Approved: May 1, 2002
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 11:55 a.m. on February 27, 2002 in Room 123-S of the Capitol.

All members were present except: Senator David Adkins - excused

Committee staff present:
Alan Conroy, Chief Fiscal Analyst, Kansas Legislative Research Department
Deb Hollon, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Becky Krahl, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Robert Waller, Kansas Legislative Research Department
Michael Corrigan, Assistant Revisor of Statutes
Judy Bromich, Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Laura Howard, Assistant Secretary, Health Care Policy, Department of Social and Rehabilitation Services
Jim Karlan, Executive Director, Southwest Guidance Center, Inc., Liberal, KS
Dwight Young, Executive Director, The Center for Counseling and Consultation, Great Bend, KS
Elizabeth Adams, Executive Director, NAMI Kansas
Pete Zevenbergen, Executive Director, Wyandot Center for Community Behavioral Healthcare
Diane Drake, Executive Director, Franklin County Mental Health Center

Others attending: See attached list

Chairman Morris called the Committee's attention to discussion of:

SB 508--Emergency medical services board, financial support, authorizing certain transfers

Staff distributed a copy of a chart, State Fire Marshal Fee Fund (Attachment 1). Committee questions and discussion followed on the bill.

Senator Jackson moved, with a second by Senator Schodorf, to amend **SB 508** to repeal the requirement that the 20 percent of Fire Marshall Fee Fund receipts be remitted to the State General Fund. Motion carried on a voice vote.

Senator Schodorf moved, with a second by Senator Salmans, to recommend **Substitute for SB 508** favorably for passage as amended. Motion carried on a roll call vote.

Chairman Morris continued the meeting with a discussion of the Department of Social and Rehabilitation Services Mental Health 2000 Initiative:

Laura Howard, Assistant Secretary, Health Care Policy, Department of Social and Rehabilitation Services, briefed the Committee on the implementation of the initiative and issues regarding financing and delivery of mental health services (Attachment 2). She mentioned that the goals of the initiative are to increase accountability in the public mental health system, increase timely access to services and fill gaps in crisis services available in local communities. Ms. Howard also explained mid-course adjustments to the Mental Health Initiative 2000 and the impact of the Mental Health Initiative 2000 on Medicaid caseloads.

James Karlan, Executive Director, Southwest Guidance Center, Inc., spoke briefly about mental health reform (Attachment 3). Mr. Karlan expressed concern about the issues of redistribution and the placing of

community mental health centers in the State's consensus pool. He also noted that placing the community mental health centers in the consensus estimating pool will cost the State more money for the same amount of services the community mental health centers are currently delivering under the Certified Match Plan.

Dwight Young, Executive Director, The Center for Counseling and Consultation, expressed concern that the advantage of Certified Match to the State is that the State General Fund commitment can be negotiated and capped each year, instead of the open ended "entitlement" of the Consensus Estimating Pool (Attachment 4). He mentioned that continuing the current funding mechanism and delaying the implementation of the Department of Social and Rehabilitation Services proposed plan would be a wise alternative.

Elizabeth Adams, Executive Director, NAMI Kansas, requested further study of the Initiative before action is taken to potentially undermine or irrevocably harm the mental health system or any individual it serves (Attachment 5). She noted that NAMI Kansas requests a Task Force that would incorporate affected and involved stakeholders to carefully plan the implementation and definite service outcomes for Mental Health Initiative 2000.

Pete Zevenbergen, Executive Director, Wyandot Center for Community Behavioral Healthcare, moved to Kansas from another state which was different in the way mental health services are funded than in Kansas and where everything was fee for service. Mr. Zevenbergen noted that Wyandot Center, in this proposed Initiative, stands to lose considerable dollars in current funding which raises concern with him. He did note that the more he looked for opportunities in the plan, the more he realized that his consumers could benefit significantly. Mr. Zevenbergen mentioned that the bottom line for his community is that when he looked at the proposed Initiative, he looked at it as an opportunity to better provide services to consumers in his community. (No written testimony was submitted.)

Diane Drake, Executive Director, Franklin County Mental Health Clinic, mentioned that she represents a small rural community mental health center of the Osawatomie State Hospital Catchment area (Attachment 6). Ms. Drake mentioned in her testimony that her center compromises despite its growing dependence on Medicaid. She noted that since she believes that the legislature is not in the position to come up with new dollars to expand certified match, she supports options examined by the Department of Social and Rehabilitation Services.

Chairman Morris thanked those who participated in the discussion. Senator Huelskamp requested information regarding variability on county mill levies in the various areas.

The meeting was adjourned at 1:20 p.m. The next meeting is scheduled for February 28, 2002.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE February 27, 2002

NAME	REPRESENTING
Mike Hutton	Ks. Govt Consulting
Dwight Young	The Center - Great Bend
Bill Persinger	KANZA Mental Health Center
Pat Roach Smith	Bert Nash Center
Diane Zook Duncan	Franklin Co Mental Health Clinic
Pete Zevenbergen	Wyandot Center - KCK
DAVID LAKE	Ks. Bd. of EMS
JAMES KARLAN	SOUTHWEST GUIDANCE CENTER.
Mary E Mulryan	Bd of EMS
Pat Lehnherr	KS Fire Services Alliance
Tim Shallenberger	Horizons Mental Health Center
Sheldon Carpenter	Trosper's Center
Shannon Jones	SLCK
Jay Arnold	Coalition For Independence
Michele Hayden	KAPS
Kirk Lowry	TILRC
Jean Krahn	KCIL
Carolyn Middendorf	Ks St Ds Assn
Steve Solomon	The Farm, Inc.
Tom Clary	The Consortium Inc.
Marty Kennedy	The Consortium
Dan Hermes	CMHC Alliance

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE February 27, 2002

NAME	REPRESENTING
Mike Hammond	Assoc. of CMHCs
Richard Miller	High Plains Mental Health Ctr.
Kermit George	High Plains MHC
Brenda Mills	Family Service & Guidance Center
Mike Heacon	Breakthrough House
Elena Nuss	KSFMO
Susan Adams	Keys for Networking, Inc.
Gale Haag	State Fire Marshal
Elizabeth Adams	NAMI Kansas/I Vote. I Count!
Amy Campbell	KMHC
Julia Thomas	DOB
Duane Goossen	DOB
Scott Brunner	DOB

State Fire Marshal's Office (SFM)

Fire Marshal Fee Fund

Transfer of $416,782

Transfer of $750,000 in FY 02 & 03

Hazardous Materials Program

3.0. FTE positions

Created by the 1999 Legislature

The Hazardous Material Response Program was created to insure all hazardous material spills, fires or explosions are handled quickly and safely with minimal exposure to Kansans and minimal threat to lives and property. This is accomplished by providing regional responders with the training and expertise to mitigate the effects of and respond quickly to hazardous material incidents

Hazardous Materials Emergency Fund

Created by the 2001 Legislature

Established a Hazardous Materials Emergency Fund to assist in the financing of hazardous materials incidents. The funding would be used to reimburse local entities for equipment utilized in the event that they are approved to respond to an emergency incident under the authority of the State Fire Marshal. The Fire Marshal is authorized to expend only up to $25,000 per incident without State Finance Council approval.

Kansas Department of Social and Rehabilitation Services

Janet Schalansky, Secretary

Docking State Office Building
915 SW Harrison, 6th Floor North
Topeka, Kansas 66612-1570

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Senate Ways and Means Committee
February 27, 2002

Discussion on SRS Mental Health 2000 Initiative

Health Care Policy
Laura Howard, Assistant Secretary
785.296.3773

Senate Ways and Means
2-27-02
Attachment 2

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means Committee
February 27, 2002

Discussion on Mental Health Initiative 2000

Mr. Chairman and members of the Committee, thank you for the opportunity to appear today to brief you on the implementation of Mental Health Initiative 2000, and issues regarding financing and delivery of mental health services. You first heard about Mental Health Initiative 2000 last year, when Governor Graves recommended and you approved this initiative. The goals of this initiative are to increase accountability in the public mental health system, increase timely access to services, and fill gaps in crisis services available in local communities.

History of Mental Health Initiative 2000

Several factors have pointed to a need for SRS to review the financing and delivery of mental health services. Two years ago, this committee reviewed a March 2000 Legislative Post Audit Report *Reviewing the Implementation of the Mental Health Reform Act.* The report documented a lack of supports and gaps in services for people with serious mental illnesses, identified serious delays in access to services, highlighted several concerns about how mental health services are financed and made a number of recommendations. The specific conclusions and recommendations are highlighted below:

- The report found that nearly 2/3 of state and federal moneys provided to CMHCs for community services are distributed in the form of block grants that aren't linked to the number of clients served or their needs. Only 1/3 is linked to specific services and directly follows the client.

- The method of distributing mental health grants results in an unequal distribution of grant dollars among the mental health centers in Kansas. For example, within the general population, the report found that grant funds for mental health services varied from $12 to $52 per person in the general population, although one would generally expect to see the same relative percentage of people needing mental health services in all areas of the state. Similar disparities were identified in the grant dollars per client served, and in the grant dollars per targeted population served.

- The report found that Kansas could significantly increase the amount of federal Medicaid funding available for mental health services. The report noted that the state was drawing down only about $25 million a year in federal funds, but had sufficient unmatched state funding committed to mental health programs to pull down as much as $73 million in federal

funds. The report noted that Kansas could bring more federal funding in at little cost to the state by increasing Medicaid reimbursement rates and using existing grant funds as match. The report noted that rates had not been raised in many years and were among the lowest of the 50 states.

A number of conclusions in the LPA report were critical in the impetus towards development of Mental Health Initiative 2000, including:

.....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 client needs are. The result is a system in which money is unevenly distributed and lacks accountability for what services are provided to clients....

Statewide shortages exist for certain mental health services-many of which are Medicaid eligible. One way the State could provide centers with additional funding for those services would be to increase its Medicaid reimbursement rates.

Funding for 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.

After reviewing the findings and recommendations from the LPA report, SRS sponsored a forum to learn about how other states have used the Medicaid program to expand mental health services. State staff and a CMHC Director from New Hampshire spent the day reviewing the impact of maximizing federal revenue on public mental health services. CMHCs, SRS, and several legislators learned a great deal from this forum and agreed that Kansas was in a good position to pursue some alternative financing methods.

Following the 2000 Legislative Session, SRS formed a committee with Community Mental Health Centers (CMHCs) in order to review the options for financing expanded services, with an emphasis on crisis supports. This committee included representation from every area of the state and met for six months to develop options for moving forward. The plan developed by this group was titled Mental Health Initiative 2000, and was included in the SRS 2001 Business Plan. The plan is attached for your reference.

Description of Mental Health Initiative 2000

The plan was based on the goals of increasing access, crisis supports, and accountability. The following describes progress in these areas:

✓ **Increase timely access to care for Kansans experiencing a mental health crisis.**

Targets for accessing care were added to CMHC contracts for FY02, including targets for emergency care, urgent care, and routine care. A summary of these new contract provisions is attached.

✓ **Increase crisis supports in every catchment area in the state.**

Each CMHC was required to submit an initial plan for filling gaps in crisis services in their catchment area by July 2001. These plans required involvement of local communities in identifying gaps in services, inclusion of crisis case management services for individuals diverted from hospitalization, and increased crisis services for children and families. The second phase of crisis plans is due April 1, 2002 and includes requirements for increasing mobile crisis response, meeting minimum standards for after-hours crisis supports, and development of alternatives to hospitalization.

SRS staff have worked to help each community individualize their plans, according to local needs and the amount of new revenue projected for that catchment area. Some examples of new and expanded services include crisis medication clinics where someone in crisis can be seen without an appointment, access to case management within 24 hours for new referrals, increased attendant care for in-home crisis supports, expanded mobile crisis response, and crisis residential services as an alternative to hospitalization.

✓ **Increase accountability of the public mental health system in Kansas.**

The component of the plan that increases accountability was to be phased-in after new rates and services began, and includes shifting a portion of grant dollars into fee-for-service. This shift is scheduled to occur in July 2002, and would increase the amount of funds directly tied to services for people.

Initial Funding Plan for Mental Health Initiative 2000

- There is no state general fund impact during implementation. Existing mental health grants will be used to fund the planned growth in Medicaid services. CMHCs receive these grant funds back as they provide and bill for services.

- The plan includes increased earnings for each CMHC, but this revenue will be earned by providing direct services to people.

- Medicaid rates increase for the targeted services most needed to serve individuals and families in their home communities.

- Remaining grant funds provide a balance between grants and fee-for-service. This balance is critical in order to continue to support individuals without Medicaid. Grant funds also support services that Medicaid does not pay for, but which are critical to the recovery of people with mental illness.

- The Certified Match program would be eliminated, and CMHCs would receive the federal and state payment for services, as those services are provided. Currently, CMHCs receive the federal payment as services are provided, a part of the state portion in a quarterly grant, and use other non-federal dollars to certify the remaining required state match. The attached flow chart of how the Certified Match program works highlights the changes.

- The remaining grant funds would be distributed based on a formula that includes the factors of population, poverty and size of the catchment area. This formula would be phased-in over time as increased federal funds are realized.

- And finally, a hold harmless clause is included in order to insure stable funding in each area of the state and to meet increased contract obligations.

Adoption and Implementation of the Plan

SRS worked with the Executive Board of the Association of CMHCs, and agreed in the fall of 2000 to move forward on the plan. The plan was changed several times to include input from CMHCs. However, there continued to be disagreement about the distribution of grant funds, and SRS agreed to consider other alternatives to the distribution formula. In January of 2001, targeted increases in Medicaid rates were implemented and CMHCs began receiving new revenue.

During this time the Governor announced his support of the plan, and included the increased revenue in his funding package for FY02. The 2001 Legislature endorsed the Governor's recommendations and approved the increased revenue.

CMHC contracts were amended for FY02, and included targets for access to care, and requirements for local crisis plans, to be completed in two phases. Many CMHCs began filling the gaps in their communities with new and expanded services. This expansion occurred during FY02, in order for the state share of the expansion to be funded by existing state grant dollars in the mental health system.

In addition, the 18 month phase-in period allowed CMHCs to plan for a shift from reliance primarily on grants to a reliance primarily on fee-for-service earnings when services are provided. The phase-in also provided CMHCs with cash flow critical to make this shift.

After implementation began and rates were raised, an alternative plan was developed by several CMHCs. This plan eliminated critical components of the initial plan. Specifically it no longer included shifting from a mainly grant funded system to a system that pays for services to people. SRS continued to meet with CMHCs, but has been firm that movement toward connecting services and people more closely to funding must be a part of the plan. Initially the alternative plan received wide support among CMHCs. However, recent SRS modifications to the original initiative have resulted in broader support for moving forward with the initiative, although the Association of CMHCs has taken no formal position. The alternative plan no longer has the support of a majority of CMHCs.

Mid-Course Adjustments to Mental Health Initiative 2000

Recent meetings with the Association of CMHCs have been very productive, and SRS has agreed to several changes to the original plan. Those changes still preserve the initial goals of the initiative. Those changes include phasing-in the shift of grant dollars to Medicaid, with the initial shift occurring for targeted services on July 1, 2002. This accomplishes several things; it gives CMHCs additional time to shift business practices into a fee-for-service model, and it reduces the financial risk to the state during FY03.

SRS has also agreed to distribute the remaining grant dollars according to the current distribution, rather than redistribute state funds based on a formula. While we continue to believe it is critical to move towards a more equitable distribution, it may need to happen more naturally over time, with new funds or other opportunities.

SRS has committed to doing everything possible to make this initiative a success for every CMHC, but maintains that important components of the plan cannot be eliminated.

Accommodations to the original plan include:

- Changing the hold harmless clause from $100,000 increase to a 9% increase of grants and Medicaid. No CMHC will have less than a 9% increase in total grant and Medicaid funding.
- Phase-in shifting of grant dollars, beginning with targeted services July 2002. This reduces the amount of grants that must be shifted to fund Medicaid services.
- Eliminating redistribution of grant funds based on a formula.
- Assisting each CMHC with cash flow concerns during implementation, by adjusting the timing of grant distributions to ease the transition.

The net effect of the final version of the plan increases Medicaid revenue by $26.8 million between FY99 and FY02, and shifts approximately 30% of state mental health grants ($17 million) in order to insure no state general fund increases during implementation.

Impact of Mental Health Initiative 2000 on Medicaid Caseload

During this time, the revenue picture for the state has changed dramatically, and new budget realities have caused SRS to further examine the initiative in light of the impact it could have on the Medicaid program.

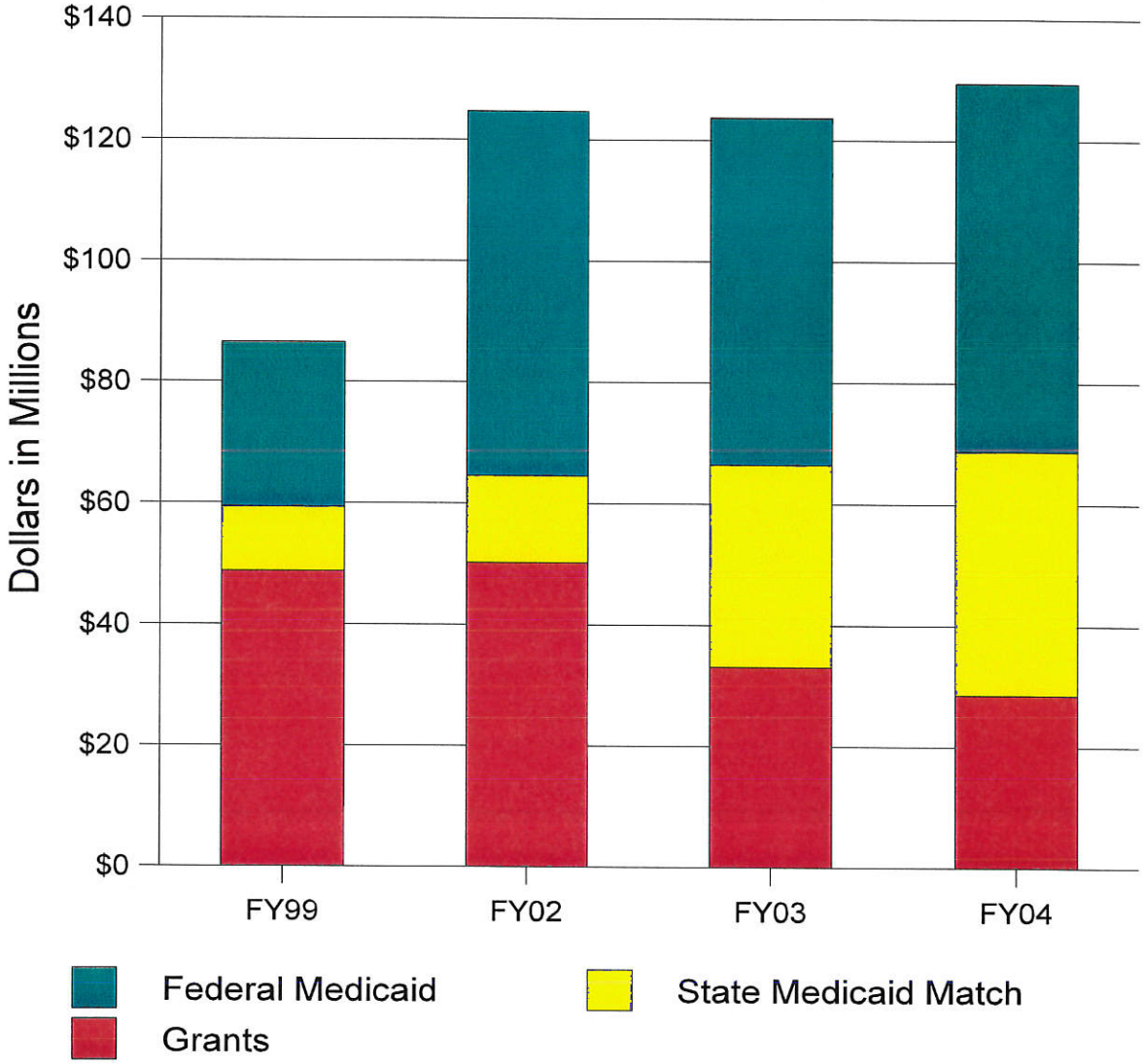
The initiative has always been designed to be budget neutral during implementation, with modest growth in subsequent years. During implementation, the planned increases in the state share of Medicaid will be funded by unmatched state funds already in the mental health system. As planned, growth in new services was highest during the six months after rates were increased, with a leveling of growth over time.

In addition, there are several current efforts that would reduce the state risk over time. One of these changes is limiting the Medikan program to 24 months. Several other policy decisions included in the Governor's FY2003 budget will also reduce the state risk during coming years, including reducing rates for all Medikan services back to rates prior to the initiative, adjusting the rate for one of the services raised January 2001, and reducing payment for CMHC services to individuals in NFMHs. These policies will moderate any future increases in the Medicaid budget.

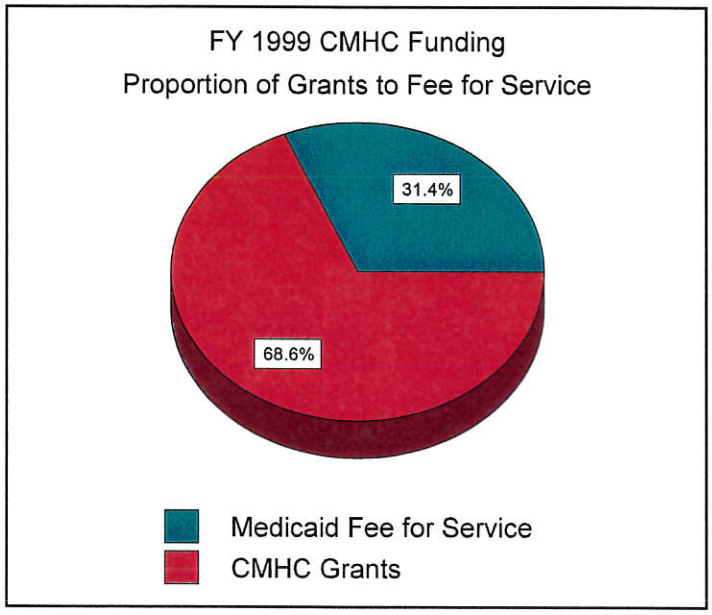
Prior to this initiative, Medicaid Mental Health services were considered as a part of the caseload process. However, the state share of increase was financed through a combination of increases in the Certified Match program and an expectation that each CMHC contribute other non-federal funds. This initiative does not add new service categories or new eligible populations, it simply uses a different method of financing this portion of the Medicaid budget. The growth due to new rates was purposefully done during a time when there would be no risk to the state. The additional risk to the state will include only the portion of increase that would not have been funded through the Certified Match grant. See the following charts that show the projected impact on Medicaid caseloads, and graphs showing the shift from grants to fee-for-service.

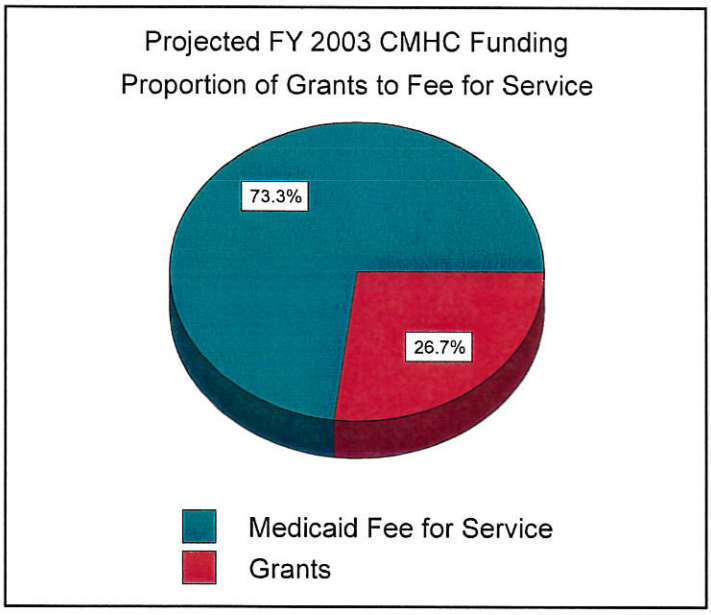
MH Initiative 2000 Funding

FY99 Actual and FY02 - FY04 Projections



Source	FY99	FY02	FY03	FY04
Grants	$48.72	$50.17	$33.10	$28.57
State Medicaid Match	$10.62	$14.37	$33.34	$40.14
Federal Medicaid	$27.19	$60.12	$57.28	$60.72


FY 1999 CMHC Funding
Proportion of Grants to Fee for Service
31.4%
68.6%
Medicaid Fee for Service
CMHC Grants


Projected FY 2003 CMHC Funding
Proportion of Grants to Fee for Service
73.3%
26.7%
Medicaid Fee for Service
Grants

Some Remaining Concerns About Mental Health Initiative 2000

As stated earlier, SRS has worked together with CMHCs to address many of the concerns about the plan and to propose changes that mitigate some of these concerns. These types of large systems change efforts always come with difficulty and can rarely occur without some disagreements. Different CMHCs certainly start in different places before the initiative and they are impacted differently based on many factors. We have heard and considered the following from those few centers that have continued to have concerns about the initiative:

One concern is that the distribution of new revenue is not "fair" as some CMHCs have significantly more revenue than others.

The distribution of new revenue is not equal among centers. However, many of the factors that control this distribution are related to local provision of services. For instance, of the 9 CMHCs that earn the lowest percentage of new revenue, all of them have a larger percentage of Medicaid eligibles than their percentage of Medicaid payments.

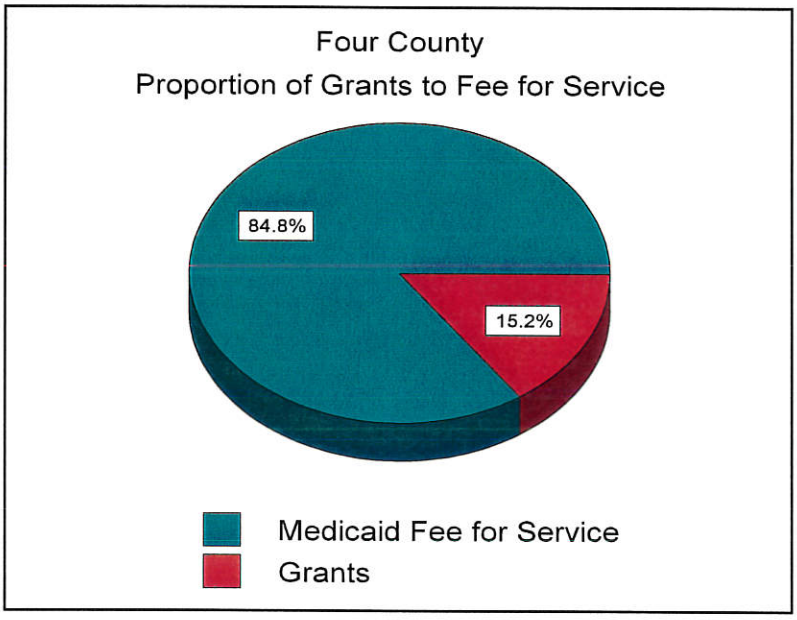
Some of these differences are extreme; for instance, the CMHC in Great Bend had 2.35% of the state Medicaid eligible population in 1999, but their share of Medicaid payments is estimated to be 0.9% for FY02. This CMHC would have more than doubled their distribution if they had provided increased Medicaid services during implementation of the initiative. In fact, they have the lowest rate of increase of any CMHC in the state. Another factor that these CMHCs have in common is that their percentage of state grant funds exceeds their percentage of the state population.

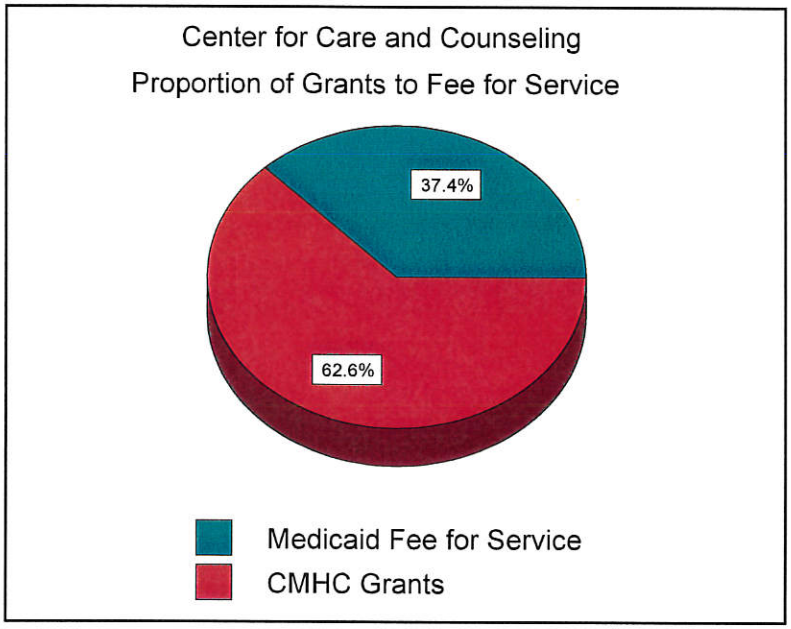
The following chart is one illustration of how the initiative impacts CMHCs in various ways. These two CMHCs were chosen because although they have similar population sizes and both have multiple counties that are fairly rural, one is in the group of CMHCs receiving the most new revenue and one is in the group receiving the least:

	Four County CMHC	Center for Care and Counseling
% of population of the state	2.02	1.90
% of FY99 Medicaid eligibles in the state	3.28	2.35
% of FY02 projected Medicaid paid claims	5.54	0.90
% of state grants prior to Mental Health Initiative 2000	2.34	2.65
% of grants reduced due to Mental Health Initiative 2000	37.42	0.34

The following charts also compare the percentage of grant and Medicaid funds of these same CMHCs:

Proportion of Grants to Fee for Service
Projected for FY03 with Mental Health Initiative 2000





It is more difficult to find factors in common for the CMHCs with the highest amount of earned revenue. There are large centers and small ones, urban and rural, centers with previous federal grants to help build services and those without that opportunity, and centers with high per capita state grants and those with low per capita grants. The one thing these centers do have in common is that they provide more service to more people.

Another concern expressed by some is that it is not "fair" to ask CMHCs that provide relatively few Medicaid services to use their grant funds to fund the state share of the increase. They suggest that each CMHC should only be asked to fund their own share of Medicaid payments.

SRS believes that each catchment area should maintain a balance between grants and fee-for-service, in order to insure that individuals without Medicaid are served, and services that Medicaid does not pay for are included.

The drawback to CMHCs funding their own share of Medicaid billings is that this would then leave some CMHCs with no state grant funds, and in fact some would not have enough grant money to fund their portion of the state match. These programs have provided these Medicaid services with low rates and less than 100% of the payment due to the Certified Match program. To then penalize them by removing all state grants would increase the inequitable distribution of grant funds.

On the other side, some have expressed a concern that SRS has gone too far in trying to broker a compromise.

Some CMHCs have concerns that the issue of equity in distribution of grant funds has not been sufficiently addressed. In addition, others believe that shifting grants to fund the 9% hold harmless clause increases inequities by rewarding CMHCs who have provided the least amount of services.

SRS has tried to come to a compromise that holds to the original principles while mitigating the impact with protections and alterations in the plan. Any further compromises would simply change the agencies who disagree rather than bring agreement, and would likely compromise further the original intent of the plan.

See the attached spreadsheets that highlight the differences between CMHCs in new revenue earned, and how the plan impacts grants.

MENTAL HEALTH INITIATIVE 2000 FUNDING COMPARISON

CMHC	Previous Funding Adj. FY 99	Adj. Total FY 2003	Difference Gain '99 to '03	All Funds % Increase	Per capita Grant funds
Four County MHC	$3,069,367	$5,894,312	$2,824,945	92.04%	$16.52
Franklin Co. MHC	$1,550,552	$2,877,282	$1,326,730	85.57%	$17.02
Miami County MHC	$1,201,088	$2,009,965	$808,877	67.35%	$10.78
MHC of E. Central KS	$2,697,221	$4,467,414	$1,770,193	65.63%	$7.45
Crawford County MHC	$2,423,611	$3,674,978	$1,251,367	51.63%	$15.94
COMCARE-SEDGWICK	$14,589,174	$21,033,949	$6,444,775	44.18%	$9.35
Central Kansas MHC	$2,491,396	$3,552,044	$1,060,648	42.57%	$7.02
Shawnee/Valeo	$9,060,746	$12,421,655	$3,360,909	37.09%	$16.33
Cowley County MHC	$1,275,262	$1,715,708	$440,446	34.54%	$9.67
Iroquois Center for H D	$1,140,347	$1,529,277	$388,930	34.11%	$23.84
Kanza MH & GC	$1,224,315	$1,617,439	$393,124	32.11%	$10.17
Family Life Center.	$1,226,270	$1,557,790	$331,520	27.03%	$15.66
Southeast Kansas MHC	$2,541,166	$3,152,073	$610,907	24.04%	$10.87
Bert Nash	$2,863,854	$3,504,860	$641,006	22.38%	$8.52
Johnson County MHC	$7,964,665	$9,447,779	$1,483,114	18.62%	$6.47
Northeast Kansas M.H. &	$2,574,726	$3,031,202	$456,476	17.73%	$7.66
Sumner County MHC	$818,519	$942,751	$124,232	15.18%	$11.95
Pawnee MH Services	$5,479,319	$6,122,387	$643,068	11.74%	$9.34
South Central MHC	$1,000,901	$1,090,983	$90,082	9.00%	$8.71
Labette Center for MH	$1,280,261	$1,395,484	$115,223	9.00%	$18.40
Southwest Guidance Ctr.	$1,321,033	$1,439,926	$118,893	9.00%	$16.35
Center for C&C	$1,879,842	$2,049,028	$169,186	9.00%	$25.16
Prairie View MHC	$2,608,812	$2,843,605	$234,793	9.00%	$15.91
Horizons MHC	$3,329,741	$3,629,418	$299,677	9.00%	$15.74
Area MHC	$4,320,773	$4,709,643	$388,870	9.00%	$17.93
High Plains Comm. MHC	$4,631,906	$5,048,777	$416,871	9.00%	$28.54
Wyandot MHC	$7,173,881	$7,819,531	$645,650	9.00%	$21.34
TOTAL	$91,738,748	$118,579,260	$26,840,512	29.26%	12.31

COMPARISON OF GRANT FUNDING*

CMHC	2002 Grants	2003 Grants	Percent Reduction
Four County MHC	$1,431,222	$895,661	37.42%
Franklin Co. MHC	$638,027	$421,884	33.88%
Miami County MHC	$541,962	$305,729	43.59%
MHC of E. Central KS	$1,084,172	$634,357	41.49%
Crawford County MHC	$933,374	$609,704	34.68%
COMCARE-SEDGWICK	$7,430,934	$4,234,604	43.01%
Central Kansas MHC	$1,067,690	$625,865	41.38%
Shawnee/Valeo	$4,820,414	$2,773,394	42.47%
Cowley County MHC	$607,100	$350,827	42.21%
Iroquois Center for H D	$480,837	$264,275	45.04%
Kanza MH & GC	$716,900	$430,878	39.90%
Family Life Center.	$563,453	$354,057	37.16%
Southeast Kansas MHC	$1,264,595	$741,846	41.34%
Bert Nash	$1,509,256	$851,612	43.57%
Johnson County MHC	$4,985,275	$2,919,686	41.43%
Northeast Kansas M.H. & G.	$1,368,078	$795,676	41.84%
Sumner County MHC	$546,944	$310,111	43.30%
Pawnee MH Services	$2,633,337	$1,514,179	42.50%
South Central MHC	$561,223	$518,006	7.70%
Labette Center for MH	$626,062	$420,080	32.90%
Southwest Guidance Ctr.	$845,603	$603,430	28.64%
Center for C&C	$1,286,989	$1,282,636	0.34%
Prairie View MHC	$1,645,756	$1,206,022	26.72%
Horizons MHC	$2,030,799	$1,494,324	26.42%
Area MHC	$2,741,848	$2,032,293	25.88%
High Plains Comm. MHC	$3,286,043	$3,138,804	4.48%
Wyandot MHC	$4,525,472	$3,368,729	25.56%
TOTAL	$50,173,365	$33,098,669	34.03%

*** Does not include the $3 million reduction contained in the GBR**

Moving Forward with Mental Health Initiative 2000

SRS is here today to ask that you continue your support of Mental Health Initiative 2000. We and many of our partners believe that it is an important step towards insuring that public mental health services in Kansas are responsive, accessible, and accountable. That accountability is critical to the future of the mental health system. It is time in the evolution of this system that we move towards connecting funding directly to the people we are here to serve.

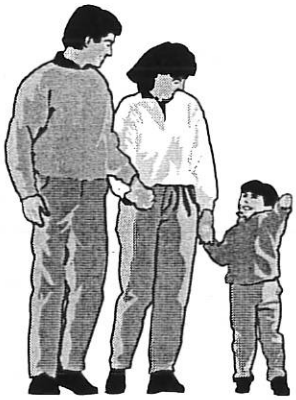
The system is full of complexities and we have joined with our partners over the last 18 months to design system changes that take these into account. Further delaying or changing the initiative at this point would undermine the principles on which it was built.

Thank you and I would be happy to answer any questions.

MENTAL HEALTH INITIATIVE 2000

Social and Rehabilitation Services
Division of Health Care Policy

October 2000



CRISIS SUPPORTS
ACCESS
ACCOUNTABILITY

WHERE HAVE WE BEEN?

- Kansas recently celebrated 10 years of Mental Health Reform. During that decade, the following improvements were accomplished:

  - ✓ Increased capacity of community programs, with nearly 23,000 adults and children with serious mental illness now being served in the community
  - ✓ Development of a coordinated system of care, with single point of entry for publically funded mental health services
  - ✓ Hospital screening established, in order to decrease use of institutions and shift care into the community
  - ✓ Reduction in state hospital beds from 1,003 beds in 1990 to 375 in 1999
  - ✓ Reduction in average length of stay by 47% for both children and adults
  - ✓ Liaisons between the state hospitals and community programs
  - ✓ Closure of Topeka State Hospital due to success of community programs

- A significant increase has occurred in the last decade in the capacity of communities to serve people with a mental illness. Services in the community have grown, and with very rare exceptions, people do not live their lives in state institutions.

- Kansas was one of very few states to begin measuring the outcomes of services in the lives of people served by the public mental health system.

- This state has made a commitment to a safety net of mental health services for all citizens, ensuring that Kansans receive critical mental health services, regardless of their ability to pay.

- The system increased efforts to address the mental health needs of children and their families, with the implementation of community-based services for children, the SED Waiver, and the Family Centered System of Care. The number of children served in case management has increased by 30% since 1998.

- Case management services have been one of the strengths of this system in the 1990s, with small case load sizes and the use of the strengths and abilities of people with mental illness. We now know, through research and improved outcomes, that these services are considered best practices nationally.

- More importantly, for those receiving case management, 85% are living independently and 24% are working in competitive jobs.

- For children with serious emotional disturbances who receive case management, 84% are remaining in their home, 81% attend school regularly, and 80% have no contact with law enforcement.

WHERE ARE WE NOW?
TAKING STOCK FOR A NEW DECADE

- Mental illness is among the leading three causes of disability in the world. One in five individuals in Kansas experiences symptoms of a mental illness in any given year.

- The first Surgeon General's Report on mental health in the history of this country, issued in December of 1999, gives guidance on the future of mental health services. We know that
  - ✓ adults and children with mental illness can get better with early intervention and treatment
  - ✓ there is scientific evidence that treatment works, and
  - ✓ the difference between what we know about mental illness, and what we do about it - is lethal

- From research on best practices, and from the outcomes that Kansas has measured for a decade, we know what works. We also know our system has gaps that prevent us from making full use of what we know works.

SYSTEM ON THE VERGE OF CRISIS

- Waiting times for critical services have increased and are a serious threat to the safety net for Kansas citizens.

- There are severe shortages of services for prescribing and monitoring medications. CMHCs prescribe medications for thousands of Kansans, for whom timely access to psychiatric care is critical to their health and safety.

- The continuum of crisis services necessary to support individuals safely in their communities, is not available in any Kansas community. Crisis services are almost exclusively 24-hour phone response and screening for hospitalization. This is clearly not what best practice and research proves to be effective in treating mental illness.

- Crisis services that are available focus on the needs of adults, and services for children need to be more readily available.

- Too many adults with mental illness are entering the state and local correctional systems, and too many children with mental illness are entering foster care and JJA; due in part to a lack of access to mental health services.

- Because of a lack of access to community services, Kansans with mental illness are living in institutional settings such as nursing homes. The Olmstead Supreme Court decision puts pressure on Kansas to ensure adequate access to community-based care.

IT IS TIME FOR A CHANGE

SRS has been gathering information from a wide range of community partners, hospitals, families, people with mental illness, and other state agencies. They all agree it is time to take the next step in Kansas, to assure that people with mental illness get the help they need, when they need it, in order to live in their own communities. The following reports support the need for Mental Health Initiative 2000:

- Performance Audit Report by Legislative Post Audit, March 2000
  - ✓ crisis stabilization, attendant care, respite, and case management were identified as the services most needed; more than one–third of case managers surveyed said their clients were not getting all the services they need

- Children's Crisis subcommittee of the Governor's Mental Health Planning Council
  - ✓ there are gaps in the mental health service delivery system for children and a lack of a Crisis Response System in many parts of the state; availability of such systems would prevent or greatly reduce reliance on out-of-home placements

- Forensics subcommittee of the Governor's Mental Health Planning Council
  - ✓ estimates are that adult and juvenile offenders with serious mental illness who are incarcerated cost Kansas 27.5 million dollars annually

- Satisfaction Surveys completed by families, adolescents, and adults served by CMHC's
  - ✓ families of children with serious mental illness report being least satisfied with the help they get in a crisis

- Hospital Stakeholder Task Force, April-November 2000
  - ✓ there is no Kansas community with the full range of crisis services necessary to support people with mental illness in their home

- Crisis Evaluation, a system review of crisis services in Kansas, report to be completed November 2000
  - ✓ preliminary findings indicate most communities suffer from a severe shortage of crisis services

- Testimony from the Mental Health Task Force, September-December 2000
  - ✓ many concerns about waiting times for appointments and lack of crisis services

- James Bell report monitoring the needs of children in foster care
  - ✓ many children enter foster care, not because of abuse or neglect, but because they need services and supports to keep them with their families

MH INITIATIVE 2000:
WHERE WE ARE GOING?

Mental Health Initiative 2000 establishes results in these three areas:

★ CRISIS SUPPORTS

★ ACCESS TO CARE

★ ACCOUNTABILITY

The ***PLAN***

- ★ raises performance of publicly funded mental health services in all areas of the state
- ★ adds critical targeted improvements for crisis services, and
- ★ includes a funding strategy supporting these improvements

The ***OUTCOMES***

- ★ more adults with mental illness living and working in their community, and
- ★ more children with mental illness living with their family, attending school, and not having contact with law enforcement

WHAT ARE CRISIS SUPPORTS?

Crisis supports are a continuum of services, from least to most restrictive. Too much emphasis on the most restrictive alternatives actually increases the number of people who need crisis services. Every CMHC in Kansas will fill gaps in services in each catchment area. A full continuum of crisis services would include at a minimum, the following:

Crisis Prevention and Early Intervention	Community-Based Crisis Supports	Facility-Based Crisis Supports
Case Management	24-Hour phone response	48 Hour Crisis Stabilization
Attendant Care	Mobile Crisis Response	Access to acute care beds
Respite Care	Assertive Community Treatment	Social Detox
Peer Support and/or Parent Support	Emergency Medication Appointments	Integrated treatment for people with co-occurring disorders
Medication Services	Crisis Residential	
Wellness/Recovery Planning	Crisis Attendant Care	
Wraparound supports and planning	48 Hour Crisis Stabilization	
Employment Supports	Partial Hospital	
In-Home Family Therapy		
Short-term individual, group, and family counseling		
Housing Supports		
Aggressive Outreach		
Specialized forensics services		
Integrated treatment for co-occurring disorders		
Psychosocial Treatment Groups		

CRISIS SUPPORTS

VISION

Both children and adults with symptoms of mental illness will remain safely and successfully in their homes and communities when experiencing a crisis, with an array of supports that:

- are located in every region of the state
- focus on early intervention
- include natural resources like friends and family, in addition to formalized services

REALITY

Crisis services in Kansas consist primarily of screening individuals for the hospital and 24-hour phone response. If a crisis cannot be resolved over the phone, and hospitalization is not necessary, there is very little support currently available.

Most crisis services are designed for adults, and do not focus on the unique needs of children and families in crisis.

The community system built by Mental Health Reform focused on individuals that had been living in state hospitals. People experiencing symptoms today are more mobile, use more alcohol and other drugs, are more likely to be homeless, and are less likely to seek out services. The system must respond to these changes.

RESULTS

There will be community crisis plans developed in each CMHC catchment area. These will be developed with consumers and families, and local partners such as law enforcement, schools, child welfare contractors, juvenile justice agencies, and Area SRS Offices.

Individuals will receive assistance in gaining access to services recommended in a hospital diversion plan. Specifically, CMHCs will make crisis case management services available in conjunction with screening for hospitalization.

Individuals in crisis will receive assistance to remain safely and successfully in their home and community. Specifically, CMHCs will

- Increase medical services that assist individuals in managing psychiatric medications.
- Add hours of attendant care and case management for adults with serious and persistent mental illness and children with severe emotional disturbance.
- Provide evening and weekend case management, in-home family therapy, and attendant care.
- Improve crisis services to children by insuring that staff with expertise are available 24 hours a day.

CRISIS SUPPORTS (continued)

The following are examples of some of the targeted improvements that will take place in Kansas communities:

Crisis Stabilization: The Kansas City area will reestablish crisis stabilization services to replace those lost with closure of the KUMC unit.

Mobile Crisis: Mobile Crisis Response services will be added in several communities, and will respond in a variety of locations to try and resolve a crisis close to home. This may involve response to schools, jails, homeless shelters, or in-home crisis services for some individuals. These services will be available to adults and children and their families.

Corrections, Law Enforcement, and Juvenile Justice: The number of children and adults with mental illness in these systems will decrease as Sedgwick, Shawnee, and Douglas counties add specialized services. By far, concerns about access to mental health treatment received from law enforcement and community corrections more often come from these more populated communities.

Foster Care: To address the high rate of out of home placement in Sedgwick County, the CMHC and the SRS Area Office will establish a specialized team to keep more children with mental illness out of custody, and successfully return them home sooner when they are placed in custody.

Community-Based Alternatives: Alternatives to hospital care will be added in several areas of the state. This will include respite and crisis residential beds, and intensive case management. A major focus of these services will be rural communities with few acute care resources, and communities such as Sedgwick County where unmet mental health needs are putting a strain on local resources.

Assertive Community Treatment: Shawnee County has historically been challenged with serving people with mental illness who come to Topeka for treatment. To decrease the number of individuals that "fall through the cracks" the CMHC will add an Assertive Community Treatment (ACT) team, including assertive case management, outreach, and mobile medication services.

Community Specific Services: Communities, based on their particular needs, will develop other services such as: collaboration with schools, Therapeutic Preschool, and services to special populations such as the elderly and individuals with both a mental illness and an addiction.

Facility-Based Services: Increased reimbursement for facility-based 48-hour acute care services to stabilize that service.

ACCESS

VISION

Kansas citizens will have timely access to mental health care, so they get the help they need, when they need it, to remain safe and successful in their local communities.

REALITY

Waiting times for critical services like medication appointments or case management are growing, and a 4-8 week wait time for new referrals is not unusual.

Access standards for mental health care have never been established in Kansas, which means that access varies widely across the state.

Even when individuals get timely access in an emergency, they must wait long periods for follow-up care.

RESULTS

SRS will enforce improved access standards for public mental health services and will include these in new licensing standards for CMHCs by July 1, 2001. This includes access standards for individuals based on acuity. The following are examples of specific situations, and how standards will be applied:

Acuity	Expectation	Example
Emergency care	Immediate	A mother calls about her 14 year-old, who is talking about suicide. She wants an evaluation.
Urgent care	Within a few days	A homeless shelter calls about someone with a serious mental illness, who has no medications, is not in treatment, and is hearing voices.
Emergent care	Within 10 days	A Corrections Officer calls, referring someone with a serious mental illness who is leaving jail, and will have a 10 day supply of medication upon discharge, which is in 2 weeks.

ACCOUNTABILITY

VISION

The Kansas public mental health system is effective, responsive, and accountable. Improved outcomes in peoples' lives is the focus of the system. Funding mechanisms and performance based contracts are used to increase accountability, quality of services, and outcomes.

REALITY

Current funding formulas result in a range of state grant funds from $12 to $52 per capita throughout the state. The current formula no longer provides an adequate rationale for distribution of grants, and makes it difficult to serve individuals who move, since population is not a factor in how funds are distributed. This results in a lack of core services and decreased access in some areas.

The system is funded mainly through grants which support programs rather than people. Most funding is not tied directly to the number of people served, the amount of service, or outcomes. These programs are critically important, but the state needs to have a balance between grants and fee-for-service in order to most effectively manage the system.

Medicaid rates are very low, have not increased in a decade, and do not come close to covering the cost of providing services. Kansas is not maximizing Medicaid revenues to improve crisis supports and access.

The definition of the target population, which is the focus of State resources, is vague, outdated, and applied inconsistently.

Contract monitoring has been inconsistent, and the services SRS purchases are not well defined. The information necessary to most effectively monitor the system has not been collected or available.

People with mental illness, their families, and other stakeholders do not have easy access to information showing each CMHCs performance on key outcomes.

Currently, only a small percentage of individuals in the target population have outcomes measured; 26% of children with SED and 37% of adults with SPMI. Outcomes are measured for individuals in case management, a service often limited due to low Medicaid rates.

ACCOUNTABILITY (continued)

RESULTS

This proposal provides a coordinated and coherent approach to public funding of mental health services. In addition, a balance of grant and fee-for-service funding is achieved to continue to provide critical services to individuals who are indigent.

A portion of grant funds will be transferred to a fee-for-service system. This move increases accountability by connecting funds to people and services. This change will link the services provided to payment for those services.

Remaining grant funds will be allocated based on a formula that includes the factors of population, poverty, and geography.

Local SRS quality enhancement staff will monitor contract compliance, assist in resolving grievances, and license CMHC's. These staff will also work directly with CMHC's to improve the quality and accessibility of effective mental health services.

SRS will develop uniform definitions for the services that it purchases and for the populations that will receive priority for services. These will be monitored to ensure consistency across the State.

The newly implemented information system will provide key data for performance monitoring, with initial data available during FY 2001.

CMHC Report Cards that measure performance will be posted on a web site and available for consumers, families, and other stakeholders.

Targeted increases in Medicaid rates will provide an incentive to serve individuals with the highest level of need, to provide those services we know are effective, and to maximize federal funding. Increased community-based care results in an increase in the number of people included in outcome measures.

HOW WILL IT BE FUNDED?

- These critical improvements in the mental health system will be financed by maximizing federal Medicaid revenues.

- Medicaid rates will be increased with an emphasis on services that assist individuals to live and work successfully in their communities.

- The state will pay the full Medicaid rate for mental health services. The state share of these rate adjustments will be covered by using a portion of mental health grant funds. The current method of paying only a portion of the Medicaid rate would be phased-out, with limited financial risk to the State during a phased-in implementation period.

- The remaining grant funds will continue to support individuals who are indigent and pay for services not covered by Medicaid, as required by Kansas statute. SRS will distribute grants based on a rational formula. This can be done without harm to any catchment area due to increased Medicaid rates.

- The plan includes increased earnings for each CMHC, but this revenue will be <u>earned</u> by providing direct services to individuals.

- The plan provides an incentive for CMHC's to assure that people who qualify for Medicaid are enrolled in the program. This helps people with mental illness get much needed treatment and support and maximizes federal revenue.

HOW WILL OUTCOMES AND RESULTS BE MEASURED?

- The new data system will measure the following outcomes on all individuals receiving intensive services:

  - ✓ Number and length of hospitalizations for children and adults, state and private hospitals
  - ✓ Housing status for adults (independent living, group home, nursing home)
  - ✓ Employment status for adults (competitive, sheltered, unemployed)
  - ✓ Residential status for children (permanent home, residential placement, foster care)
  - ✓ Whether children attend school regularly
  - ✓ Whether children succeed in school, measured by getting A, B, or C grades
  - ✓ Whether children have reduced contacts with law enforcement

- It will also, for the first time, provide a core set of data for all individuals served at CMHCs. This includes an unduplicated count of people served, number served in the target population, payment source, and waiting time for first appointment

- New expectations will be included in CMHC contracts.

- SRS will revise licensing standards for CMHCs, and these will reflect the expectations in this plan.

- Each CMHC will submit a plan for crisis services, developed in conjunction with community partners, families, and consumers. These plans will be monitored by SRS staff responsible for contract monitoring and licensing.

TIME LINE FOR IMPLEMENTATION

	TARGET DATES	STEPS TAKEN
PHASE 1	January - June 2001	Targeted Increase in Medicaid rates Submit new licensing standards for approval Local planning and submission of crisis plans for each community Increased access to Medicaid services Information system fully implemented, testing for accuracy
PHASE 2	FY 2002 July 2001 - June 2002	Approval of crisis plans Targeted improvements begin and are included in contracts effective 7/1/01 Begin measurement of compliance with access standards Collaboration with stakeholders for development of Report Cards
PHASE 3	FY 2003 July 2002 - June 2003	Full payment of Medicaid rate for services and elimination of certified match Move grant funds to pay state portion of increase Begin phase-in of formula based grant distribution, reviewing revenue to insure no area receives decreased funding

TARGETS FOR ACCESSING CMHC SERVICES

SRS has developed standardized targets for the time it takes to receive mental health services from Community Mental Health Centers. These targets will be phased-in during the next fiscal year, with the initial 6 months dedicated to building the capacity to meet these targets, and the capacity to measure whether they have been met.

Emergent Situations: services that are needed immediately to meet the needs of an individual who is experiencing an acute psychiatric crisis which is at a level of severity that may meet the requirements of hospitalization, and/or who, in the absence of immediate services may require hospitalization.

> **Response Time:** Face-to-face assessment and crisis intervention services within 3 hours
> Follow-up treatment and/or coordination of services is required, as necessary to ensure stabilization and diversion from potential hospitalization.

Urgent Situations: services required to prevent a serious complication or deterioration in the individual's health and cannot be delayed without imposing undue risk on the individual's well being and if not promptly treated, could rapidly become an emergency situation. Additionally includes situations when an individual's discharge from the hospital or other inpatient/acute care setting such as crisis stabilization unit, structured residential setting, NFMH, etc., will be delayed until services are provided.

> **Response Time:** Face-to-face assessment and service intervention within 72 hours
> Follow-up services and/or coordination of services is required as necessary to ensure stabilization.

Routine Situations: non-crisis in nature.

> **Response Time:**
> ***Applies to all new clients***: Assessment within 10 working days, 80% of the time
> ***Applies to all new clients***: Assessment within 14 working days, 90% of the time
> ***For target population only***: Treatment to begin within 10 working days of the assessment, 90% of the time

Exclusions from routine targets:

1. Specialized treatments not required in licensing or contract, i.e. anger management, sex offender groups, court ordered psychological evaluations.
2. Family/Individual Choice- i.e.the client prefers a specific time or prefers to see a specific treater.
3. Unable to reach individual/family- (center must document attempts to contact)
4. Family/individual cancels or no-shows
5. Family/individual changed mind/declined services*

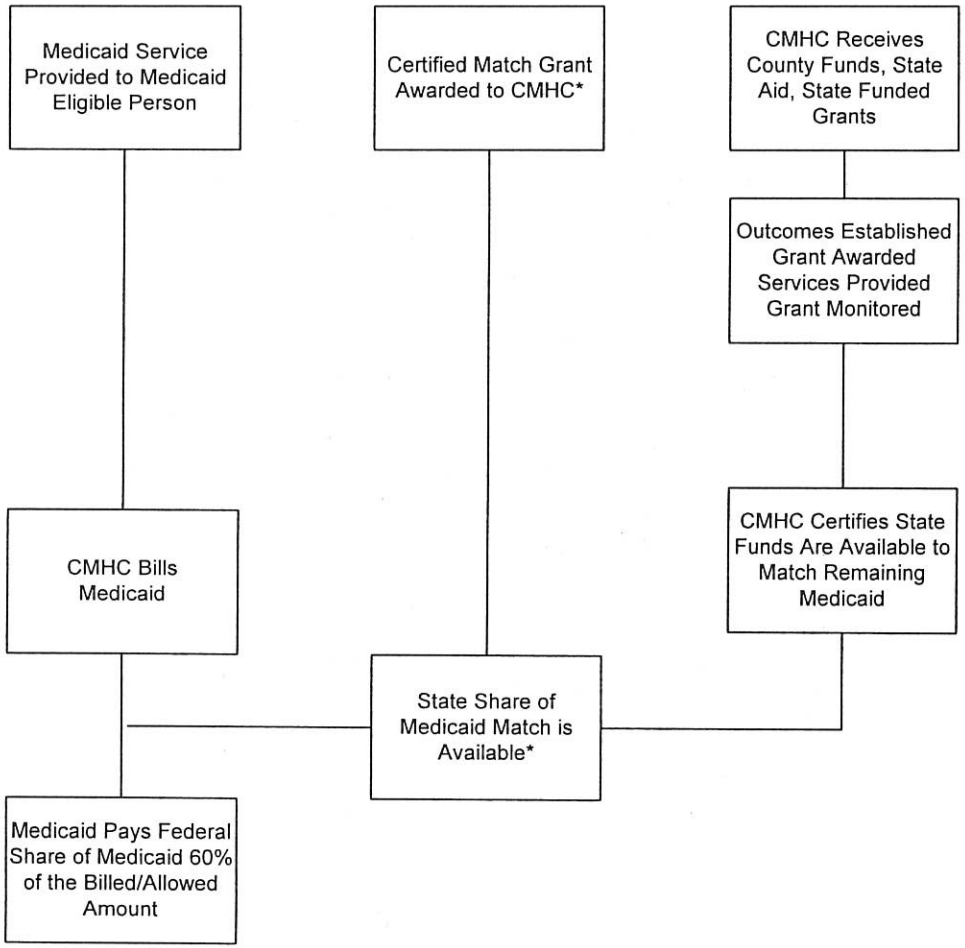
* this does not exclude the center from making efforts to outreach the target population and attempt to engage persons into services, for example, a homeless individual with a severe and persistent mental illness who is declining services.

If a center is unable to comply with the access requirements, staff shall document for whom the center could not respond timely and the reasons therefore and shall report and analyze this information in the center's quality improvement program and shall report this information to the Divisions' Quality Enhancement Program to be utilized in the center's quarterly performance assessment meetings with the QEC.

Comparison Of Medicaid Payment Before And After MH Initiative 2000
February 27, 2002

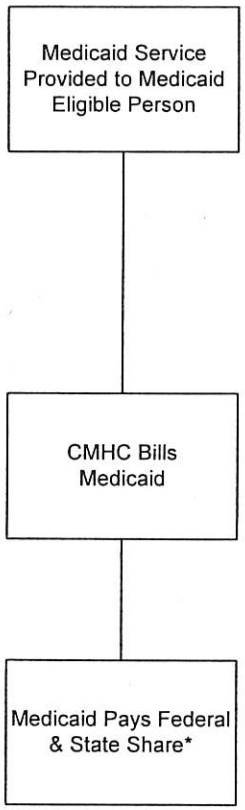
Attachment 3

Certified Medicaid Match Process For CMHCs



*Certified Match Grants Are Not Typical Of Other SRS Certified Match Agreements

Typical Medicaid Payment Process Used By MH Initiative 2000



*During Implementation Of MH Reform 2000 State Share From Grants

Presentation to

The Ways & Means Committee

Regarding

Mental Health Initiative 2000

James J. Karlan, LCP, LMLP, CBHE
Executive Director
Southwest Guidance Center, Inc.
Liberal, Kansas

MENTAL HEALTH REFORM

In 1989, the Kansas Legislature created Mental Health Reform. Mental Health Reform was a joint effort between the State Department of Mental Health and the statewide network of community mental health centers to develop simultaneously an extensive array of community-based mental health services and to close 270 state psychiatric hospital beds between July 1, 1991 and June 30, 1996.

Mental Health Reform was implemented in the then-existing three mental health Regions of the State in staggered fashion: In the Eastern Region, on July 1, 1991; in the Middle Region on July 1, 1992; and in the Western Region on July 1, 1993. Each Region was allocated 6 million dollars. SRS directed the community mental health centers in each Region to develop a formula for allocation of that Region's state funding to each community mental health center so that a Region-wide system of care could be developed to treat mentally ill persons no longer residing in state psychiatric hospitals.

The initial five-year phase of Mental Health Reform was a complete success. Statewide, 270 beds, 90 within each of the then existing three Regions, were closed. In 1995, with the closing of Topeka State Hospital, the original 3 Regions were collapsed into two: Western and Eastern.

In September 2000, the State Mental Health Authority presented its Mental Health Initiative 2000 to the community mental health centers. The Initiative contained two phases, both of which I will be taking issue with today: redistribution; and the placing of community mental health centers in the State's consensus estimating pool.

Redistribution:

The State's Mental Health Initiative 2000 seeks to take the mental health reform funds allocated to each Region in the early 1990's and redistribute a portion of that money. Of the initial 18 million dollars of Mental Health Reform funding, the State proposes to redistribute almost 4.6 million dollars. When asked to explain its rationale for this redistribution, the State indicated that the original allocation of funds in the early 1990's to each of the three Regions had been "inequitable."

The original Mental Health Reform funding of 18 million dollars was equally divided among the three Regions to accomplish an equal task: The closing of 90 state hospital beds in each Region; and the development, updating, and constant maintenance of a community-based system of mental health services to treat persons with mental illness and keep those state hospital beds closed.

SRS is not seeking to build on the historical development of community-based services, but to abruptly change the funding in such a way as to make it difficult to maintain the current system of care. Their plan lacks the continuity and consistency which the ongoing development of any system requires. As a result of redistribution, the maintenance and care of the community-based system put in place during the initial phase of Mental Health Reform will be extremely difficult, at least in Western Kansas, to continue at its current level.

Consensus Estimating Pool

As unfair and illogical as redistribution is, the State's proposal to place community mental health centers in the State's consensus estimating pool will create poor and rich centers and cost the State more funds than if community mental health centers were to continue to operate under the current Certified Match Plan, which has produced over 30 million dollars in new Federal Medicaid funding during FY2002.

My center, for example, is projected in FY 2002 to collect approximately $874,000 in total Medicaid funding. Of this amount, approximately $180,000 will be state matching funds. The remainder, $694,000 will be federal funds. If my center had been placed in the census estimating pool at the beginning of FY 2002, and if my center had recouped a total of $874,000 under that system, my center would have received $350,000 in state matching funds instead of $180,000. Why? Because the State would have committed itself to give a community mental health center 40 cents in State funding for each 60 cents it was able to recoup in federal funds under Medicaid.

In summary, let me say that redistribution violates the pledge the State gave the community mental centers across the state of providing sufficient funding to close state hospital beds and develop and maintain the community-based system of mental health services which are to keep these beds closed. Placing the community mental health centers in the consensus estimating pool will cost the State more money for the same amount of services the community mental health centers are currently delivering under the Certified Match Plan.

Presentation to the Senate Ways and Means Committee
Regarding Mental Health Initiative 2000

Dwight Young, M.S., M.B.A. – Executive Director
The Center for Counseling and Consultation
Great Bend

February 26, 2002

SRS proposes to abandon Certified Match, a tried an extremely reliable method of funding for community mental health services. Such a move will be extremely costly for the State and create uncertainty among providers and recipients of these services.

In 1989, the Association of Community Mental Health of Kansas and SRS established the "soft match" funding program which evolved into the current Certified Match funding mechanism in which the centers bill for Medicaid services and are paid the FFP for those services. Each center also receives a share of the Certified Match Grant, a pool of SGF funding that supports community mental health Medicaid services. For all billings that exceed that center's share of the SGF funding, the center "certifies" that there are eligible funds, i.e. state grants or county mill levy, on hand as match for those services.

This funding program allows centers to continue to provide services beyond those supported by State SGF through excess capacity, favorable margins, and efficiencies. Prior to Certified Match, the centers would face annual restrictions in services, reductions of rates, and even threats that, as an "optional service" the programs could be eliminated if cost continued to rise! Then centers were criticized for "milking" Medicaid. Now, SRS is proposing establishing 29 dairies!

The advantage of Certified Match to the State is that the SGF commitment can be negotiated and capped each year, instead of the open ended "entitlement" of the Consensus Estimating Pool. For the past twelve years, the negotiated match was 50% of the growth in the program with the community mental health centers committing additional grant funds for the remaining expansion. This has provided a steady but controlled growth in services and stable programs for Medicaid clients as well as non-Medicaid clients. In a Consensus Estimating environment, the growth would be exponential. In the past twelve years, the SGF in Certified Match increased from five million dollars to eleven million. Under the SRS plan, that growth would have been from 5 to 40+ million dollars.

SRS believes Certified Match resulted in "lost funding" for the community services in the last twelve years and hopes to correct that by moving to Consensus Estimating where such growth "will not even be noticed." We believe that such growth would have been resisted with restrictions placed on services or rates reduced to hold down cost. Just to get into Consensus Estimating, SRS plans to reduce a critical adult psychosocial rate which will result in the lost of 3.5 million dollars from the current system, a cut that exceeds the Governor's budget reduction.

Senate Ways and Means
2-27-02
Attachment 4

With the mandate from the 2000 Legislature to maximize federal participation, SRS agreed to raise Medicaid rates for community mental health services for the first time in eleven years. The rates went into effect in February of 2001 and will produced an estimated 33 million dollars in new FFP revenues in 2002 without costing the State one dollar in additional SGF because of the Certified Match Program. The current plan efficiently utilizes all available grant funding, including county mill levy. Access to over 20 million dollars in county funding will be lost as match in the SRS plan.

It should be noted that Mental Health Reform Contracts do not call for these funds to be used as matching funds for Medicaid. Reducing grants puts those contracts and the associated services at risk. The Department's assumption that Medicaid income will be used to replace that lost grant funding is wrong and at odds with CMS cost shifting policies. Therefore, the Medicaid revenue, as earned income, can not be tied to the services in the Mental Health Reform Contracts, and this weakens the accountability that SRS is seeking.

The SRS plan is a risky shift in policy that is not reversible. It is totally dependent on the concept of the Consensus Estimating Pool being a "blank check" for services in the pool, which is very questionable, particularly under the current economic circumstances. If such unlimited match does not materialize as the billings continue to increase, then we will be in 1989 all over again, but the communities will have lost over 20 million dollars in grants to support non-Medicaid services.

The attached chart titled "Where Does The Money Go" attempts to answer the question as to how a provider system can produce 33 million dollars in new revenue, but SRS would end up having to "loan" money to centers to approximate our current revenues! Please note that the projected distribution does not equal earned income. The current allocation, including the new 32 million, was "earned" under the current certified match program. The projected distribution is simply a windfall for the "winners" that result from the "change in the rules" initiated by SRS to get support for the "buy in" into their Consensus Estimating plan. The 9% "hold harmless" is a loan that allows SRS to claim that no center loses in their plan. Those grant funds are to be reclaimed in a yet to be determined formula.

It is of interest to note that SRS has a "money is money" philosophy when fee for service income is expected to replace lost grant funding, but such a policy does not apply to the same funds when analyzing per capita revenues. As the chart shows, the SRS plan produces significant shifts in per capita distribution when all sources of state funding are considered.

The lost of Mental Health Reform funds, combined with our share of the Governor's three million dollar reduction, plus the region's share of the SRS reductions in MediKan rates, Adult Psychosocial rates, and NF/MH services, along with the budget reductions at Larned State Hospital will make an already critical situation unmanageable in Western Kansas. **Continuing the current funding mechanism and delaying the implementation of the SRS proposed plan would a wise alternative.**

"WHERE DOES THE MONEY GO?"

(Information from "page 5" of SRS presentation 2/22/02)

CMHC	U.S. Census 2000 Populations	Total Funds FY 1999	Adj. Total FY 2002	Difference Gain '99 to '02	% Increase	Total Funds FY 1999 per capita	Adj. Total FY 2002 per capita
Four County MHC	54,204	$3,069,367	$5,894,312	$2,824,945	92.04%	$56.63	$108.74
Franklin Co. MHC	24,784	$1,550,552	$2,877,282	$1,326,730	85.57%	$62.56	$116.09
Miami County MHC	28,351	$1,201,088	$2,009,965	$808,877	67.35%	$42.36	$70.90
MHC of E. Central KS	85,204	$2,697,221	$4,467,414	$1,770,193	65.63%	$31.66	$52.43
Crawford County MHC	38,242	$2,423,611	$3,674,978	$1,251,367	51.63%	$63.38	$96.10
COMCARE-SEDGWICK	452,869	$14,589,174	$21,033,949	$6,444,775	44.18%	$32.21	$46.45
Central Kansas MHC	89,207	$2,491,396	$3,552,044	$1,060,648	42.57%	$27.93	$39.82
Shawnee Community MHC	169,871	$9,060,746	$12,421,655	$3,360,909	37.09%	$53.34	$73.12
Cowley County MHC	36,291	$1,275,262	$1,715,708	$440,446	34.54%	$35.14	$47.28
Sub-total				**$19,288,890**	**71.86%**	**$39.18**	**$58.88**
Iroquois Center for H D	11,084	$1,140,347	$1,529,277	$388,930	34.11%	$102.88	$137.97
Kanza MH & GC	42,347	$1,224,315	$1,617,439	$393,124	32.11%	$28.91	$38.19
Family Life Center.	22,605	$1,226,270	$1,557,790	$331,520	27.03%	$54.25	$68.91
Southeast Kansas MHC	68,229	$2,541,166	$3,152,073	$610,907	24.04%	$37.24	$46.20
Bert Nash	99,962	$2,863,854	$3,504,860	$641,006	22.38%	$28.65	$35.06
Johnson County MHC	451,086	$7,964,665	$9,447,779	$1,483,114	18.62%	$17.66	$20.94
Northeast Kansas M.H. & G.	103,891	$2,574,726	$3,031,202	$456,476	17.73%	$24.78	$29.18
Sumner County MHC	25,946	$818,519	$942,751	$124,232	15.18%	$31.55	$36.34
Pawnee MH Services	162,095	$5,479,319	$6,122,387	$643,068	11.74%	$33.80	$37.77
Sub-total				**$5,072,377**	**18.90%**	**$26.17**	**$31.30**
South Central MHC	59,482	$1,000,901	$1,090,983	$90,082	9.00%	$16.83	$18.34
Center for C&C	50,988	$1,879,842	$2,049,028	$169,186	9.00%	$36.87	$40.19
Area MHC	113,322	$4,320,773	$4,709,643	$388,870	9.00%	$38.13	$41.56
Wyandot MHC	157,882	$7,173,881	$7,819,531	$645,650	9.00%	$45.44	$49.53
Horizons MHC	94,953	$3,329,741	$3,629,418	$299,677	9.00%	$35.07	$38.22
Southwest Guidance Ctr.	36,911	$1,321,033	$1,439,926	$118,893	9.00%	$35.79	$39.01
Prairie View MHC	75,784	$2,608,812	$2,843,605	$234,793	9.00%	$34.42	$37.52
High Plains Comm. MHC	109,993	$4,631,906	$5,048,777	$416,871	9.00%	$42.11	$45.90
Labette Center for MH	22,835	$1,280,261	$1,395,484	$115,223	9.00%	$56.07	$61.11
Sub-total				**$2,479,245**	**9.24%**	**$38.15**	**$41.58**
Total	**2,688,418**	**$91,738,748**	**$118,579,260**	**$26,840,512**	**29.26%**	**$34.12**	**$44.11**

Senate Ways and Means Committee
Testimony on Mental Health Initiative 2000
Submitted by: Elizabeth Adams, Executive Director, NAMI Kansas

Chairman Morris and respected Senators of Kansas, today I am representing thousands of families and mental health services consumers statewide, not only through paid memberships to NAMI Kansas—The Alliance on Mental Illness, but with the grassroots participants of the voter empowerment campaign **"I Vote I Count!"**

First, we thank you. It was the wisdom and request of the Legislature that required the SRS to bring more dollars to the mental health system for services to consumers by increasing Kansas' very low Medicaid reimbursement rates. It is to your credit that millions of new dollars are now entering our system of care.

It is not right to impose policy that would administer these new dollars to the probable detriment of select centers, which clearly means detriment to consumers dependant on those centers' services. While families and consumers are not technical experts in Medicaid regulatory policy, we would present these concerns:

- When respected leaders in our mental health system can be diametrically opposed on the potential safety and benefit to consumers and the system, as they are on the proposed policies attached to these new dollars, we are concerned.
- When programs and services guaranteed through Mental Health Reform dollars are threatened due to immediate loss of those vital funds, particularly in catchment areas not serving a primarily Medicaid client base, we are concerned.
- When budget-driven hospital bed closures and Nursing Facilities for Mental Health bed closures (and entire NFMHs folding from the fiscal impact) are taking place and desperately needed crisis services and multiple other promised programs are ALL, according to the SRS, going to be covered by the panacea of the new, comparative to the need, few Medicaid dollars, we are concerned.
- When the experimental nature of unproven policy is woven so intricately throughout the radical proposed changes in our currently fragile mental health system, we are very concerned.

The National Governors' Association has "universally" cited unsustainable growth in an increasingly demanding Medicaid budget. It has negotiated for days this week on the fiscal crises in the states and the ramifications of Medicaid dependency in the future. Removing Mental Health Reform money in Kansas portends an uncertain and unstable future for people needing mental health services.

Our request is for further study of this experiment before action is taken to potentially undermine or irrevocably harm our mental health system or any individual it serves. We request a Task Force incorporating affected and involved stakeholders to carefully plan the implementation and definite service outcomes for Mental Health Initiative 2000; a brief moment for caution, the time to make an informed decision on data, not guesswork. As you initiated this great benefit, families and consumers are turning to you again for the security of certain beneficial outcomes for the entire state and every citizen in need of mental health services. Thank you.

Senate Ways and Means
2-27-02
Attachment 5

Senate Ways and Means Committee on Medicaid Refinancing

Testimony 02-27-02

Diane Z. Drake, M.N., A.R.N.P.
Executive Director
Franklin County Mental Health Clinic

I am representing a small rural community mental health center of the Osawatomie State Hospital catchment area. Franklin County has a population of 25,000; however, treats one of the largest per 10,000 per capita populations of seriously emotionally disturbed children and severe and persistently mentally ill adults.

I am providing you with testimony today to acknowledge that SRS has come a long way in the many months of discussion, examining a variety of factors to have a compromise. Issues of disparity for a number of centers have been addressed by the compromised position.

My center compromises despite its growing dependence on Medicaid. The position of the western centers hurts the consumers I represent, as our mental health center runs out of certified match in the present funding system. Running out of match inhibits future growth and access for new consumers. Since I believe the legislature is not in the position to come up with new dollars to expand certified match, I support options examined by SRS.

Franklin County Mental Health Clinic

Total Clients Served During 2001: 1637
Total Clients Served During 2000: 1429
Total Clients Served During 1999: 1318

Client Visits/Total Clients Served

	1997	1998	1999	2000	2001
January	1666/373	1502/374	2039/432	2573/456	3803/552
February	1774/394	1598/386	2123/450	2895/491	3245/538
March	1637/374	1636/395	2288/464	2813/499	4013/601
April	1682/386	1812/392	2305/440	3276/537	3679/499
May	1448/358	1354/350	2029/450	3073/499	3500/522
June	1415/360	1598/383	1745/415	2758/488	374/491
July	1531/369	1658/369	1817/400	2390/461	3976/521
August	1682/386	1405/386	1593/393	2865/509	3847/564
September	1596/341	2032/392	2039/414	3147/518	3905/544
October	1698/404	2180/436	2836/478	3420/530	4810/584
November	1464/373	1952/417	2768/492	3136/515	4630/597
December	1355/370	1749/414	2689/498	2594/516	4040/572