to move moneys away from State mental health hospitals and into communities. Based on the projected spending for fiscal year 2000, State General Fund spending on State hospitals will have declined by $31 million (adjusted for inflation) from fiscal year 1992 to fiscal year 2000. During that same time period, State General Fund spending on community services will have increased by $34 million. This means there has been more than a dollar-for-dollar shift of State funds away from

Total Funding for Community Mental Health Centers In Fiscal Year 2000



Sources: Survey responses from mental health centers, Department reports compiled by Legislative Post Audit.

the State hospitals and into community mental health services. This shift is demonstrated in the graph at the bottom of the following page.

About One-Third of the State and Federal Money Provided for Community Services Is Linked to Specific Services and Directly Follows the Clients

For fiscal year 2000, the State and federal government will spend about $33 million on community mental health services to provide specific services to identifiable clients. By their very nature, all these fee-for-service funds follow the clients. Except for the Anti-Psychotic Drug Program, all these funds are passed on to service providers through the mental health centers. The table at the top of the next page summarizes those funds that can be called fee-for-service.

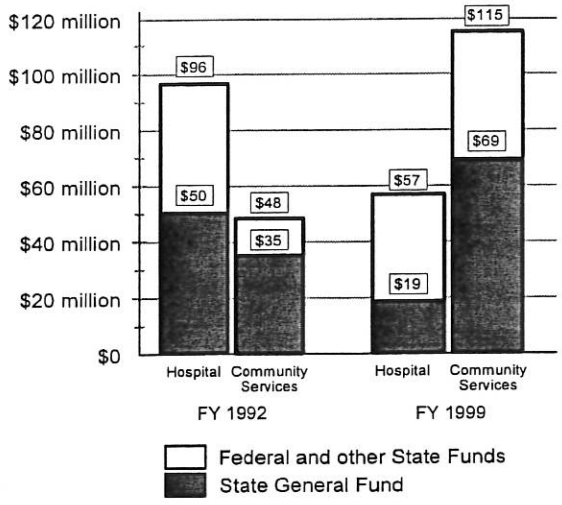
Mental Health Funding That Is Client Specific and Based on a Fee-for-Service

Funding Source	Purpose	FY 2000 Amount
Federal Medicaid Reimbursement	The federal government helps to reimburse health care providers when they serve clients that meet certain income eligibility guidelines. (As we noted earlier, the State's share of Medicaid is paid to mental health centers up-front in the form of grants, rather than on a fee-for-service basis.)	$24.8 million
Medicaid Waiver for Severely Emotionally Disturbed Children	These federal and State funds give the most severely disturbed children access to Medicaid-funded services, regardless of their family's financial standing.	$5.0 million
Medikan	These State funds pay for clients' services while their Medicaid eligibility is being processed.	$2.0 million
Anti-Psychotic Drug Program	State funds under this program help ensure that clients continue to get their prescription drugs after they are released from a State hospital.	$800,000
Total		$33 million

Source: Department reports compiled by Legislative Post Audit.

It's important to note that unlike many programs that receive Medicaid funding, the State's share of Medicaid funding for mental health services isn't paid to the centers on a fee-for-service basis. Rather, it's distributed to the centers, in advance, in the form of quarterly grant payments. This means that centers earn only the federal part of the Medicaid reimbursement when they provide a service.

The Changing Focus of Mental Health Spending
In 1999 Dollars (in millions)



State funds have shifted dollar-for-dollar from State hospitals to community services. From fiscal year 1992 to fiscal year 2000, annual State General Fund spending on State hospitals dropped from $50 million to $19 million, a ***$31 million*** decrease. Annual State General Fund spending on community services increased from $35 million to $69 million, a ***$34 million*** increase.

Source: Budget reports prepared by Legislative Research.

Nearly Two-Thirds of the State and Federal Moneys Provided for Community Services Are Distributed in the Form of Grants That Aren't Necessarily Linked to the Number of Clients or Their Needs

The table below provides more detail on the purposes and amounts of these grants, which will account for about $65 million of the moneys available to fund the mental health centers in fiscal year 2000. In general, these grants are given to community mental health centers to develop and provide needed mental health services in the community. As long as they are used for such general purposes, there are few specific restrictions on how the centers may use them.

Mental Health Funding That is Distributed as Block Grants

Funding Source	Purpose	FY 2000 Amount
State Aid	These funds are given to centers to help them establish a basic level of community mental health services in their areas.	$10.2 million
*Mental Health Reform**	This grant is to build community services that can be used as an alternative to hospitalization.	$18.9 million
*Hospital Closure**	This grant is to expand community services to serve more clients after the Topeka State Hospital was closed.	$8.5 million
*Federal Block Grant**	This helps centers provide special services to the mentally ill.	$ 2.3 million
*Special Purpose Grants**	These are grants the Legislature has awarded over the years for certain services, including case management and community support.	$4.2 million
State Medicaid Reimbursement	The State pays its share of the Medicaid reimbursements to centers in advance in the form of grants.	$11.1 million
Family Centered System of Care	This money comes from the State's tobacco settlement and is targeted for mentally ill children who don't qualify for the children's Medicaid waiver.	$5.0 million
Homeless Grants	There are two grants, one federal and one State, that are used to seek out homeless people who have mental illness and provide them with services.	$1.0 million
Vocational Rehabilitation	These grants are to help mentally ill adults find and maintain employment.	$1.4 million
Community Internships	These internships help some centers attract psychiatrists and provide those doctors with experience in community services.	$250,000
Healthwave	This provides services to low income children that don't qualify for Medicaid.	$1.3 million
Consumer Grants	These aren't given to centers but are used to provide peer support and other consumer run services for the mentally ill.	$620,000
		$65 million

* Included in the Department's consolidated contract with each mental health center.

Source: Department reports compiled by Legislative Post Audit.

Because there are numerous grants with few restrictions, the Department has tried to simplify things by combining about half the grant moneys into a "consolidated" contract with the mental health centers. As a condition of their contracts, centers agree to meet certain general outcomes, such as limiting their use of State hospital beds. In addition, each center undergoes an annual financial-compliance audit. However, these outcomes and audits don't provide information on what specific services were provided to clients, or the cost of those services. We discussed the contract outcomes in more detail in Question 2.

There are some grants that are restricted in the way they may be spent. The vocational rehabilitation, homeless, and Family Centered System of Care grants all must be used to implement the specific proposals for which the grants were awarded. These grants total about $8 million and represent around 12% of all grant funding.

Most mental health centers are sharing State Medicaid matching funds, but they're not required to. As we noted earlier, the State distributes its share of the Medicaid reimbursement to the mental health centers in advance as a grant. When this audit was approved, legislative questions were raised about whether mental health centers were sharing State Medicaid matching funds with their subcontractors who provide Medicaid-covered services. Officials we contacted at the Health Care Financing Administration told us the mental health centers weren't required to share these funds. They said the only requirements the centers must follow are those they write into their contracts with their subcontractors.

We contacted officials at the 13 centers that have subcontractors, to determine how they pay those subcontractors and whether they share the State Medicaid match grants they receive. Here's what we found.

- For 8 centers, the issue of sharing State Medicaid match grants doesn't really apply. Officials in those centers told us they've negotiated separate fees with their subcontractors for the services they provide–and often these fees are much more than the Medicaid reimbursement rate. For example, a center may negotiate with a psychiatrist to work in its clinic 2 days a week for a set fee. In these cases, the mental health center pays the subcontractor the agreed-upon fee, bills Medicaid itself for any eligible services the subcontractor provided, and keeps the federal Medicaid reimbursement to help defray the cost of the service.

- For 5 centers, the issue of sharing State Medicaid match grants does apply because they base the fees they pay their subcontractors on Medicaid rates. Officials at 3 centers told us they

pay their subcontractors the State's full share of the Medicaid match, one center pays its subcontractors for part of the State's share, and one doesn't pay its subcontractors any of the State's share.

The Department's current method of distributing mental health grants results in an unequal distribution of State and federal dollars among the mental health centers in Kansas. To help assess the extent to which grant moneys (both federal and State) were distributed based on client numbers or needs, we performed 3 types of comparisons, as shown in the following table.

Comparison of Grant Funding to Three Measures of Mental Health Center Service Population FY 2000

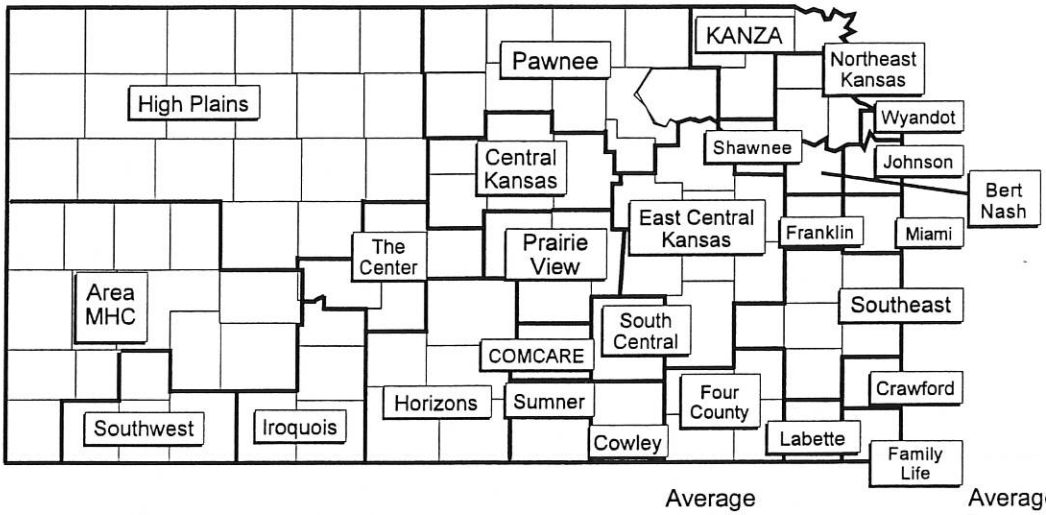
	Grant $$ per person in the general population		Grant $$ per client served in FY 1999		Grant $ per targeted population client served in FY 1999	
High	$52	Iroquois *(Kiowa Co.)*	$1,208	Southwest *(Seward Co.)*	$6,656	South Central *(Butler Co.)*
Low	$12	South Central *(Butler Co.)*	$314	Cowley Co.	$805	Cowley Co.
Average	$24		$719		$2,616	

As the table shows, the amount of grant funding available for people with mental illnesses is unevenly distributed regardless of what measure is used. For example, within the general population, grant funds for mental health services varied from $12 to $52 per person, even though mental health experts told us you'd generally expect to see the same relative percentage of people needing mental health services in all areas of the State. More information is shown for all catchment areas in the chart on the following page.

In reviewing the system for funding mental health services, we identified the following reasons why grant funding isn't distributed according to the number of clients needing to be served:

- **State Aid, the initial form of State funding for community mental health centers, was based on the amount of local money the centers were able to raise each year, rather than on the amount of funding that was actually needed.** The amount of State Aid to be distributed was frozen by State law in 1987, and the distribution has remained unchanged since then. One University of Kansas professor, who has monitored the system for more than 10 years, told us that State aid has laid the foundation for the unequal funding of mental health centers that exists today.

Mental Health Center Funding Compared to Catchment Area Population
Fiscal Year 2000



Catchment Area Served by This Participating Community Mental Health Center	Catchment Area Population[1]	Grant dollars[2]	Average Grant dollars per person	AIII Revenues[3]	Average Revenue dollars per person
Area MHC	104,152	$3,006,485	$29	$5,410,864	$ 52
Bert Nash Community MHC	89,899	$1,820,509	$20	$4,816,291	$ 54
The Ctr for Counseling and Consultation	50,740	$1,560,772	$31	$2,364,043	$ 47
Central Kansas MHC	87,213	$1,574,820	$18	$3,647,296	$ 42
Cowley Co MHC	37,055	$796,815	$22	$2,426,766	$ 65
Community MHC of Crawford Co	36,337	$1,084,060	$30	$4,603,048	$127
Family Life Ctr	22,505	$742,812	$33	$1,844,104	$ 82
Four Co MHC	55,539	$1,711,493	$31	$4,203,824	$ 76
Franklin Co MHC	23,565	$680,556	$29	$1,948,000	$ 83
High Plains MHC	110,719	$3,696,985	$33	$6,438,947	$ 58
Horizons MHC	93,200	$2,468,133	$26	$5,138,000	$ 55
Iroquois Ctr for Human Development	11,496	$593,347	$52	$1,302,266	$113
Johnson Co MHC	408,341	$5,542,748	$14	$16,755,276	$ 41
KANZA MH & Guidance Ctr	41,098	$874,817	$21	$1,860,629	$ 45
Labette Ctr for MH Services	22,869	$784,165	$34	$2,074,609	$ 91
MHC of East Central Kansas	83,833	$1,541,979	$18	$4,065,725	$ 48
Miami Co MHC	25,933	$673,219	$26	$1,551,509	$ 60
Northeast Kansas MH & Guidance Ctr	103,652	$1,735,646	$17	$3,897,157	$ 38
Pawnee MH Services	155,753	$3,438,131	$22	$8,567,948	$ 55
Prairie View	71,748	$1,916,650	$27	$16,306,977	$227
COMCARE	422,437	$9,487,382	$22	$19,835,958	$ 47
Shawnee Community MHC	164,938	$6,483,083	$39	$16,069,809	$ 97
South Central MH Counseling Ctr	59,226	$718,833	$12	$1,358,500	$ 23
Southeast Kansas MHC	67,705	$1,673,933	$25	$3,554,000	$ 52
Southwest Guidance Ctr	33,707	$1,017,455	$30	$1,664,936	$ 49
Sumner Co MHC	26,901	$692,211	$26	$1,700,000	$ 63
Wyandot MHC	153,427	$5,736,111	$37	$12,754,101	$ 83
Total	**2,563,988**	**$62,053,150[4]**	**$24**	**$156,160,583**	**$ 61**

Sources:
1 *Statewide Summary Consumer Status Report: April, May, June 1999,* University of Kansas School of Social Welfare.
2 *Community Mental Health Awards–SFY 2000,* Provided by the Department. Includes: Mental Health Reform, Hospital Closure, Federal Block Grant, and Special Purpose Grants; State Aid distribution reported by the Department.
3 Survey responses from mental health centers.
4 This total doesn't include $2,515,878 in grants that don't go to centers. It also doesn't include $16,745 to the Wichita Child Guidance Center. If these are included, the total is $64,585,773.

- **The use of historical formulas has perpetuated or increased any funding inequities.** Department staff told us that several grants–including State Aid, State grants for mental health reform and hospital closure, and the federal block grant–are based on what each mental health center received the previous year. Thus, any geographic shifts in the distribution of the State's population of mentally ill clients aren't taken into account when those grants are awarded.

- **New sources of funding appear to have been added to the system without taking into consideration the funding that was already in place.** The same University of Kansas professor characterized the funding system as a "patchwork quilt." New sources of funding are added to the mix on top of other sources of funding that weren't distributed based on population or need.

- **Historically, the Department hasn't had the information it needs to make effective funding decisions.** As we noted in Questions 1 and 2, the Department doesn't have current and accurate client counts, or information about the services recommended and provided to clients, or information about the costs of those services. Although the new information system, "AIMS" will provide some of this information, such as overall client counts–it won't provide cost-per-client information. Without this information, the Department can't effectively redistribute grant money to where the greatest needs are.

Finally, we noted that mental health centers that get fewer grant dollars per person don't necessarily have the lowest total funding per person. This is because grant funding is only one of several sources of funding that mental health centers rely upon. For example, in fiscal year 2000, Crawford County will receive about the same amount of grant funding as the average amount received by mental health centers in the State. Yet, it will get more than twice as much total revenue as the average center. That's because Crawford County will get about 4 times as much funding per person from private sources, including private fees, insurance, and donations as the average mental health center.

The Distribution of Grant Funding Was the Key Issue in a Conflict Between Two Mental Health Centers in Sedgwick County

During 1999, a dispute arose between two existing mental health centers about whether one center (the Wichita Child Guidance Center) was entitled to receive a portion of the State grant moneys the other (COMCARE) received. The Guidance Center alleged it was treating two-thirds of the children in Sedgwick County, but was only receiving 4% of the funding for children's services. It has since filed a lawsuit against COMCARE to try to recover some of those moneys. A chronology of the dispute can be found in the profile box on the next page.

In Sedgwick County, COMCARE was the participating mental health center and the Guidance Center was one of its affiliates. Historically, COMCARE provided most services to adults while the Guidance Center was the primary service provider for children. When Mental Health Reform was passed

COMCARE and the Wichita Child Guidance Center Had an Ongoing Dispute Over the Division of State Funds for Mental Health ServicesThat is Now In the Courts

In the Spring and Summer of 1999, COMCARE and the Wichita Child Guidance Center, two licensed mental health centers in Wichita, became involved in a dispute over how State funds for mental health services should be shared. The Guidance Center claimed it was serving two-thirds of the children needing services in Sedgwick County, but was receiving only 4% of the funding. Eventually, COMCARE terminated the Guidance Center's affiliation agreement which caused it to lose its mental health center status. Because of associated funding losses, the Guidance Center stopped services to hundreds of children. It sued COMCARE, and a trial is scheduled for Fall 2000. Here's a chronology of the events:

- **1985–The Sedgwick County Department of Mental Health (now replaced by a new entity known as COMCARE) and the Wichita Guidance Center entered into an affiliation agreement.** The Guidance Center agreed to provide mental health services to all children in exchange for a share of funding.

- **1987–To curb the escalating costs of State Aid, the Legislature froze the amount that each center could receive.** At the time, the Guidance Center was receiving 14% of Sedgwick County's total State Aid, a percent that remained in effect until the termination of the affiliation agreement in 1999.

- **1990–The Legislature passed the Mental Health Reform Act.** COMCARE was made the "participating" mental health center for Sedgwick County and given the new Mental Health Reform grant to develop community services (currently worth $2.3 million). Although the Guidance Center wasn't made a "participating" center, it was allowed to remain a community mental health center because of its affiliation with COMCARE.

- **1991–At the Department's direction, COMCARE created its own internal division to provide comprehensive mental health services for children.** Although the Guidance Center continued to serve most children in the community, COMCARE became the primary service provider for the most severely ill children in Sedgwick County.

- **1997–The State closed Topeka State Hospital.** COMCARE began receiving the closure grant to enhance community services (currently $1.5 million).

- **August 1998–COMCARE asked the Guidance Center to sign an updated affiliation agreement.** COMCARE officials told us the 1985 affiliation agreement had become outdated.

- **November 1998–The Guidance Center proposed a new contract that included provisions for distributing all State funding (including the Mental Health Reform and Closure grants) in a manner more closely related to the number of children that each center served.** The Guidance Center claimed it was serving two-thirds of the children in Sedgwick County, while receiving only 4% of all State funding that went to COMCARE for children's services. This reportedly was creating severe financial problems for the Center. The contract proposal was rejected by COMCARE in February 1999.

- **April 1999–COMCARE notified the Guidance Center that its existing affiliation agreement would be terminated in 90 days, and offered the Guidance Center a new contract.** Negotiations were at a standstill and COMCARE wanted to force the Guidance Center to sign an updated contract.

- **June 1999–COMCARE offered the Guidance Center a 30-day affiliation agreement.**

- **July 1999–The affiliation agreement was terminated.** In accordance with the Mental Health Reform Act, the termination resulted in the Guidance Center losing its mental health center status. This cut off its ability to access both State Aid and Medicaid. It had to downsize its operations and discontinue services to the more than 100 severely ill children it was serving. According to the 15 parents who responded to our survey, at least 8 of these children aren't getting all the services that they were previously receiving through the Guidance Center, and 3 aren't getting any services at all.

- **August 1999–The Guidance Center filed a lawsuit.** It claimed COMCARE owed it money from the Mental Health Reform grants, the Topeka State Hospital Closure grants, and a federal children's services grant because: 1) the 1985 affiliation agreement entitled it to 14% of the funds, 2) by law it was entitled to State funding, and 3) it should get more funding because it was serving more children.

- **November 1999 & January 2000–SRS Audits released two audit reports on COMCARE.** The reports concluded that: 1) COMCARE had complied with its contracts with SRS and the Guidance Center, 2) COMCARE was building up excessive amounts of money in its children's program, and 3) COMCARE owed the State $500,000 in unspent Hospital Closure funds, including $93,000 that had been earmarked for children's services.

and the Topeka State Hospital was closed, Sedgwick County began receiving annual grants that now total about $3.8 million to establish community services for those clients who were at risk of hospitalization. According to Guidance Center officials, about a third of this new funding was for children's services. As the participating mental health center, COMCARE was responsible for these grants.

At the time of mental health reform, Department officials directed COMCARE to use the new sources of funding to develop community services. Under mental health reform, the Department wanted to see children's mental health services built around case-management instead of therapy, as had traditionally been done. Although the Guidance Center was the primary provider of services for children in Sedgwick County, it relied heavily on therapy to serve those children. The Guidance Center wanted to develop the new children's program as part of mental health reform, but Department officials told us at that time it lacked confidence that the Guidance Center would develop the new services around case management. Therefore, the Department instructed COMCARE to develop a new children's program itself.

Under this arrangement, the Guidance Center remained the primary provider of children's services to the general public but COMCARE developed new community services for the most severely emotionally disturbed children–those children in the targeted population. The Guidance Center built its own children's program to serve severely ill children, and ended up treating the majority of the children in Sedgwick County including a significant number children in the targeted population. Because the new State funding was being used by COMCARE to develop its own program, the Guidance Center received only a small share of the State funding.

The conflict between COMCARE and the Guidance Center involves several complicated issues. The two entities continued to operate under a 1985 agreement the Guidance Center signed with the Sedgwick County Department of Mental Health (COMCARE's predecessor) which said:

"In return for providing children's mental health services, etc... Wichita Guidance Center, as a licensed mental health center, will receive funds from the Department utilizing the same formula applied by the State of Kansas for distribution of State Aid to Community Mental Health Centers as defined by K.S.A. 65-4401 et.seq., and accompanying regulations."

We noted several things about this agreement that make it difficult to determine what was expected of each of the parties.

- *The contract never defines the term "funds."* Thus it's unclear exactly which moneys the two parties agreed would be provided to the Guidance Center.

- *One of the original parties to the agreement, the Sedgwick County Department of Mental Health, no longer exists.* When COMCARE came into existence to take its place, it was an entirely new entity. However, the parties never drew up a new agreement regarding which entity would provide which services, and how those services would be funded.

- *The funding formula referenced in the contract was part of a statute that since has been repealed.* The 1987 Legislature repealed K.S.A. 65-4401, which contained the formula for distributing State Aid. It appears that the parties should have redrafted the agreement or provided contract amendments to deal with this change, because it would have had a big impact on how funds were to be provided to the Guidance Center.

- *When mental health reform was passed, the Department of Social and Rehabilitation Services directed COMCARE to change the focus of how children's services were provided in Sedgwick County.* As mentioned above, the Department directed COMCARE to develop its own children's program built around case management. This would have had a major impact on the division of responsibilities between COMCARE and the Guidance Center, but the contract was never amended to reflect this change.

All of these issues made it virtually impossible for us to come to a conclusion about what should have happened in this instance. It's clear that many of these problems could have been avoided if the parties had had a well-written contract and kept it updated. This dispute currently is in litigation and is scheduled for trial in Fall 2000.

Although Shawnee County also has more than one mental health center, it hasn't experienced the same type of conflict as Sedgwick County. Shawnee County also has a participating and an affiliated community mental health center. As with Sedgwick County, the participating center in Shawnee County historically served adults and the affiliated center served children. The key difference between the two counties is that the affiliated center in Shawnee County was allowed to develop the children's

program after mental health reform, whereas the Guidance Center wasn't. As a result, the centers in Shawnee County share the Mental Health Reform and Hospital Closure grants and don't appear to have a conflict. We asked Department officials why the affiliate in Shawnee County was allowed to develop a children's program. They told us they realized the affiliated centers in the 2 counties were handled differently, but couldn't explain why. The differences between participating and affiliated mental health centers is discussed in more detail in the overview on page 3.

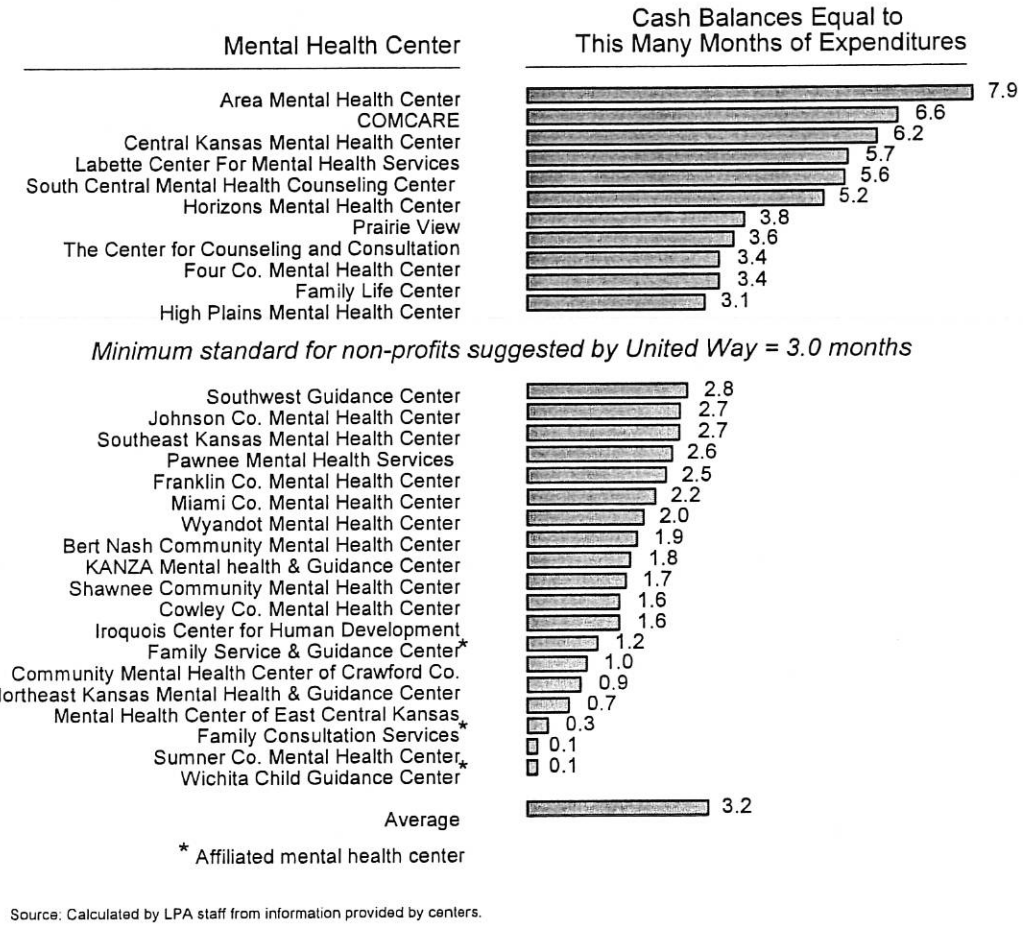
Some Community Mental Health Centers Have Significant Cash Reserves, While Others Have Little Cash On Hand To Protect Them Against Budget Cuts or Funding Shortfalls

To be prudent, mental health centers need to maintain some level of cash reserves. For example, because large chunks of their funding come from quarterly grant payments, centers need to maintain enough cash on hand to pay expenses until they receive the next quarterly payment. Also, it's a normal practice to set aside and restrict funds to replace facilities, computers, vehicles, and the like, as they age or become obsolete. However, if cash balances are excessive, centers may be holding funds that could be used for providing additional mental health services.

To assess whether community mental health centers were building up large cash balances that potentially could be used to provide services to clients, we reviewed each center's monthly cash balances for fiscal year 1999, looking at both restricted and unrestricted balances. For any restrictions the centers claimed that didn't appear to be reasonable or legitimate, we added that cash back in to the unrestricted balances.

For our analysis, we compared the centers' cash balances to the United Way standard for non-profit organizations, which suggests such organizations should keep at least 3 months worth of expenditures on hand. We found that, 11 centers had more than 3 months cash reserve on hand during fiscal year 1999. At least 6 centers had reserves equal to 5 or more months expenditures. A portion of those moneys might be able to be used for services. On the other end of the scale are 6 centers had less than 1 month of cash reserve on hand (of particular concern are two centers that had less than 3 days of reserve). The results for all 30 centers are shown in the chart on the next page. More detailed information about each center's restricted and unrestricted cash balances can be found in Appendix D.

Average Months of Unrestricted Cash Reserves
Fiscal Year 1999



Source: Calculated by LPA staff from information provided by centers.

Kansas Could Significantly Increase the Amount of Federal Medicaid Funding Available for Mental Health Services

As discussed in Question 2, Statewide shortages exist for certain mental health services–many of which are Medicaid-eligible services. One way the State could provide centers with additional funding for those services would be to increase its Medicaid reimbursement rates. Kansas' Medicaid reimbursement rates are reported to be among the lowest of the 50 states, and according to Department officials, rates for some services haven't been raised for decades.

To understand this issue, it's important to know a bit more about the Medicaid Program. Medicaid is a federal/State partnership that helps pay for mental health services for low-income clients. Most adults with severe and persistent mental illness qualify for

Medicaid, as do children who have a Medicaid card. In general, here's how Medicaid works:

- **The State sets the rates it will reimburse service providers for certain types of mental health services, such as therapy or case management.** Those rates can be set at any level, so long as the overall rates for any group of services–such as therapeutic services–don't exceed what the federal government pays for the same service under the Medicare program. If there aren't any applicable Medicare rates, the State can set its rate as high as it chooses. However, it has to be careful so that it doesn't set its rates so high that they bear no relationship to the cost of providing the services.

- **Service providers bill Medicaid, which will pay 60 cents of every dollar billed for eligible services as long as the State is able to provide the other 40 cents.** Mental health centers get the federal money through Medicaid after they provide and bill for the services. On the other hand, the State distributes its share of the reimbursement in advance through quarterly grant payments. For independent service providers (not under contract with the mental health centers) that may provide services to Medicaid patients, Medicaid pays its 60% share and the State must pay its 40% share of the cost directly.

The mental health centers have money that could be used to match the federal share of the cost of Medicaid services, that isn't being fully used. At current Medicaid rates, the mental health centers bill for enough services to "draw down" about $25 million in federal Medicaid funds. That requires the State to put forth matching moneys of about $17 million to cover its 40% share of the cost of those services. The State provides the centers with about $11 million from the State General Fund that's specifically earmarked for Medicaid match. That leaves about $6 million in additional match that needs to be provided by the State. Under the Medicaid program, any non-federal sources of funding can be used to match the federal dollars paid for services, even if those dollars are used for other purposes within the mental health program. As a result, all other sources of State (and some local) funding can be used as match.

For fiscal year 2000, Kansas already has committed to spend nearly $49 million in State moneys for mental health services, all of which could be used to "match" up to $73 million in federal Medicaid funding. That's $48 million more than the $25 million in federal Medicaid moneys the State plans to draw down.

Kansas could draw down more federal Medicaid moneys by increasing the reimbursement rates for eligible mental health services. Although it's unrealistic to think that Kansas could

Examples of How Much Higher Kansas Could Set the Medicaid Reimbursement Rates

Service	Kansas currently allows this charge.[1]	Under federal law, Kansas could allow up to this charge.[2]
Psychiatric Diagnostic Interview	$75.56	$128.30
Medication Management	$29.17	$45.66
Individual Psychotherapy	$60.00	$87.60
Group Psychotherapy	$22.24	$29.35

Sources:
1 Kansas Medicaid Reimbursement Rate, provided by the Department
2 Federal Medicare Rate for Kansas, *Physician Fee Schedule Payment Amount File*, Health Care Financing Association, http://www.hcfa.gov/stats/pufiles.htm#carrpuf

raise reimbursement rates enough to draw down the entire $48 million, if the rates were raised, centers would earn more federal money each time they provided a Medicaid-eligible service. Center officials told us that some rates aren't high enough to cover the costs of providing services The accompanying profiles show examples of how much rates might be able to be raised, and how a center could benefit if rates were raised.

A large increase in the amount of federal Medicaid moneys flowing to mental health centers could mean that significantly more Medicaid-eligible services could be provided to the State's mentally ill indigent population. Although the State wouldn't necessarily need to commit more State funding to the mental health centers if it raised the reimbursement rates, there could be some increase in costs to the State to cover its share of the services provided by mental health professionals who aren't under contract with the mental health centers. However, that cost increase is likely to be relatively small in relation to the amount of federal dollars that potentially could be brought into the system.

What Would Happen if the State Raised its Medicaid Reimbursement Rates?

When a mental health center's psychiatrist spends time providing therapy to Medicaid clients, the center gets to bill Medicaid about **$70 per hour**.

- If a typical psychiatrist provides 1,000 hours of therapy a year, the center will get $70,000 that year through Medicaid. **$42,000** of that money will come from the federal government (it covers 60% of the cost).
- If the reimbursement rate were increased to **$100 per hour**, the federal share of the $100,000 owed to the center would increase to **$60,000** per year, or $18,000 more. The center could use this extra federal money to hire more staff and to provide additional services.

The State's share of the cost for providing services technically would increase as well–from $28,000 to $40,000. However, the State already gives mental health centers extra money that could be used to "match" this federal money. Raising the rates would require only modest additional money from the State, but would provide significantly more federal funds for community services for the mentally ill.

The Department projects that it will pay about $2,650,000 ($2,050,000 from the State General Fund) to these independent providers during fiscal year 2000. Thus a 20% increase in Medicaid rates for all providers would likely cost the State General Fund about another $410,000 for State matching funds to pay independent providers.

The Mental Health Centers Need to Improve Their Procedures for Collecting Moneys Owed To Them By Private-Pay Patients and Insurance Companies

Legislators have raised questions about whether the mental health centers are making reasonable efforts to collect amounts owed to them by private pay patients and insurance companies. We gathered information about amounts owed to each center, how long those amounts had been outstanding, and how much the centers have written off as uncollectible. The table below summarizes that information.

Accounts Receivable Information for 29 Mental Health Centers At the Close of Their Most Recent Fiscal Year

Agency	Accounts Receivable Balance	Amount More Than 180 Days Past Due	Amount Written Off as Bad Debt during the year[1]
Prairie View, Inc.	$ 3,332,612	$ 608,137	$ 376,876
Area Mental Health Center	$ 2,533,911	unknown	$ 99,224
Shawnee Community Mental Health Center	$ 2,356,974	$ 304,339	$ 417,009
Horizons Mental Health Center	$ 1,420,011	$ 843,475	$ 255,741
Bert Nash Community Mental Health Center	$ 1,397,743	$ 250,000	$ 60,482
Southeast Kansas Mental Health Center	$ 1,129,268	$ 682,214	$ 157,282
Four County Mental Health Center	$ 1,102,772	unknown	$ 0
Mental Health Center of East Central Kansas	$ 1,070,590	$ 390,000	$ 150,000
Pawnee Mental Health Services	$ 722,332	$ 309,585	$ 335,660
Johnson County Mental Health Center	$ 571,590	$ 131,756	$ 110,870
Miami County Mental Health Center	$ 536,895	$ 187,875	$ 2,576
Wyandotte Mental Health Center	$ 501,376	$ 150,413	$ 2,188,985
Family Consultation Service	$ 498,796	$ 70,648	unknown
High Plains Mental Health Center	$ 419,194	unknown	$ 85,912
Northeast Kansas Mental Health and Guidance Center	$ 337,754	$ 67,551	$ 51,000
COMCARE of Sedgwick County	$ 302,382	$ 69,548	$ 218,415
Franklin County Mental Health Center	$ 289,435	unknown	$ 590,916
KANZA Mental Health and Guidance Center	$ 284,105	unknown	$ 17,500
Central Kansas Mental Health Center	$ 266,225	$ 0	$ 1,059,969
Labette Center for Mental Health Services	$ 265,393	$ 126,307	$ 14,956
Family Life Center	$ 250,118	$ 29,818	$ 4,345
Cowley County Mental Health and Counseling Center	$ 245,819	$ 29,000	$ 8,000
Family Service and Guidance Center	$ 234,532	unknown	$ 98,681
Iroquois Center for Human Development	$ 196,162	$ 90,888	$ 417,026
Center for Counseling and Consultation	$ 186,986	$ 11,438	$ 32,314
Sumner Mental Health Center	$ 183,431	$ 69,758	$ 17,451
Crawford County Health Department	$ 180,849	unknown	$ 78,933
South Central Mental Health Counseling Center	$ 101,187	$ 91,068	$ 452,786
Southwest Guidance Center	$ 50,432	unknown	$ 9,036
Total	$ 20,968,874	unknown	unknown

[1] Amounts written off as bad debts don't include amounts not billed to clients on sliding fee scale reductions.
Source: Data reported to LPA through survey of mental health centers

To determine whether the centers have developed and are following reasonable collection procedures for past due accounts, we visited three mental health centers (COMCARE, Shawnee County and Miami County). Although each mental health center sends out a monthly statement, we were looking for additional efforts to collect past due amounts. We reviewed their

procedures and examined a sample of 15 past-due accounts at each center, or a total of 45 accounts to determine whether collection procedures were followed. Here's what we found.

- **Two of the 3 centers (Shawnee and Miami County) didn't have any written collection procedures**. COMCARE was the only center we visited that had formalized procedures, which included sending out 30, 60 and 90-day past due letters to clients for overdue accounts. Miami County Mental Health Center officials told us they send a letter to inform clients about past due accounts, but that it was a judgment call for each account as to whether and when a letter was sent. Shawnee County Mental Health Center officials told us that their agency hasn't had written procedures for collection activities for at least 3 years.

- **Mental health center staff hadn't followed their own procedures or taken timely action for 10 of the 16 private-pay accounts we reviewed.** These were amounts owed to the mental health centers by the clients. At COMCARE no 60 or 90-day letters were sent out on 6 past due accounts as required by policy. At Miami County, the past due letter wasn't sent out on 3 accounts and staff told us these letters should have been sent. For one account at Shawnee County, staff couldn't provide any documentation that the client had been contacted within the last 7 months, even though the amount owed by the client dated back to 1997. In addition, of the 16 private pay accounts reviewed, only 9 clients have made any payments since January 1, 1999.

- **Staff were slow in referring accounts to a collection agency.** Two of the 3 mental health centers we visited didn't have policies about when to refer accounts to collection agencies. Of 14 accounts referred to a collection agency, 8 weren't sent until more than 6 months had elapsed from the date the client last submitted any payment. These include 5 accounts from Miami county and 3 accounts from COMCARE. Sending accounts sooner may increase the chances of collection, because the more time that passes, the more likely the clients may have moved or relocated.

- **In a third of the cases where insurance companies were billed for services, center staff didn't follow-up in a timely manner.** Staff had submitted a claim for all 15 accounts reviewed. However, in 5 cases when the insurance company had been slow to pay or respond, there was no record that agency staff had made timely follow-up contact by contacting the company or resubmitting the claim. For example, there was no record of any activity on 2 accounts at Miami County since October 1999. The other 2 centers had similar occurrences.

Agency staff told us that collecting past due amounts from both clients and insurance companies can be difficult. That's because many clients have low incomes along with severe emotional problems. Staff said the agency has little chance of collecting money from clients with low or no income. Further, because of the existing mental problems, these patients may continue to receive services, but aggressive collection efforts aren't taken because they could trigger a worsened state. Agency staff also told us that it can be difficult to get insurance companies to pay for services provided to customers with insurance coverage. Often, agency staff must submit the claim several times and provide additional information to obtain payment. Even then, some services provided, like case management, aren't reimbursed by insurance companies.

The Department Has Acknowledged a Number of Shortcomings In the System for Funding Mental Health Services, And Recently Has Taken Steps to Address Some of Them

In its business plan, the Department states that "the current funding mechanisms distribute funds in a manner that provides significantly more funding in some areas, while significantly less for others, even when size of population and poverty are considered. This contributed to a mental health system with very uneven services and wide variance in performance on outcome measures."

In addition to funding problems, the Department also identified other factors that contribute to uneven services and performance, including the following:

- unclear and inconsistent definitions of the target populations
- the absence of financial incentives for centers to improve
- inadequate data on which to base policy decisions

The Department has held discussions with representatives of the mental health centers to attempt to address some of these issues. The goals of these talks have been to find ways to:

- consistently define which individuals should receive service that are funded by the State
- maximize the amount of Medicaid funding for mental health services, which might include reallocating the funds centers currently receive and increasing the Medicaid reimbursement rates
- find better measures of the performance of centers that could be used with financial incentives to improve their performance

In addition, Department officials told us they will have a task force in place by the end of the 2000 Legislative Session. The purpose of this task force is to review alternative funding mechanisms for mental health centers, with the goal of maximizing federal funds and increasing accountability of current funds.

CONCLUSION

There's no doubt that on an overall basis money has been shifted away from mental hospitals and into community services. However, the system of grants that developed to fund the mental health centers appears to be more focused on perpetuating the status quo than on getting the funding to where the client needs are. The result is a system in which money is unevenly distributed and lacks accountability for what services are provided to clients or the cost-effectiveness of those services. Once again, without good information on what services are being

provided, their cost, and their effectiveness, the Department can't develop a funding system that will is both equitable and encourages centers to provide effective and efficient services. Until such information is available, the best the Department can do to correct the inequities that exist is to look at methods for distributing funds based on population or clients actually served. Also, it will be important for the Department to look at the Medicaid reimbursement rates it has established to make sure that they aren't set so low that they discourage the provision of services and that Kansas maximizes the amount of federal funding it receives under the program.

RECOMMENDATIONS

1. To ensure that it has the information it needs to develop a system of funding mental health services that's both equitable and encourages cost efficiencies, the Department should expand the capability of the AIMS computer system to provide information on the number, cost, and types of services provided to <u>all</u> clients served by mental health centers.

2. Until such time as it has better information available on which to allocate funding to mental health centers, the Department should begin to look at funding formulas based on population, clients served, or other measures that might result in more equitable distribution of the money.

3. To provide reasonable reimbursements to cover the cost of services and to make better use of federal medicaid dollars, the Department should review the Medicaid reimbursement rates for mental health services in Kansas, and raise any rates that are found to be low compared to reported costs or national averages.

4. To ensure that mental health centers make reasonable efforts to collect amounts due from private-pay clients and insurance companies, the Department should place provisions in each center's contract requiring them to develop and follow reasonable collection procedures. Compliance with this requirement should be spot checked during the Department's licensing visits.

5. The Department should direct those 6 mental centers with cash balances exceeding 5 months' worth of expenditures, to review their financial situation and come up with a prudent plan to re-direct some of those moneys into additional services.

APPENDIX A

Scope Statement

This appendix contains the revised scope statement approved by the Legislative Post Audit Committee for this audit on December 15, 1999. For reporting purposes, we changed the order of questions 2 and 3. The audit was requested by Senator Pat Ranson.

APPROVED
SCOPE STATEMENT

Reviewing The Implementation of the Mental Health Reform Act

The 1990 Legislature passed the Mental Health Reform Act. The Act provided for closing some of the State's mental hospitals in phases and setting up a system of community-based mental health services for those who need them. Those community-based services were intended to allow mentally ill persons to function outside of inpatient facilities to the extent of their capabilities. Community-based services include evaluation and diagnosis, case management, inpatient and outpatient services, prescription and management of psychotropic medications, mental illness prevention, education, consultation, treatment and rehabilitation services, 24-hour emergency services, assistance in securing employment, housing services, medical and dental care, and other support services.

The Secretary of Social and Rehabilitation Services has overall responsibility for a State plan to provide mental health services in the community. Individual mental health centers have responsibility for conducting annual needs assessments in their own catchment areas. The mental health centers also are responsible for providing mental health services either themselves or through contracts with other service providers.

Recently, legislators have raised questions about whether funding for mental health services is following the clients and making its way to the actual providers of services. Specific concerns also have been expressed that in some cases the mental health centers may have a conflict of interest when it comes to providing service moneys to contracted providers. Questions also have been raised about whether State funds intended to match federal moneys are actually being paid to the service providers. Finally, legislators are interested in knowing whether clients are getting the services they need in the community and whether the Department has fulfilled its responsibilities related to implementing the Mental Health Reform Act. A performance audit of this area would address the following questions:

1. **Has the Department of Social and Rehabilitation Services fulfilled its statutory duties related to implementing the Mental Health Reform Act?** To answer this question we'd review the provisions of the Mental Health Reform Act to identify the responsibilities assigned to the Department. Through interviews of Department staff, and through reviews of regulations and documents, we'd assess whether the Department has taken reasonable steps to set standards for mental health programs and monitor community-based services. We'd also assess the adequacy of systems the Department has established to account for services and the moneys spent to provide those services. We'd review other records and conduct additional testwork as needed.

2. **Does the current system for funding mental health services ensure that money for services follows the clients?** To answer this question, we'd review the Mental Health Reform Act and information about the funding provided for community mental health services. We'd look specifically at the history of each type of funding and determine what each was intended for. We'd conduct testwork at a sample of mental health centers to determine whether each type of State-appropriated funding was used as intended. We'd also look at the amount of funding they receive from the various sources, and how much of that money flows through to community service providers. In addition, we'd determine the amount of cash reserves the centers have in relation to their cash flows. Through discussions with officials from the Department, mental health centers, and service providers, we'd identify what actual or perceived inequities exist in the way the moneys currently are distributed, and what might be done to correct those inequities. To the extent possible, we'd look at the client service records to determine whether the bulk of the funding was going to where the bulk of the clients are being served. We'd also look specifically at money pledged as State match for federal moneys to ensure that those moneys are being provided to service providers in accordance with any federal requirements. We'd review other records and conduct additional work as needed.

3. **Are appropriate services being provided in the community to those in need of mental health services?** To answer this question, we'd determine the process for assessing the needs of clients who need mental health services. For a sample of clients we'd look at who assessed their needs, and what the qualifications of the members of the assessment team were. If possible, we'd try to determine what information, such as previous medical records or psychiatric recommendations, they had available at the time the needs assessments were made. We'd determine whether the process is designed to solicit input from all parties that may have clinical knowledge about, or an interest in, the individual being assessed. We'd also determine whether there's a reasonable process for appealing the treatment decisions of the assessment team when there is disagreement about the appropriateness of those services. We'd also look at the process for determining eligibility for Medicaid-paid services and what efforts are made to collect from those who should be paying for services. Through interviews or surveys of the Community Mental Health Centers, advocacy groups, service providers, and others, we'd try to determine whether there are shortages or gaps in the types of services (such as emergency beds) that are available in each catchment area, and if so, why. We'd also survey a sample of clients, guardians, and case managers to get their opinions about whether the clients were getting needed services, and whether those services were of good quality. Finally, we'd look at what types of provisions the Department has made to serve clients currently served by the Rainbow Mental Health Facility if that facility is closed as has been proposed. We'd conduct additional work as needed.

Estimated completion time : 10-12 weeks

APPENDIX B

Types of Mental Health Services

This appendix summarizes the general types of mental health services available through community mental health centers. It provides a description of each service, as well as examples as to how that service may look when provided.

Types of Mental Health Services

Type of Service	Description	Examples
Medication Management	This service helps the client maintain stability by monitoring the usage/affects of medication by a physician, psychiatrist, or registered nurse.	Depending on the severity of the client's illness, he or she may be seen anywhere from several times a week to every six weeks or so when their condition is stabilized.
24 Hour Emergency Services	This services provides 24 Hour, 7 days a week, emergency service. Contact is made by calling a 24 Hour hot-line.	Clients or family members may call the hotline. Depending on the nature of the emergency, the answering service staff will contact the police or ambulance for assistance. For clients that are in non-life threatening situations, internal professional staff are contacted to set up appointments.
Case Management	This service includes a case manager who is assigned to a client over the course of their treatment to coordinate services for that individual and help them to develop the skills needed to function in society.	Case managers may help the client achieve specific goals such as finding a job, housing, getting a medical card, devising a financial budget, or just helping clients maneuver through the bureaucracy. Case managers may also help clients develop general social skills in order to maintain themselves in the community.
Respite Care	This service is traditionally provided to families and caretakers of children with severe emotional disturbances. It provides short term and temporary direct care and supervision of the child client.	This service may be provided for families that need relief from the stress of caring for a mentally ill child.
Attendant Care	This service is designed for those clients who may be in transition into or out of the State hospital, or who may be at risk of imminent hospitalization.	Generally, this service includes supervision or one on one support of the client. This service may be provided in any setting appropriate to meet the client's needs (e.g., hospital programs, schools, etc..) to maintain daily routines critical to a stable lifestyle.
Residential Programs	This service is designed to help the client live independently.	This service may include placing clients in a group home, boarding home, or apartment.
Crisis Stabilization	This service is designed to stabilize a client who is at risk of imminent psychiatric hospitalization.	Depending on the needs of the client and severity of the crisis, this may include admitting a client to a local hospital for 24 to 72 hours in order to stabilize the client. Or, it may include providing that client with one on one attendant care in a safe environment in order to de-escalate the crisis.
Partial Hospitalization	This is a service that is provided as a step down from crisis stabilization, and is designed to help the client maximize his or her individual skills. Some mental health centers incorporate psychosocial groups to replace or supplement this service.	Generally, this service provides an ongoing set of group activities to meet the needs of clients by addressing psychological, inter-personal, intra-personal, self-care, and daily living issues.
In-Home Therapy	This service may be individual or family therapy that is provided in the home.	This service may involve treatment of the family as a "system" with the goal to preventing out-of-home placement of a child.
Drop-in Services	This service provides a place for clients to meet for a variety of activities designed to develop living skills and maintain contact with the mental health center.	This service may provide a range of activity including hot lunches, vocational activities, psychosocial group activities, and client family activities.
Psychosocial Groups	This is a group program designed to help clients minimize or resolve the effects of mental illnesses that previously required clinical or hospital services.	Group activities may include those that improve social skills, enhance personal relationships, provide leisure time training, and promote health.

Outpatient Services	This service is includes a variety of programs designed to treat the client according to individual needs on an outpatient basis.	This service may include, individual therapy, group therapy, and case management.
Screening Services	This service is done by a participating mental health center to determine if the individual needs mental health services and, if so, whether or not they can be appropriately treated in the community or whether the client should be admitted to a State hospital.	This service may be done at the local hospital or mental health center.
Liaison Services	This is a service designed to help the client experience a smooth transition after being discharged from the State hospital back into the community.	This service may include either a full or part-time mental health center employee at the State hospital that coordinates community services for discharged clients based on consultation with the client, hospital staff, and mental health center staff.
Consumer Run Services	This is a service designed to help the client develop social, vocational, and personal skills to help them transition back into the community.	This service may include a variety of programs including employing clients to manage a drop-in center, or simply make coffee or meals for the drop-in center.
Acute Inpatient Programs	Similar to crisis stabilization, this is a service designed to stabilize clients who are at risk of being admitted to a State hospital.	This service may include admission to a psychiatric unit at a local hospital.

APPENDIX C

Outcomes for Performance Indicators in Fiscal Year 1999

This appendix contains a listing of all 23 performance indicators that are tracked through various sources by the Department. It shows performance outcomes for fiscal years 1997 and 1999, and whether or not the Department's goals for fiscal year 1999 were met.

	Performance Indicators	FY 97	FY 99	Met Goal?
1	Reduce the average length of stay for adults at SMHH (in days).	84	63	Yes
2	Reduce the average length of stay for children at SMHH (in days).	128	98	Yes
3	No more than 6% of the people discharged from a SMHH will be readmitted within 30 days.	6%	7%	No
4	32% of the adults with SPMI will receive state-funded services.	14%	27%	No
5	50% of all the SPMI adults who receive services will rate their access to those services positively.	*NA	77%	Yes
6	60% of all the SPMI adults who receive services will report they've been involved in their treatment planning.	*NA	73%	Yes
7	100% of all the SPMI adults who receive services will get case management.	45%	49%	No
8	515 homeless adults with SPMI will receive federally-funded case management services.	533	646	Yes
9	6,655 rural adults with SPMI will receive state-funded mental health services.	6125	4243	No
10	1,100 adults with SPMI who receive services will get supported employment services.	732	829	No
11	1,000 adults with SPMI who receive services will be competitively employed.	868	1099	Yes
12	960 adults with SPMI who receive services will get supported housing services.	1071	832	No
13	10% of all the SPMI adults who receive services will report a positive change in their living situations.	23%	13%	Yes
14	80% of all the SPMI adults who receive services will live independently.	80%	83%	Yes
15	58% of the children with a severe emotional disturbance (SED) will receive state-funded services.	15%	18%	No
16	6,600 rural children with SED will receive state-funded mental health services.	5403	3733	No
17	The percentage of children with SED who receive case management and live at home will increase.	78%	84%	Yes
18	The percentage of children with SED who receive case management and are without law enforcement contact will remain the same or increase.	80%	85%	Yes
19	The percentage of children with SED who receive case management and are regularly attending school will increase.	74%	80%	Yes
20	68% of the SED children who receive services will get a "C" or better level score for academic performance.	68%	71%	Yes
21	The percentage of state expenditures for community programs out of the total state mental health services budget will increase.	55%	65%	Yes
22	State mental health expenditures per capita will remain the same or increase.	$63.55	$60.80	No
23	State mental health expenditures per person will remain the same or increase.	$1,618	$1,874	Yes

Table prepared by LPA, based on information contained in the FY 1999 Block Grant Implementation Report

APPENDIX D

Cash Balances for Mental Health Centers as of June 1999

The following appendix lists the cash balances (restricted and unrestricted) for 30 mental health centers, including the 27 participating mental health centers and the 3 affiliated mental health centers as of June 30, 1999. The table also explains the reasons for the restrictions.

Cash Balances of Thirty Community Mental Health Centers as of June 30, 1999				
Mental Health Center	Reported Unrestricted Cash Balances	Reported Restricted Cash Balances	Total Cash-Restricted and Unrestricted	Reported Purpose of Restrictions
Area MHC	$ 3,193,194	$ 245,914	$ 3,439,108	program start-up, vehicle
Bert Nash Community MHC	$ 570,024	$ 1,315,012	$ 1,885,036	asset replacement, contingencies for "at risk" contracts
The Ctr. for Counseling and Consultation	$ 561,863	$ 312,421	$ 874,284	self insurance, vehicle, computer
Central Kansas MHC	$ 1,778,158	$ 264,693	$ 2,042,851	capital acquisition
Cowley Co. MHC	$ 7,245	$ 5,111	$ 12,356	building
Community MHC of Crawford Co.	$ 350,726	$ 114,437	$ 465,163	Kan Focus, debt payment
Family Consultation Services	$ (76,499)	$ 209,399	$ 132,900	depreciation
Family Life Ctr.	$ 456,775	$ 326,342	$ 783,117	building, vehicle, computer
Family Service & Guidance Ctr.	$ 391,962	$ 0	$ 391,962	n/a
Four Co. MHC	$ 1,136,815	$ 1,386,603	$ 2,523,418	building, equipment, vehicle, program start-up
Franklin Co. MHC	$ 341,966	$ 0	$ 341,966	n/a
High Plains MHC	$ 871,585	$ 1,528,306	$ 2,399,891	capital acquisition, self insurance, continuing education
Horizons MHC	$ 1,678,029	$ 0	$ 1,678,029	n/a
Iroquois Ctr. for Human Development	$ 32,239	$ 86,238	$ 118,477	building, special programs
Johnson Co. MHC	$ 2,596,970	$ 0	$ 2,596,970	n/a
KANZA Mental Health & Guidance Ctr.	$ 167,028	$ 25,000	$ 192,028	special purpose donation
Labette Ctr. For Mental Health Services	$ 698,470	$ 777,655	$ 1,476,125	Kan Focus, Healthwave reserve
MHC of East Central Kansas	$ 100,395	$ 474,165	$ 574,560	benefits, computer, building, equipment
Miami Co. MHC	$ 197,957	$ 335	$ 198,292	retirement fund, bond payment
Northeast Kansas Mental Health & Guidance Ctr.	$ 146,433	$ 201,026	$ 347,459	building, bond collateral
Pawnee Mental Health Services	$ 1,460,780	$ 747,748	$ 2,208,528	building, self insurance
Prairie View	$ 4,372,167	$ 4,035,922	$ 8,408,089	bond collateral, building, self insurance, special purpose donations
COMCARE	$ 8,702,812	$ 0	$ 8,702,812	n/a
Shawnee Community MHC	$ 673,668	$ 3,497,254	$ 4,170,922	debt service, private insurance
South Central Mental Health Counseling Ctr.	$ 791,152	$ 275,000	$ 1,066,152	capital improvement, business insurance
Southeast Kansas MHC	$ 773,179	$ 89,745	$ 862,924	held for county coalitions
Southwest Guidance Ctr.	$ 248,723	$ 246,886	$ 495,609	vehicle, capital development, computer, scholarship
Sumner Co. MHC	$ 2,770	$ 20,000	$ 22,770	short term operating loan
Wichita Child Guidance Ctr.	$ 18,987	$ 17,615	$ 36,602	fundraising
Wyandot MHC	$ 1,387,718	$ 0	$ 1,387,718	n/a
Total	$ 33,633,291	$ 16,202,827	$ 49,836,118	

Source: Compiled by LPA staff from data contained in survey responses.

APPENDIX E

Comparison of Lowest and Average Cash Balances
Fiscal Year 1999

The following appendix lists the lowest and average cash balances for all 30 mental health centers, including the 27 participating mental health centers, and the 3 affiliated mental health centers for FY 99. The table also lists how many months each of these cash balances would fund expenses for at each mental health centers.

Comparison of Lowest and Average Cash Balances
Fiscal Year 1999

CMHC	Average monthly expenditures	Lowest cash balance during the year	The lowest cash balance would fund this many month's expenditures	Average monthly cash balance	The average cash balance would fund this many month's expenditures
Area Mental Health Ctr.	$ 423,223	$ 3,080,470	7.3	$ 3,338,951	7.9
Bert Nash Community Mental Health Ctr.	$ 361,225	$ 355,626	1.0	$ 702,901	1.9
The Ctr. for Counseling and Consultation	$ 173,626	$ 312,339	1.8	$ 625,283	3.6
Central Kansas Mental Health Ctr.	$ 316,320	$ 1,778,158	5.6	$ 1,967,199	6.2
Cowley Co. Mental Health Ctr.	$ 167,410	$ 7,245	< 0.1	$ 268,427	1.6
Community Mental Health Ctr. of Crawford Co.	$ 407,295	$ 210,951	0.5	$ 418,431	1.0
Family Consultation Services	$ 135,171	$ (76,499)	< 0	$ 44,828	0.3
Family Life Ctr.	$ 131,898	$ 374,860	2.8	$ 446,167	3.4
Family Service & Guidance Ctr.	$ 366,036	$ 174,373	0.5	$ 444,481	1.2
Four Co. Mental Health Ctr.	$ 330,489	$ 736,389	2.2	$ 1,108,489	3.4
Franklin Co. Mental Health Ctr.	$ 140,778	$ 283,083	2.0	$ 344,949	2.5
High Plains Mental Health Ctr.	$ 518,470	$ 871,585	1.7	$ 1,591,863	3.1
Horizons Mental Health Ctr.	$ 383,266	$ 1,678,029	4.4	$ 1,979,110	5.2
Iroquois Ctr. for Human Development	$ 128,947	$ 32,239	0.3	$ 201,421	1.6
Johnson Co. Mental Health Ctr.	$ 1,272,272	$ 2,596,970	2.0	$ 3,496,138	2.7
KANZA Mental health & Guidance Ctr.	$ 146,665	$ 167,028	1.1	$ 266,988	1.8
Labette Ctr. For Mental Health Services	$ 161,886	$ 698,470	4.3	$ 916,980	5.7
Mental Health Ctr. of East Central Kansas	$ 334,664	$ 45,956	0.1	$ 220,253	0.7
Miami Co. Mental Health Ctr.	$ 114,712	$ 171,776	1.5	$ 253,845	2.2
Northeast Kansas Mental Health & Guidance Ctr.	$ 272,465	$ 43,709	0.2	$ 233,383	0.9
Pawnee Mental Health Services	$ 710,119	$ 1,403,325	2.0	$ 1,811,458	2.6
Prairie View	$ 1,327,357	$ 4,372,167	3.3	$ 5,050,196	3.8
COMCARE	$ 1,316,717	$ 6,485,255	4.9	$ 8,660,595	6.6
Shawnee Community Mental Health Ctr.	$ 866,264	$ 673,668	0.8	$ 1,436,372	1.7
South Central Mental Health Counseling Ctr.	$ 131,282	$ 605,273	4.6	$ 740,467	5.6
Southeast Kansas Mental Health Ctr.	$ 288,364	$ 598,491	2.1	$ 766,321	2.7
Southwest Guidance Ctr.	$ 124,630	$ 246,746	2.0	$ 346,430	2.8
Sumner Co. Mental Health Ctr.	$ 146,786	$ (49,934)	< 0	$ 11,123	0.1
Wichita Child Guidance Ctr.	$ 238,038	$ 1,739	< 0.1	$ 14,890	0.1
Wyandot Mental Health Ctr.	$ 949,865	$ 1,387,718	1.5	$ 1,861,877	2.0

Source: Calculated by LPA staff from data contained in survey responses.

APPENDIX F

Agency Responses

On March 14, 2000, we provided a draft copy of the audit report to the Department of Social and Rehabilitation Services. We also provided relevant sections of the draft report to COMCARE, Shawnee Community Mental Health Center, Miami County Mental Health Center, and the Wichita Child Guidance Center. These were some of the mental health centers where we conducted parts of our audit work. The responses we received from the Department and the mental health centers are included in this appendix. COMCARE and the Guidance Center were the only centers that provided responses. After carefully reviewing all the responses, we made minor changes to clarify or improve the accuracy of various sections of the report. These changes didn't affect our overall findings and conclusions.

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

March 22, 2000

Ms. Barbara J. Hinton, Legislative Post Auditor
Legislative Division of Post Audit
Mercantile Bank Tower, Suite 1200
800 SW Jackson
Topeka, KS 66612-2212

Dear Ms. Hinton:

We have reviewed the draft copy of "Reviewing the Implementation of the Mental Health Reform Act". In general, we found the audit to be a thorough and helpful review of mental health issues, and we agree with many of the findings. We also appreciate the recognition given to steps in place or those planned by the Department, over the course of the next year. There are however, several areas that need clarification, and/or areas of disagreement. Comments are organized in relation to the three questions reviewed in the report.

Question #1: Has the Department of Social and Rehabilitation Services Fulfilled Its Statutory Duties Relating to Implementing the Mental Health Reform Act?

1. Annual Needs Assessment: The report states that the Department did not complete an annual needs assessment in 1999 as required by State law. The Department did complete an annual needs assessment in 1999, although it was a condensed version for reasons cited in the report. Agencies were contacted to determine if needs had changed in the last year, and those agencies reported that they had not. Demographic information and number of people served were updated in the needs assessment, but the actual needs identified the previous year were not revised. As suggested in the recommendations, the Department will ensure that required annual needs assessments are completed.

2. State Plan: The Department agrees that improvements can be made in the State Plan. The recommendations in the report will be incorporated into the next planning cycle. The Department has several clarifications in the area of planning. The report states that no additional funding requests were forwarded to the Legislature to fill gaps identified in the needs assessments. There are many ways that gaps are identified, not by the needs assessment alone. The additional funding request for FY2001 reflected the spending patterns in the Atypical Antipsychotic Medication Program, and the fact that this program was spending on a monthly

basis, nearly twice the budgeted amount. This program has been a high priority due to the significant impact of newer medications on the lives of people with mental illness, and new funding was requested for the program.

The report indicates that the decrease in the projected number of individuals to be served in rural areas is an indication of the need for improvement. Another possibility that the report does not consider, is that the lower number of persons served may simply reflect the general decline in population for certain areas of the state.

3. Governor's Mental Health Planning Council: The Department agrees that meetings of the council have been sporadic recently, and that this has led to a lack of long range planning and community input. For these reasons, staff have worked with the chairperson of the council to review attendance, recruit new members, and make plans for future meetings. The first meeting of the reappointed and new council members occurred on March 21, 2000, with nearly 100% attendance. Several new committees have been formed, and the next meeting will include discussion of an updated report on the service gaps in the mental health system.

4. Appeals Process: The report states that the Department has not implemented a local and state level appeals process, although this is required by law. Current statute does provide for a local grievance and complaint process, and this is reviewed during licensing visits to insure that providers meet this requirement. A state level appeals process is also in place through the Office of Administrative Hearings. We believe that these processes are not easily understood and used by individuals needing mental health services, and need to be refined. We are revising licensing requirements, and this is an area that will be improved. However, we do believe that we currently meet the legal requirements for a local and state level appeals process.

5. Uniform Mental Health Services: The Department believes that it does have uniform service definitions, although the implementation of these services vary according to community need. The example used in the report was "crisis stabilization". We agree that this service looks very different across the state, but believe that this is a positive outcome of local communities determining what works best. Crisis stabilization will most likely look different in Morton County than it does in Shawnee County.

The report states that the Department has not set uniform performance standards for all mental health centers. This is true, and we believe reflects the current reality of our system. In addition to unique community resources and challenges, there are also communities that receive significantly less funding per capita than others. Even if the differences in state funding are addressed, inequities also exist in the level of county support.

We believe that a more individualized approach focusing on performance improvement in each area is preferable to uniform standards that do not take into account variances in community needs. If the standard is set so that each mental health center can meet the same performance

standard, we then actually lower the standard for other communities that are currently performing above the state average. However, the Department does believe that the variance in performance between communities should be addressed, and has sponsored stakeholder meetings to discuss alternative funding strategies that would provide incentives for increased performance.

6. Quality Enhancement Positions: The Department agrees that the functions performed by the Quality Enhancement Coordinators are critical to the mental health system and to individuals in Kansas that need these services. We have made filling these positions a priority for FY2001.

7. Program Monitoring: The Department agrees that the definitions of target populations need updating, and we are in the process of reviewing standards in use by other states in this area. The goal is to have several mental health centers testing a new definition for adults by July 1, 2000. The definition for children will also be reviewed, but is more complex due to the multiple systems involved. The Quality Enhancement Coordinators will audit local agencies once these new definitions are in place, to insure uniform implementation.

As the report states, we are in the process of implementing a new information system that will improve the data available to monitor services. The report also states that the Department does not have current and accurate client counts. SRS does collect information on the number of individuals served each year, both in the target populations and non-target populations. This information is also collected by gender, age, and race. This data is not an unduplicated count, and is collected annually in the needs assessment. While the new data system will significantly improve this process, it is not accurate to say there are no current counts of individuals served. The report also states that the new data system will collect no information on costs. We believe that it will give us the ability to track the amount and type of service provided to individuals in the target population. This will provide some data on cost, although it will not be comprehensive.

The final issue regarding monitoring involves the statement in the report that the Department's performance standards have been set at very low levels. The example compares the licensing standard for treatment planning to the number of individuals satisfied with their involvement in treatment planning, based on a satisfaction survey. One is a licensing requirement and is expected to be documented 100% of the time, or a corrective action plan is required. The other is the individual's perception of their involvement. It would not be accurate to equate these as represented in the report.

Question #2: Are Appropriate Services Being Provided in the Community For Those Who Need Mental Health Services?

1. Hospital Screening: The Department agrees that there should be consistent criteria to determine when individuals are screened for hospitalization. We will review the findings to determine if measures need to be taken to improve this process.

2. Ensure Services Are Received: This finding relates to whether the Department directly monitors if clients get the recommended services. We believe that with the limited resources available for measurement, it is a priority to measure whether people believe they got the help they needed, and in fact whether positive changes happened in their lives. It is important to understand the nature of mental illness, and the quickly changing needs of individuals who suffer from severe mental illness. Treatment plans may change on a daily basis depending on the needs of the person. We believe it is neither efficient nor necessary to spend resources on determining if individuals receive recommended services. We believe it is a much better use of state resources to measure if people believe they got the help they needed, and whether they are working, attending school, and living in their homes rather than in institutions.

The Department agrees that a long-range planning process would include identifying gaps in funding for services. The services identified are a priority, and future funding requests will reflect a focus on these needs.

3. Other Issues Identified: There are also several clarifications we would like to make in the report, that are not related to the recommendations. First, of the performance indicators that were not met, there were clearly several errors in the report used to collect this information. These errors were made on our part, and will be corrected in the state plan for this year. For example, actual performance on the indicator for the number of children in the target population receiving state funded services was 16% and 17% in previous years; in contrast, last year's target was 58%. This target was unrealistic and could not be attained.

In addition, the audit report lists several states with higher qualifications for individuals who assess consumer for hospitalization. This comparison is not very useful, since Kansas is really a leader in the area of hospital screening because we require screening at the community level. Other states mentioned do not have prior approval for state psychiatric hospitalization. These states continue to screen individuals for hospitalization by the admitting hospital psychiatrist. While these individuals do have more training, there is also a financial incentive for the hospital to keep beds full. In addition, whether someone is able to be diverted from hospitalization is much more dependent on available community resources than clinical assessment. Individuals with the most knowledge of these resources are not hospital-based psychiatrists.

Question #3: Does the Current System for Funding Mental Health Services Ensure That Money for Services Follows the Clients?

1. Expansion of AIMS: The Department has discussed some expansion of the new information system called AIMS. However, the priority for expansion will be for targeted populations and individuals using crisis services. These are the individuals that receive the most state funding. This is a long-range goal that will be discussed when the new system is functioning well for the initial population to be covered.

2. Funding Formulas: We agree that revised funding formulas should be explored. This will be done in collaboration with local agencies, and in conjunction with other financial incentives. The goal of more equitable funding needs to be accomplished in a manner that does not decrease services in local communities.

3. Federal Funds: As stated above, the Department agrees that there should be a review of the use of federal funds, and this should be done in conjunction with new funding formulas. These options will be pursued, with careful analysis of any increased state cost involved.

4. Collections: Contract provisions requiring each agency to develop and follow collections procedures will be reviewed during the next contract negotiations. This recommendation would be fairly easy to implement and monitor, and we agree that it would help ensure that reasonable efforts are being made to collect these funds.

5. Cash Balances: The issue of cash balances was presented well in the report, and the Department agrees that there is a great concern about agencies with very low cash balances. We do question the use of a minimum balance based on United Way standards. Most not-for-profit organizations do not have statutory obligations as do local mental health authorities. These organizations can maintain waiting lists, or discontinue services when funds are depleted. These are not options for mental health centers. For this reason, we believe that there should be a range of acceptable cash balances, rather than a specific limit, and that any requirement on cash balances should allow mental health centers to manage finances in order to provide continuous, uninterrupted service.

6. Other Issues Identified: There are several other statements in the audit that we would like to clarify. The SED Waiver was reduced for FY2000, but the base budget for this program remains at $7 million, not $5 million as the report indicates. In addition, the report states that SRS does not monitor the way funds are spent. Actually, SRS does monitor expenditure of these funds, and in fact recoups money every year based on audits of grants and contracts. There is also a requirement of an annual audit that each agency must submit, in addition to random and special purpose audits performed by SRS. While there may be ways to improve this process, we believe that to say SRS does not monitor funds is not accurate.

Finally, on the issue of the provider dispute in Wichita, there are several clarifications. First, Wichita Child Guidance Center was offered a contract agreement that they chose not to sign. This fact is unclear in the report. Also, the statement that the Guidance Center served two-thirds of the children but received 4% of the funding is somewhat misleading. The funds in question were for children with severe emotional disturbance, and the report does not specify what percentage of these children in the target population were served in which agency. In addition, some support services provided through this funding were not required through the Guidance Center, such as 24-hour hospital screening and diversion.

Conclusion

In conclusion, the Department believes that the initiatives outlined in the SRS Business Plan this year address most of the concerns found in the recommendations. We are reviewing the manner in which mental health centers are reimbursed, definitions of target populations, and current funding inequities. There are also processes in place to improve planning through the Governor's Mental Health Planning Council, and to hire the additional Quality Enhancement Coordinators. In general, the recommendations are very consistent with the direction we believe is best for the Kansas mental health system.

Sincerely,

Janet Schalansky

Janet Schalansky, Secretary
Social & Rehabilitation Services

JS:KS

COMCARE

COMPREHENSIVE COMMUNITY CARE OF SEDGWICK COUNTY
OF SEDGWICK COUNTY

635 NORTH MAIN WICHITA, KANSAS 67203 TEL: (316) 383-8251 FAX: (316) 383-7925
24-HOUR CRISIS SERVICE: (316) 263-3770

Deborah J. Donaldson, LMLP, MBA
EXECUTIVE DIRECTOR

March 22, 2000

Barbara J. Hinton
Legislative Post Auditor
Legislative Division of Post Audit
Mercantile Bank Tower
800 Southwest Jackson St., Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

We appreciated the opportunity to review the sections on the dispute between COMCARE and the Wichita Child Guidance Center (WCGC) and the section on collection procedure and practices. There were some areas we had concerns about:

1. The WCGC's claim that it only received 4% of all state funding is inaccurate. It is a very misleading figure. The WCGC received over $1 million in funding, either through access to funding due to the affiliation or through contracts.

2. Throughout the sections relative to the COMCARE/WCGC dispute, there are references to funding COMCARE receives. However, the report does not clarify that a <u>third</u> of the state funds received by COMCARE are contracted to other community providers.

3. The 1985 affiliation agreement with the WCGC was not only "outdated,"

but had provisions that would have resulted in extreme hardship for the WCGC if they had been enforced. Further, COMCARE was not a party to the 1985 agreement and the validity of the old agreement is questionable. COMCARE proposed, either verbally or in writing, no less than four agreements that would have allowed WCGC to retain its affiliate status prior to the termination of the agreement. All four offers were rejected.

4. The Topeka State Hospital (TSH) Closure grants referred to were new funds in 1997. This resulted in new and expanded programs with six months to spend the funds. The State provided separate startup funds so the TSH funds were not needed for this purpose. It should have been expected that all funds would not be spent.

5. We are very concerned about the implication that three children with SED were not receiving needed services. It is of grave concern to us that they have not been brought to our attention so services could be provided. WCGC had an obligation to provide these services or refer the clients to COMCARE.

6. The text in the profile box on page 34 and at the bottom of page 35 implies that COMCARE still receives individual grants for mental health reform and hospital closure. That is incorrect. For at least the past three years our annual participating mental health center contract has provided a single amount of money with which we are to provide (either directly or by contracting with others) all necessary services in our catchment area. The State obtains the funding from a variety of state and federal sources, but those sources have no distinct identity when the State combines them to provide our funding. Thus, there is not a specific amount of money the State expects us to use in providing services to children rather than adults, or to a particular targeted group of children rather than the general population.

7. An objective summation of the SRS audits of COMCARE would not

merely state the conclusion of SRS that "COMCARE was building up excessive amounts of money in its children's program;" it would note our response which was attached to the SRS report. That response was in essence, that no amounts of money "belong" to the children's program because under COMCARE's contracts with SRS the allocation of money among programs is purely a matter of local discretion based solely on our assessment of needs.

8. The accounts receivable issue continues to be one with which COMCARE struggles. We believe collection of bills is appropriate and important, but must be individualized. Actions which result in a consumer deciding not to receive needed services can result in hospitalization, which is currently more expensive than the usually minimal fee collected.

Thank you for your consideration.

Sincerely,

Deborah J. Donaldson

Deborah J. Donaldson, LMLP, MBA
Executive Director

DJD:bs

WICHITA CHILD GUIDANCE CENTER

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March 16, 2000

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Attention: Barbara J. Hinton

Re: Audit Report (Report) of SRS
Concerning portion relating to COMCARE and Guidance Center

Dear Barbara:

We have made suggested changes in facts and format by phone this morning. This response goes to the substance of the Report and we understand it will be attached to the Report.

1. **Community Mental Health Center**: It is important, particularly in Sedgwick County, to understand that community mental health centers have much in common. Your Report describes the distinction between **participating** and **nonparticipating** community mental health centers and may not sufficiently show what they hold in common. Here is what they have in common:

   A. The obligation to serve children regardless of their ability to pay.

   B. The obligation to evaluate the child, by a qualified mental health professional, to determine the appropriate services needed.

   C. Both are to report to the SRS for the work performed. These combined reports became the justification for the money sent to Sedgwick County for children's mental health.

   What COMCARE and the Guidance Center did not have in common is also worth noting:

   A. COMCARE was entrusted, by the Secretary of SRS with **all** of the State grant money to be used for children in Sedgwick County who were identified as meeting the criteria of the **target population.**

Licensed Community Mental Health Center
Affiliated with COMCARE of Sedgwick County

B. **Only** COMCARE was the gatekeeper for children going into or coming out of State psychiatric hospitals. The cost of this gatekeeper function is relatively small.

2. **Target population**: This refers to children with a severe emotional disturbance (SED). The State has developed a set of criteria that have to be present in order for the child to be identified as SED. An evaluation by a qualified mental health provider is required to determine if a child is SED. Some SED children need non-traditional (Community Based) services but most need some traditional services, such as outpatient therapy and medication management. Whether community based services are needed often depends on the family support system.

   When mental health reform was first implemented, many children were in psychiatric hospitals, and therefore COMCARE defined their responsibility as primarily serving the children who were in a hospital or at risk of entering a hospital. As more services became available in the community, fewer children were at risk of entering a hospital but they still met the criteria of SED.

3. **The work performed**: The Guidance Center has been the largest provider of mental health services to the targeted population over the past 10 years. The Report states that in 1990 the SRS questioned whether the Guidance Center would or could address the mental health needs of the targeted children as justification for COMCARE getting into this area. The Report should also state that SRS has always encouraged the Guidance Center to continue its work with SED children, including therapy and community based services. There may have been doubts in 1990, but history has shown which Agency has provided most of the services that were to be funded by the State grant dollars.

4. **The cost expended**: The Guidance Center is much more efficient in collecting reimbursement, for its services from third parties, including Medicaid. Regardless of the grouping used, the cost expended by COMCARE per child is roughly twice as much as the cost expended by the Guidance Center. This has never been placed in serious dispute, but these facts are not noted in the Report. We believe that the Legislature intended the money be used efficiently. It should be noted that the SRS Audit in November of 1999 found that COMCARE was not able to adequately trace its revenues with its expenditures.

Are the State grant dollars intended for targeted children being appropriately and wisely spent in Sedgwick County? No, they are not. Up until recently, there has been little accountability by COMCARE for these grants. SRS is demanding funds back from COMCARE for its mismanagement of the entrusted funds.

5. **Victims**: The notion of privatization, choice, and competition has been undermined by COMCARE because of its unwillingness to fairly allocate the State grant resources entrusted to it. One victim of this mismanagement is the Guidance Center. The real victims are the children who have not been served when the resources have been there to serve them.

The portion of the Report given us to review does not suggest solutions to the problems raised. We believe that the Legislature has every right to expect:

A. That the entrusted State grant dollars follow the child. This would require equity in allocation where there is more than one community mental health center in a service delivery area.

B. That the Secretary be mandated to see that all targeted children in the service delivery area receive the services in the most cost effective way possible.

C. That privatization, choice, and competition be encouraged in the provision of mental health services to children.

We do appreciate the opportunity to offer our comments and the responsiveness of the auditors in developing the draft Report.

Respectively Submitted,

John Roper
Board Chair