Approved: 3-14-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 3:30 p.m. on March 11, 2003 in Room 231-N of the Capitol.

All members were present except: Senator Barnett, excused
Senator Brungardt, excused
Senator Feleciano, excused

Committee staff present: Norman Furse, Revisor of Statutes
Emalene Correll, Legislative Research
Ann McMorris, Secretary

Conferees appearing before the committee:

Others attending: Guest list not taken

At 3:30 p.m. the President's Task Force on Medicaid Reform joined the House Social Services Budget Committee in Room 514-S to hear testimony from:

Alliance for Kansas with Developmental Disabilities which represents service provider organizations and families of persons with developmental disabilities presented testimony on Hospital Closure and on SB 42 which addresses consolidation of the administrative infrastructure of developmental disability services. (Attachment 1)

Community Developmental Disability Organizations. (Attachment 2)

Individual Support Systems, Inc., a provider of developmental disability services, Topeka.(Attachment 3)

Kansas Council on Developmental Disabilities. (Attachment 4)

Community Mental Health Centers of Kansas, Inc. - Michael Hammond. (Attachment 5)

InterHab by Tom Laing. Proposal to mandate consolidation of CDDO areas. (Attachment 6)

Kansas Association of Counties - Randall Allen (Attachment 7)

Following these presentations, the President's Task Force on Medicaid Reform returned to Room 234-N to continue round table discussions on the Mental Health issues. Mr. Pete Zevenberger of the Wyandotte County Mental Health Center discussed the Kansas programs as compared with other states. He noted Kansas' Medicaid system is much stronger and provides more services than other states. In some other states they prefer to not use federal money and therefore offer less services. Kansas is more progressive and uses state, local and federal monies in their mental health programs. More questions regarding fraud and abuse. Senator Huelskamp was given the assignment of checking attorney general reports on fraud and abuse to the mental health programs and reporting to the task force.

Representatives of SRS, Pharmacutical Research and Manufacturers of America, Kansas Medical Society, Post Audit and others joined in the round table discussion. The Chair noted there are various people working on different segments of the report which he hopes can be finalized on Monday, March 17.

The next meeting of the Task Force will be on March 13, 2003.

Adjournment.

Respectfully submitted,
Ann McMorris, Secretary

Attachments - 7

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

e Alliance
For Kansans with Developmental Disabilities

The Alliance for Kansans with Developmental Disabilities

2113 Delaware St. • Lawrence, Kansas • 66046-3149 • (785) 865-5520 x 119 • (785) 865-5695 (fax)

March 10, 2003

RE: Testimony on Hospital Closure

Chairman Landwehr and members of the committee, thank you for the opportunity to testify today. My name is Stephanie Wilson, and I am the executive director for The Alliance for Kansans with Developmental Disabilities.

The Alliance is an association which represents service provider organizations and families of persons with developmental disabilities. Currently we have ten provider members who serve over 800 consumers with developmental disabilities in Kansas. Four of the ten providers specialize in serving persons with severe to profound cognitive, behavioral and medical disabilities. These four providers serve approximately 250 persons who once resided in Kansas institutions, including three fourths of the persons from Winfield State Hospital and Training Center who moved into community settings five years ago.

Many of you who sat on the SRS Transition Oversight Committee during the closure of Winfield State Hospital may remember our successes in this endeavor. I was working in SRS Central Office at the time and was responsible for the approval of the transition and funding plans for the persons moving into community-based settings. As this committee recommends looking at future hospital closure efforts, it is important for us not to forget how we have successfully completed such efforts in the past.

One of primary factors which contributed to our success with the closure of Winfield State Hospital was the opportunity for persons and families to choose from multiple community-based service providers and service settings, all of which were a lower cost option than the institution. 195 persons residing in Winfield State Hospital moved into community-based settings within 18 months. They each chose either a community-based setting funded through the HCBS/MR waiver, or a private ICF/MR depending upon which best met their needs. SRS provided $6,000 per person in one-time start up funds to assist with the cost of rental deposits, utility deposits, furniture, household supplies, and staff training.

Many of the individuals who moved from Winfield required constant support within their home and work settings, as well as other professional supports such as nursing, occupational and physical therapy, and psychological services. Several of the individuals had significant medical issues such as feeding tubes, significant seizure disorders, and tracheotomies. Others had significant behavioral issues which required behavioral planning and medication oversight.

One of the keys to successful community placement was the ability of community service providers to negotiate an individualized rate for the individuals who had extraordinary needs. In addition, those whose needs were better met in an ICF/MR setting were allowed to choose that level of support.

Through the most recent allotment, individualized and special tier rates provided to persons with extraordinary need were cut by 5%. SRS and the CDDOs are considering reducing them even further. In addition, the GBR for FY04 proposes to cut private ICF/MR rates by 10%. SRS has also reduced the start-up funds amount available to persons moving from institutions from $6,000 to $1,200. Even though state institutions are more costly than HCBS/MR or private ICF/MR funded programs, we have chosen to jeopardize the systems which make state hospital placements possible.

If we are to consider closing another state mental retardation hospital for the purpose of redirecting funding to community-based care, we need to reinstitute stable individualized or special tier funding to persons who have extraordinary needs, and stable, sufficient ICF/MR rates to serve persons who need that level of care. If we are to be successful at this effort, we cannot jeopardize the programs which would best meet the needs of the individuals to be placed.

I would be happy to answer any questions you may have.

The Alliance
For Kansans with
Developmental
Disabilities

The Alliance for Kansans with Developmental Disabilities

2113 Delaware St. • Lawrence, Kansas • 66046-3149 • (785) 865-5520 x 119 • (785) 865-5695 (fax)

February 24, 2002

RE: Testimony Regarding SB 242

Chairman Morris and members of the committee, thank you for the opportunity to provide testimony today regarding SB 242 which addresses consolidation of the administrative infrastructure of developmental disability services. My name is Stephanie Wilson and I am the Executive Director of The Alliance for Kansans with Developmental Disabilities.

As you are aware, there are currently 28 private Community Developmental Disability Organizations with which SRS contracts to organize services. The administrative regions vary in size from 151 to 17,000 square miles, and in number of persons served from 57 to 1289. The population of Medicaid eligible persons served within each area ranges from 45% to 88%. The total reimbursement to CDDOs for administrative expenses ranges from $480 to $1625 per person per year. SB 242 reduces the number of CDDOs from 28 to 13 or fewer.

The Alliance supports SB 242 for the following reasons:

- **Better Maximization of Existing Funds:** Each CDDO has a different amount of state and local funds which are available for match. The federal government prohibits each CDDO from independently increasing its Medicaid service rates up to the amount of match available. Instead, all CDDOs can only match up to the amount of the lowest common denominator. If only 13 CDDOs existed at the beginning of FY03, we could have come close to obtaining the $30 million we hoped to achieve through federal maximization efforts. However, because of the existing CDDO structure, approximately $10 million was left unmatched. By pooling available matching funds through consolidation of CDDO regions, the lowest common denominator can be raised to bring in additional federal funds.

  Attached is a spreadsheet developed by SRS which indicates how the fragmented use of available match is becoming a problem even for maintaining current services. The spreadsheet was provided last week by SRS to the SRS/CDDO Statewide Funding Committee. It indicates that some CDDO areas which have less state and local funds are currently running out of available match for Targeted Case Management services, while other areas have up to $3.3 million left in matchable funds. Currently this is the only service provided to persons who are on the waiting list which has the potential of keeping persons out of crisis situations.

The maximization of match problem was also identified in a recent letter from the Wichita CDDO to Senator Feliciano. As the CDDO director pointed out, many stakeholders participated in a workgroup established by SRS to try and maximize federal funding. Although both SRS and members of the group proposed several ideas for maximizing funds, the group continued to run into the roadblock of the varying amounts of available match, and percentage of non-Medicaid eligible persons served, which prohibited the workgroup from being able to increase the statewide Medicaid rates for services in an equitable fashion. Instead SRS implemented a maximization plan which was later disallowed by CMS.

Creation of More Efficient/Objective CDDOs:

- The Alliance has discussed with SRS, the Legislature, and Legislative Post Audit the issue of conflict of interest when a CDDO is also a service provider organization. In 1999 the Division of Legislative Post Audit identified this conflict of interest to be a problem in need of correction. Although SRS has taken steps to include "conflict of interest" language within regulations, the problems continue to exist.

  Recently the Alliance acquired the findings of a 2001 audit completed internally by SRS on the issue of conflict of interest. The findings of the audit indicate that although the developmental disability system has an adequate infrastructure of statute, regulation, and policy, the existing conflict of interest when a CDDO is also a service provider prohibits the system from working in an effective way for the consumers. The audit points out that CDDOs compete with service providers for available consumers and available funds. The consumer has become a commodity within the system with no objective means of making choices about needed services.

  Providers and consumers who are located in areas where a CDDO has separated itself from service provision have communicated improvement. An independent CDDO is much more suited for providing objective information to consumers about services, and for objectively managing available funding.

  CDDOs which are independent from service provision are also able to provide more funding management and quality assurance oversight without the current duplication of these responsibilities by SRS.

  You recently heard in testimony that the CDDO infrastructure is one of the most economical, costing only 2.4% of funds available. This data is not all inclusive of the funding CDDOs receive, or have independently taken for administrative uses. As indicated in The Alliance proposal, CDDOs receive anywhere from $488 to $1600 per person per year for administration. In addition, through the most recent efforts of SRS to match additional federal funds through targeted case management, CDDOs each decided locally what percent of new administrative dollars to take out of the new funds. The Alliance made an open records request to obtain each CDDO's local funding plan. 24 of the 28 CDDOs responded. Out of the 24 responses we learned that CDDOs were taking anywhere from 2.4% to 15% of the new federal funds even though no additional persons were being served. The total amount was over $ .5 million. Two of the CDDOs who did not respond to our request

indicated that it was a local decision and that they do not have to divulge how the funds are being utilized.

Answers to Concerns Raised

A few concerns have been addressed with legislators, SRS and The Alliance regarding SB 242. We have the following responses:

- **Local county investment:** In order to assure counties that they will maintain control of how their local dollars are expended, The Alliance suggests adding language to the Chapter 19 statutes which indicates that each county will pass its county mill funds through the designated CDDO for the sole purpose of match, but will retain the ability to designate how and where the funds are expended.

  In addition, The Alliance supports SRS working with local county government in the establishment of the realigned CDDO infrastructure. Local county commissions and providers should give input as to what services are currently available, and what services are needed. This information will help SRS to ensure that the needs of each county are met within its assigned region. County commissions within a given CDDO region can also participate in the selection of board members for the newly established CDDO. This will help to assure local government that their consumers are adequately represented in decision making.

- **Transferring SGF from non-Medicaid services to Medicaid services:** SRS currently utilizes state and county funds which are designated to cover the cost of CDDO administration and services to non-Medicaid eligible persons as certified match for federal funds. The Alliance proposal indicates how this current system can be utilized through consolidation to gain even more federal dollars. If CMS should decide to discontinue some or all of the current uses of certified match, many existing developmental disability services are going to be placed in jeopardy. CDDOs will be better positioned to incur these changes if they are in larger regions with pooled funds, where dollars can be more easily shifted to meet existing needs.

- **Lack of CDDO input to The Alliance proposal:** Although a few CDDOs have indicated that no input was given regarding The Alliance proposal, we have received input from a handful of CDDOs. Some CDDO directors stated that it is probably time to look at this option in order to gain efficiency and maximization of current funds.

- **Loss of jobs:** We do not believe that a significant number, if any, current CDDO staff will lose their jobs through consolidation. 24 of the 28 CDDOs also provide direct services. With the high turnover rate in our industry, we believe that persons will be able maintain jobs within their service provider organizations.

Thank you again for the opportunity to testify. I would be happy to answer any questions you may have.

From SRS 2/19/03 TCM 2

1-6

	A	B	C	D	E	F	G	H	I	J
		State Funds from Allotment	Correct.	Available County Mill	TOTAL	SSBG	Total - SSBG	CDDO Estimated TCM Cost	Required match	Remaining match
1										
2	CDDO Name									
3	Achievement	$234,337.00		$0.00	$234,337.00	$128,993.00	$105,344.00	$240,000.00	$96,000.00	$9,344.00
4	Arrowhead West	$844,213.00		$513,825.00	$1,358,038.00	$372,798.00	$985,242.00	$1,132,868.00	$453,147.20	$532,094.80
5	Big Lakes	$574,631.00		$310,332.00	$884,963.00	$200,652.00	$684,311.00	$855,768.00	$342,307.20	$342,003.80
6	BCDS	$110,046.00		$46,509.00	$156,555.00	$51,424.00	$105,131.00	$287,930.00	$115,172.00	-$10,041.00
7	CLASS Ltd.	$755,630.00		$458,700.00	$1,214,330.00	$202,064.00	$1,012,266.00	$2,484,564.00	$993,825.60	$18,440.40
8	COF	$675,271.00		$266,431.00	$941,702.00	$416,411.00	$525,291.00	$1,111,560.00	$444,624.00	$80,667.00
9	COMCARE	$3,156,132.00		$2,155,886.00	$5,312,018.00	$1,518,620.00	$3,793,398.00	$6,000,000.00	$2,400,000.00	$1,393,398.00
10	Cottonwood Inc.	$735,069.00		$370,127.00	$1,105,196.00	$421,033.00	$684,163.00	$1,742,509.00	$697,003.60	-$12,840.60
11	CCDS	$386,498.00	$252,817.00	$0.00	$386,498.00	$0.00	$386,498.00	$1,182,000.00	$472,800.00	-$86,302.00
12	DPOK	$793,510.00		$576,658.00	$1,370,168.00	$325,023.00	$1,045,145.00	$1,931,912.00	$772,764.80	$272,380.20
13	DSNWK	$1,006,635.00		$580,828.00	$1,587,463.00	$407,779.00	$1,179,684.00	$1,736,000.00	$694,400.00	$485,284.00
14	Flinthills Services	$355,387.00		$65,500.00	$420,887.00	$177,692.00	$243,195.00	$605,605.00	$242,242.00	$953.00
15	Futures Unlimited	$170,129.00		$21,000.00	$191,129.00	$70,413.00	$120,716.00	$335,796.00	$134,318.40	-$13,602.40
16	Hetlingers	$314,236.00		$25,000.00	$339,236.00	$118,958.00	$220,278.00	$603,328.00	$241,331.20	-$21,053.20
17	JCDS	$1,304,936.00		$3,975,000.00	$5,279,936.00	$492,083.00	$4,787,853.00	$3,625,000.00	$1,450,000.00	$3,337,853.00
18	MCDS	$214,787.00		$45,265.00	$260,052.00	$39,914.00	$220,138.00	$653,441.00	$261,376.40	-$41,238.40
19	Nemaha County	$250,380.00		$41,600.00	$291,980.00	$149,026.00	$142,954.00	$169,637.00	$67,854.80	$75,099.20
20	New Beginnings	$90,160.00	$53,772.00	$0.00	$90,160.00	$0.00	$90,160.00	$330,960.00	$132,384.00	-$42,224.00
21	Northview	$325,101.00		$66,179.00	$391,280.00	$136,235.00	$255,045.00	$690,927.00	$276,370.80	-$21,325.80
22	Riverside	$327,157.00		$99,309.00	$426,466.00	$98,631.00	$327,835.00	$529,934.00	$211,973.60	$115,861.40
23	SDSI	$960,170.00		$555,118.00	$1,515,288.00	$372,029.00	$1,143,259.00	$1,373,173.00	$549,269.20	$593,989.80
24	Sunflower	$356,099.00		$57,540.00	$413,639.00	$9,206.00	$404,433.00	$1,269,998.00	$507,999.20	-$103,566.20 *
25	TARC	$1,254,524.00		$419,020.00	$1,673,544.00	$530,455.00	$1,143,089.00	$2,811,269.00	$1,124,507.60	$18,581.40
26	TECH	$495,283.00		$475,000.00	$970,283.00	$249,816.00	$720,467.00	$960,000.00	$384,000.00	$336,467.00
27	Tri-Ko	$740,982.00		$221,483.00	$962,465.00	$492,338.00	$470,127.00	$790,758.00	$316,303.20	$153,823.80
28	Tri-Valley	$326,131.00		$179,447.00	$505,578.00	$33,843.00	$471,735.00	$1,014,620.00	$405,848.00	$65,887.00
29	Twin Valley	$313,777.00		$0.00	$313,777.00	$153,605.00	$160,172.00	$416,084.00	$166,425.60	-$6,253.60
30	WCDDO	$807,412.00		$351,217.00	$1,158,629.00	$394,524.00	$764,105.00	$1,450,000.00	$580,000.00	$184,105.00
31		$17,878,623.00	$306,589.00	$11,876,974.00	$29,755,597.00	$7,563,563.00	$22,192,034.00	$36,335,621.00	$14,534,248.40	$7,657,785.60

SSBG

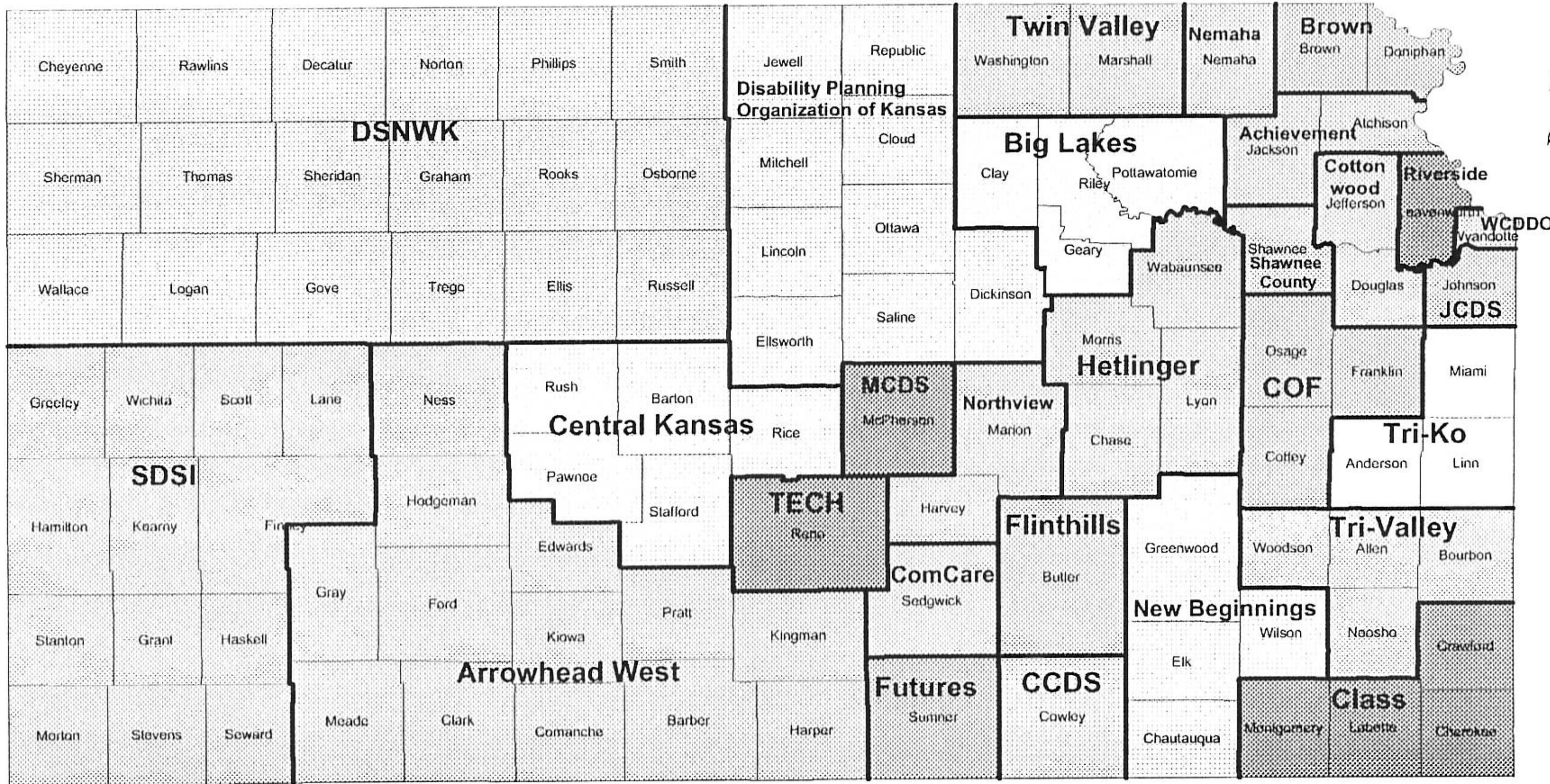
-320,000
+260,000 Reserve
-60,000

Potential Solutions:

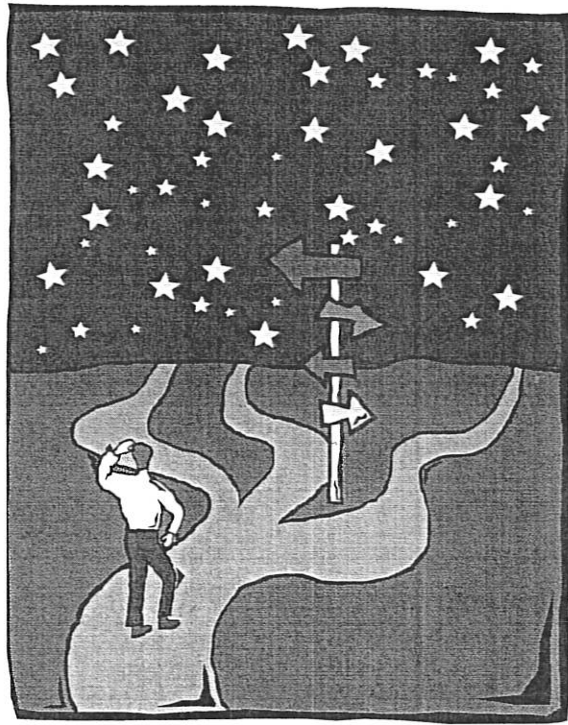
1. SRS has $260,000 in Reserve to correct areas with not enough match.
2. The SSBG funds can be shifted out of areas who are running out of match and replaced with matchable SGF.

Kansas CDDO's

President's Task Force
on Medicaid Reform
March 11, 2003
Attachment 2-1



Date of Map: July 8, 2002



DD Institution Closures In Five States

Brief Summary

2-2

What led to Closure?

- ❑ Financial realities of supporting institution(s)—true in all surveyed states.
- ❑ Moratoriums on long-term admissions, as WI currently has.
- ❑ Some momentum came from Department of Justice investigations (none of which required closure but led to a closure process—MN, OR)
- ❑ Lawsuits filed on behalf of people on waiting lists for disability services (the outcomes of which also did not call for closure – VT, WV).
- ❑ Departments also wanting to see closure happen and were instrumental in heading up and backing the effort – sticking by their decision to close.
- ❑ Advocates' efforts.

Unions

Oregon

- ➢ Unions were engaged in discussions about closure before decision to close.
- ➢ Long-Range Planning Group was formed comprised of "two of everyone" – representatives from the State, unions, providers, etc.
- ➢ Also formed a Labor Sub-Group that addressed what the institution would do to help employees find jobs elsewhere.
- ➢ **Help for Institution Employees:**
    - Dept. of Labor set up an employment office at the institution.
    - Governor directed other state agencies to prioritize employees for other state positions (esp. in Corrections).
    - Retraining for other state positions.
- ➢ Unions never agreed to closure but said, "If you do close…this is what we think should happen."
- ➢ 1000 FTE employees and less than 200 did not end up with jobs.

2-3

Minnesota

- During settlement negotiation, opposition from the unions was very high. However, by the time people were moving out and state-operated facilities were created, opposition was "0."
- Employees saw the success of community services and liked working there better.
- Many employees felt that there was a large core of people that would never be able to move out to the community.
- A Memorandum of Understanding was created through the negotiated settlement process. Terms were included in the closure legislation.

WestVirginia

- State employees for direct care and service were unionized.
- Union members were not incorporated into discussions about closure before the decision to close was made.
- There was not anything "put on the table" that made closure acceptable to the unions.

Vermont

- Department of Employment & Training opened an office on campus with computer banks of jobs and held job fairs.
- Human services granted special priority to people from the institution for jobs.
- Some staff became public guardians for former residents that they knew.

Alaska

- Unions extremely opposed to closure. Valdez a very small town with very few job prospects.
- Unions requested that sick leave and annual leave (vacation) be combined into a personal leave system (not cost-effective so unable to accommodate).
- Formed a Labor Management Committee that listened to employees and tried to incorporate their wishes as much as possible into the agreements that were negotiated. Unions were not part of the actual decision-making process, however.
- Many employees were relocated to other parts of the state because commuting was not an option.
- Did not offer severance packages but worked with other state offices to streamline the transfer process where employees were prioritized for jobs.

- Some employees went to Alaska Psychiatric Institute—similar environment to Harborview.
- Offered career counseling, aptitude testing, training, workshops on resume writing, retraining through the vo-tech school. Actively marketed staff to nursing homes.
- Some of the staff followed residents into the community and many ended up working in home settings.

Crisis Intervention

Oregon –Crisis Beds

- State was divided into 6 regions, with 15-20 beds/region
- Crisis bed environments are very similar to specialized foster homes
- Outreach to community an integral part of the program—support local providers to help someone stay in their home.
- Have 3 staff/region (1 medical specialist, 1 behavioral specialist—although the real need has been in the area of behavior).
- **KEY**= Short-term county $$ for extra supports (for 90 days).
- Group homes not successful for crisis intervention.

Minnesota – METO Program

Two-pronged: a) Outreach efforts
b) Residential services

- 48 beds in a town home-like setting; generally serves about 36 people at any given time. 4-6 people in each town home.
- Average length of stay is less than 1 year—many stay 60-90 days.
- ONLY available for individuals who are a danger to themselves or others—they are court committed to state services.
- METO works with providers to build services around individuals in their home communities.
- Typically serve people with multiple needs such as mild mental retardation, substance abuse, mental illness, and involvement with the law.

West Virginia – Life Quilters

- Patterned after Vermont's crisis program.
- Included outreach, consultation, training, and crisis beds.

2-5

- Facilities were up to 3 beds (in addition, 1-2 beds in strategic population sites) TOTAL = 7 beds.
- Problems with crisis beds in WV:
    - Providers not wanting to ask for help from crisis.
    - Insuring that they are not being used as respite for staff.
    - DD Council currently contracts with a university to provide behavioral support/consultation.

Vermont – VT Crisis Network

- VT Crisis Network was developed by an agency that was doing successful work with challenging behaviors.
- They can provide emergency placement but the focus is to build agency capacity around the state.
- **There are 3 levels of service:**
    1) **Monthly meetings** are held where members of agencies consult and problem-solve. State administrator attends these meetings regularly and decisions can be made about increased staff needs at that meeting.
    2) **1 or 2 people from Network can visit the individual and his/her family, if appropriate, and the agency providing services.** Together, they develop a plan for change. (Usually the Director of the Network provides this consultation). It is important to have someone involved that has decision-making power.
    3) **If the individual is considered at risk, the Network provides emergency placement.** 2-3 individuals is capacity. Resources have also been converted to allow emergency assistance to be provided in at least one person's home, too. Decision collaboratively made by Network as to who gets that service. Agency members providing service must attend weekly planning meetings. Agency is expected to develop supports the person needs in 30-60 days. Must refer on if can not do it in that timeline. One regional network created—pooled funding.

State-Operated & Other Programs

Oregon – State-Operated Group

- 60 of 300 residents from the institution went into state-operated group homes.
- **2 types of homes:** 1) Medically fragile 2) Significant Behavior Issues with increased risk to themselves and others.

- Families helped come up with the criteria for the homes in order to keep the number of residents small.
- 3-5 Residents per home.
- 145 people are now served in the state-operated group homes (out of 4500 served in the system).
- There is no current plan to down-size or phase-out the state-operated homes.
- Homes were a concession to the unions. Some institution employees followed residents into the community.

Minnesota – State-Operated Facilities

- Held a competitive bidding process for state-operated services.
- Major negotiating aspect with the unions.
- Typically a waivered, 4-person or smaller living arrangement.
- Some medically fragile residents went to these homes from the institution—but today the majority of medically fragile people are ***not*** in state-operated facilities.
- There is an active plan to eventually convert these facilities to the competitive market place.

West Virginia

- Short-term residential services for children:
  - Potomac Center (private) has short-term intervention stays for children.
  - 24 beds on the campus
  - Stiff penalties for going beyond 18 month stay (Short-term is not statutorily defined).
  - Most stays are less than 11 months.
- Specialized Care Homes for Children:
  - For children who can't be with their natural families.
  - Funded better than foster care and have a maximum of 2 people in a home.

Vermont

- 9 community mental health centers were already in place throughout Vermont with a small number of independent providers who were sub-contracted.
- Due to time pressures, a limited number of agency-operated, group living situations were developed using the "Developmental Home Model."

2-7

Land Use

Oregon

- Fairview — Mothballed" - Purchase Pending by private university

Minnesota

- Fairbeau — Federal Prison (negotiated before closure legislation passed)
- Moose Lake — Federal Prison (people with psychopathic disorders)
- Cambridge — Limited use by Human Services but interest by a community college, the County, and the City.

West Virginia

- Spencer — Demolished
- Weston — Vacant
- Greenbrier — Community College
- Colin Anderson — Medium Security Correctional Facility

Alaska

- Harborview — Vacant – maintained by local hospital

2-8

3615 SW 29th St.
Suite 201
Topeka, KS 66604
FAX 785-228-9640
785-228-9443

March 10, 2003

RE: Testimony Regarding Individualized/Special Tier Rates

Madame Chair Landwehr and members of the Committee, I appreciate the opportunity to testify today. My name is Kathy Stiffler, and I am the Chief Executive Officer of Individual Support Systems, a provider of developmental disability services in Topeka.

Two weeks ago I provided this committee with information about Individual Support Systems. Our organization was founded to primarily serve persons from state mental retardation hospitals with severe cognitive, behavioral, health and other significant needs. I discussed with you how persons who historically were placed from institutions are quickly having their individually negotiated rates reduced or even taken away. I presented how SRS implemented within the FY03 contract with CDDOs a "sub-allocation" for such rates which left many CDDOs with inadequate funding to continue those rates. Persons placed from institutions have thus taken the 5% rate cut implemented through Gov. Graves' allotment, and, in addition, have had their funding cut through this sub-allocation provision.

Over the past two weeks, our situation has only worsened. SRS has presented estimates indicating that on a statewide basis CDDOs will overspend the fiscal year 2003 HCBS/MR waiver allocation by over $3 million. SRS, the CDDOs and other stakeholders have developed recommendations for how to deal with the overspending in the next four months, and SRS has allowed the CDDOs to vote on the recommendations. Not surprisingly, 25 of the 28 CDDOs have voted in favor of further reductions to individual and special tier rates, rates to persons whom CDDOs primarily do not serve.

This additional threat to individualized rates initially resulted in our agency beginning to develop a list of persons who we will no longer be able to safely serve. **As we reviewed the difference between Tier rates and the Individualized rates currently provided to the people we support, we determined that ISS would no longer be able to support the 60 individuals we currently help. We are a non-profit agency and will plan on closing our doors; if SRS and the CDDOs decide to discontinue Individualized/Special Tier rates. Approximately 31 people we currently support will end up back in the state institutions, as their needs are so specialized that other**

President's Task Force
on Medicaid Reform
March 11, 2003
Attachment 3-1

agencies will more than likely not serve them at the current Tier rates. These are persons who previously resided in institutions because other community agencies were unable, or unwilling to serve them. **Specifically, the Tier rates provided are not adequate to fund their needs. Please note that the individualized rates continue to be less than the daily rate at state institutions.**

Ron is a person we support, who has been very successful living in the community. He resides with one other gentleman. Ron works at Capital Plaza Hotel about 25 – 30 hours weekly. **He is a tax payer in the State of Kansas.** He lives in a two bedroom duplex, pays his rent, and living expenses. Ron uses The Lift for most of his transportation. He was institutionalized most of his life; and demonstrated severe self-mutilation, and repeated suicide attempts during his institutionalization. Ron left KNI and moved into his home in Topeka in 1996. He receives an Individualized Rate. His rates continue to be significantly less than if he were institutionalized. Ron continues to have severe bouts of depression and suicide attempts; however, he no longer demonstrates the self-mutilation. He is happy and successful; however, his life will dramatically change when he is placed back into a state institution.

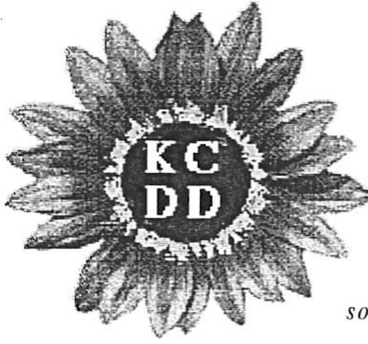
At the same time ISS has begun to identify who from institutions we will no longer be able to serve, this committee has made a recommendation to develop a work group to look at the possibility of closing another state mental retardation hospital. ISS and other agencies which specialize in serving the most difficult persons with developmental disabilities will simply not be able to assist with another closure until the individualized and special tier rate structure becomes stable again.

If we are to be successful in closing another institution, and assisting those persons in securing successful community-based services, SRS needs to take a leadership role in protecting the rates to those they have identified has having extraordinary need. The DD Reform Act is clear on the requirement for funding these persons:

"*For persons moving from institutions into the community, directs funding to follow in an amount not less than that which is required to reimburse community service providers for services as set forth in such person's plan for transfer from the institution to community services including expenses of relocation and initiation of services.*"

Therefore it doesn't make sense for SRS and the CDDOs to continue to threaten funding to these persons more than to those who have fewer needs. We request that this legislature will guide SRS to strengthen the system of funding needed to continue serving persons who have been placed from institutions, and to support those who will be placed if a closure plan is developed.

I would be happy to answer any questions you may have.



Kansas Council on Developmental Disabilities

KATHLEEN SEBELIUS, Governor
DAVE HEDERSTEDT, Chairperson
JANE RHYS, Ph. D., Executive Director

Docking State Off. Bldg., Room 141, 915 Harrison
Topeka, KS 66612-1570
Phone (785) 296-2608, FAX (785) 296-2861

"To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities"

SOCIAL SERVICES BUDGET SUBCOMMITTEE

March 10, 2003
Room 514-S

Madame Chairperson, Members of the Committee, my name is Jane Rhys and I represent the Kansas Council on Developmental Disabilities. I am here to speak about the current Kansas Developmental Disabilities system.

The Kansas Council is federally mandated and federally funded under the Developmental Disabilities Assistance and Bill of Rights Act of 2000. We receive no state funds. It is composed of individuals who are appointed by the Governor, including representatives of the major agencies who provide services for individuals with developmental disabilities. At least 60% of the membership is composed of individuals who are persons with developmental disabilities or their immediate relatives. Our mission is to advocate for individuals with developmental disabilities to receive adequate supports to make choices about where they live, work, and learn.

I am pleased to report that the Council met Thursday to review both Senate Bill 242 and the Alliance proposal. Both Stephanie Wilson, of the Alliance, and Tom Laing, of Interhab, were present to assist us in understanding each document and the possible ramifications. After much discussion, the Council voted and asked me to convey to you their recommendations.

The Council does not support Senate Bill 242 or any similar version of that Bill. We have carefully reviewed it as well as the Alliance proposal and have grave concerns with both. First, recognize that we have problems with our current system. There is not enough money to fund services for those in desperate need. We also recognize that there are conflict of interest issues in parts of our system and support improvements that would reduce or eliminate this problem. We believe that a careful review of

our system might provide us with savings that could be used to serve additional people as well as reduce the conflict of interest problem. However, we believe that more thought needs to go into the solution.

The Kansas Developmental Disabilities Reform Act was the product of two years of intense deliberations. It took most of the 1995 Legislative Session for the House Select Committee on Developmental Disabilities to write the Bill. The Committee met several times a week with full stakeholder participation. Stakeholders included primary consumers of services, parents, advocates, and service providers of all types, thus ensuring their support of the Act. The Act did not take effect on July 1 but was delayed until January 1 to give the system time to evolve and meet the requirements needed for implementation. SB 242 would take effect July 1, not enough lead time to adequately prepare for Community Developmental Disabilities organization (CDDO) consolidation or the development of new CDDOs. It should be noted that not all CDDOs may choose to remain a CDDO. Some may prefer their role as a service provider.

With all due respect, neither SB 242, nor the Alliance Proposal, was developed by all or even a majority of DD system stakeholders. We again suggest that you appoint a committee that includes all DD stakeholders to study the system and make recommendations to you in the 2004 Session. This will produce a proposal that has the support of many and one developed with careful thought by those who thoroughly understand all ramifications.

Some concerns expressed by the Council were possible loss of funding in the following areas:

- Infant/Toddler programs, many supported by CDDOs;
- County mill levy (reduced or eliminated if counties have no part choosing local administration);
- Elimination of funding for children and adults not receiving waiver services (they could either be driven to more expensive services if forced to be on the waiver or lose all services if they do not qualify);
- Accessibility issues (public transportation is an unmet need statewide);
- What is the optimum size for a CDDO? Is it based on square miles, population? Do we know? Are larger CDDOs more efficient and less costly than smaller ones? In a careful review of per person administrative costs, it appears that both small CDDOs and large ones are represented in the "least expensive" column (see attachments); and
- The start up time of July 1 does not provide enough lead time to accomplish the goals of the Bill.

On January 22 we asked that the State of Kansas convene a group of stakeholders and charge them with the task of reviewing the current system to see if and where savings could be realized. The Council highly recommends that you look at our request, not only because the state is facing a budget crisis, but because we need to improve, to make our system the most effective, efficient state DD system in our nation.

As always, we greatly appreciate the opportunity to speak to you and would be happy to answer any questions.

Jane Rhys, Executive Director
Kansas Council on Developmental Disabilities
Docking State Office Building, Room 141
915 SW Harrison
Topeka, KS 66612-1570
785 296-2608
jrhys@alltel.net

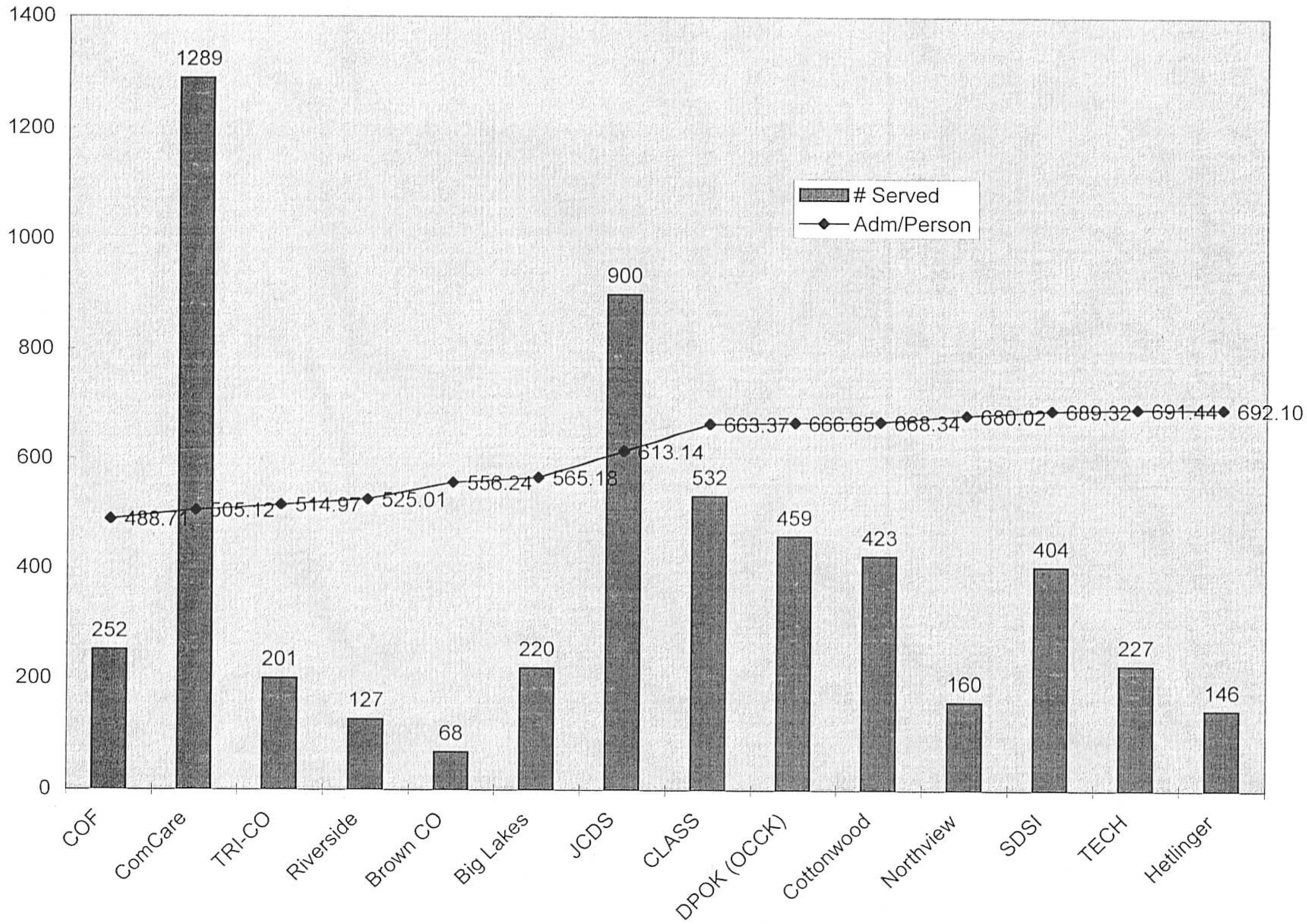
Attachment 1

CDDO Administrative Costs - 2003

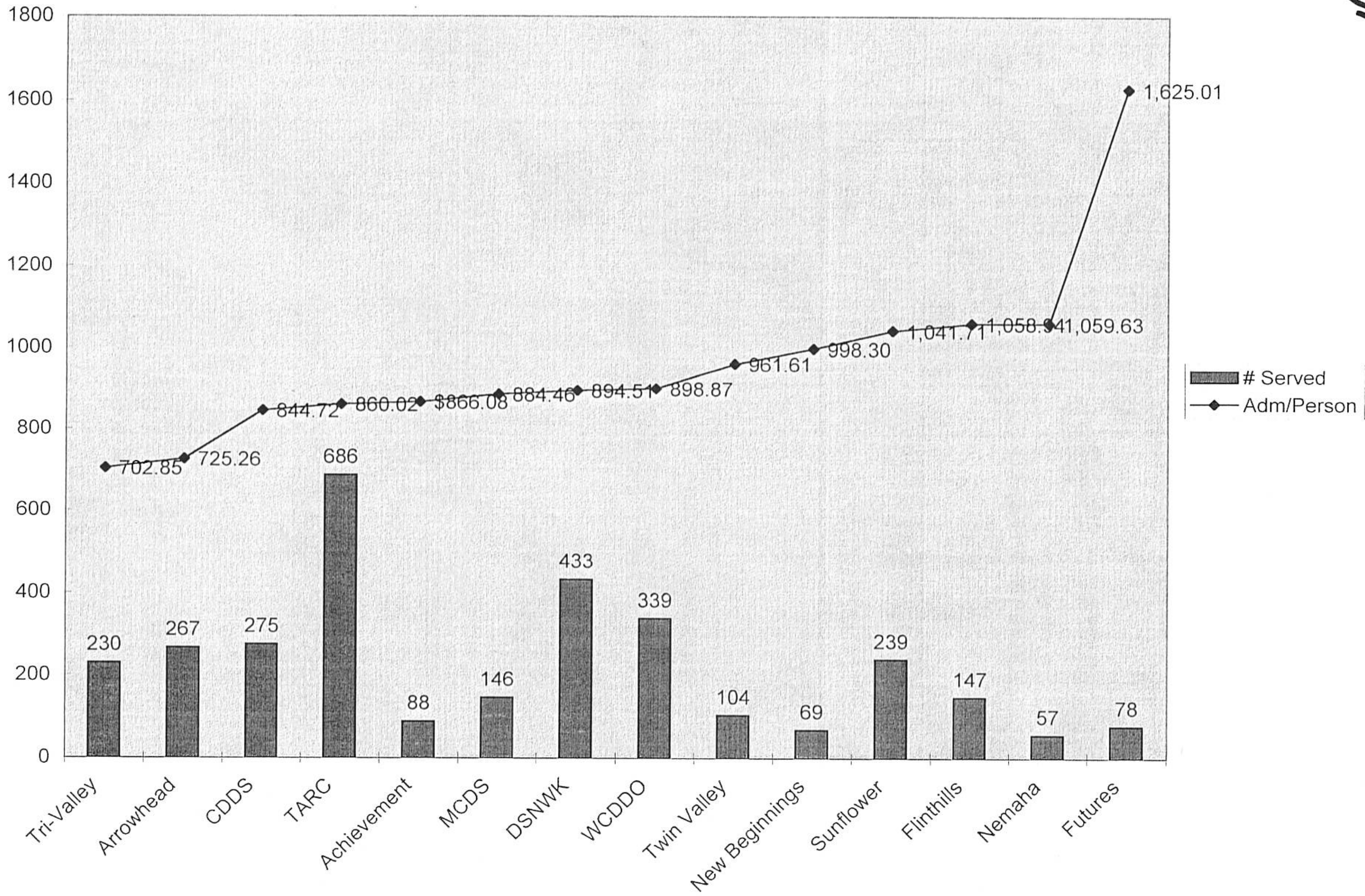
CDDO	# Served	Sq miles	Serv Alloc	Admin SGF	Total Admin	Admin/Person
COF	252	1887	5758693	72230	123154	488.71
ComCare	1289	1000	29189513	361192	651094	505.12
TRI-CO	201	1884	5632828	60708	103509	514.97
Riverside	127	463	2259947	39106	66676	525.01
Brown CO	68	960	1876411	22184	37824	556.24
Big lakes	220	2447	4964195	66722	124339	565.18
JCDS	900	477	19852783	265894	552061	613.40
CLASS	532	2477	13939860	187445	352913	663.37
DPOK (OCCK)	459	6793	10225180	132822	305993	666.65
Cottonwood	423	996	11578070	116247	282707	668.34
Northview	160	1484	4301827	43138	108803	680.02
SDSI	404	10029	9148105	106051	278486	689.32
TECH	227	1254	5237287	70967	156958	691.44
Hetlinger	146	2904	3591291	53062	101047	692.10
Tri-Valley	230	2217	6196496	59249	161655	702.85
Arrowhead	267	11520	6417632	91864	193645	725.26
CDDS	275	1128	13899656	86390	232297	844.72
TARC	686	550	17682827	222281	590505	860.79
Achievement	88	1089	1651356	26092	76215	866.08
MCDS	146	900	4349005	48858	129131	884.46
DSNWK	433	17065	11924262	138263	387324	894.51
WCDDO	339	151	6715091	99207	304716	898.87
Twin Valley	104	1778	2382660	31214	100007	961.61
New Beginnings	69	3004	1608324	19725	68883	998.30
Sunflower	239	3884	7243916	67141	248969	1041.71
Flinthills	147	1428	4273997	44572	155664	1058.94
Nemaha	57	719	849483	23019	60399	1059.63
Futures	78	1183	1868451	23339	126751	1625.01

Sorted by per person costs.

Attachment 2A
CDDO Per Person Administrative Costs



4-5



4-6

State DD Hospital Closure Work Group
Recommendations

March 11, 2003

Recently you asked us to develop a proposal for hospital closure. Stephanie Wilson, Gina McDonald, and I met March 10 and have the following proposal.

\\Jane Rhys

General: The following are general recommendations:

- Use the closure of Winfield State Hospital and Training Center (WSH&TC) closure as the model with some modifications.
- Close one hospital immediately. Plan for closure of the second hospital within five years.
- The majority of the persons residing in the facility should move to the community of their choice.
- All money saved from closure if not needed for the institutions' residents in the community, must be used for community services for people with developmental disabilities.
- Stabilize current community services funding in order to allay concerns of parents and service providers regarding future loss of services.

The following Steps are those recommended by the Hospital Closure Work Group:

Step 1: Develop timelines for closure of the facility;

Step 2: Put one SRS employee in charge of closure for oversight and contact purposes;

Step 3: Contact parents/guardians regarding the future of institution, include deadlines/timelines/options in the letter;

Step 4: Contact each CDDO of record with list of parents/guardians in their area, the CDDO will be in charge/responsible for Community Integration Planning;

Step 5: Set up contacts for parents/guardians with WSH&TC parents/guardians, SRS staff, community service providers, and others who can be of assistance;

Step 6: Ensure that Medicaid funds follow the person to the community and start up costs of up to $6,000 for community integration and special tier rates are available if needed;

Step 7: Provide a benefits package for those state employees who work at the facility similar to the one provided for WSH&TC employees; and

Step 8: Convene a joint State/County/City entity to make recommendations for use of facility after closure.

Association of Community Mental Health Centers of Kansas, Inc
720 SW Jackson, Suite 203, Topeka, Kansas 66603
Telephone: 785-234-4773 / Fax: 785-234-3189
Web Site: www.acmhck.org

Randy Class, President
Michael J. Hammond, Interim Executive Director

Testimony to the House Social Services Budget Committee and the President's Medicaid Reform Task Force

March 11, 2003

Madame Chair and Mr. Chairman, members of Committee and Task Force, I am Mike Hammond, Interim Executive Director of the Association of Community Mental Health Centers of Kansas, Inc. Thank you for this opportunity to appear before you today to touch on the issue of consolidation. Joining me today are three Community Mental Health Center (CMHC) Executive Directors – David Boyd of Crawford County Mental Health Center in Pittsburg; Scott Jackson of Family Life Center in Columbus; and Pete Zevenbergen of Wyandot Mental Health Center in Kansas City;

The Association represents 29 licensed Community Mental Health Centers (CMHCs) - providing mental health services in every county in 120 locations. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,000 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems.

Primary Goal of CMHCs

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals through mental health programs in the least restrictive environment. The CMHCs strongly endorse treatment at the community level in order to allow individuals to keep functioning in their own homes and communities at a considerably reduced cost to them, third-party payers, and the taxpayer.

Shared Governance – A Partnership Between State and Local Government

Most Kansans are probably unaware that county government is the cornerstone of the Kansas public mental health system. In 1962, the Kansas Legislature passed the Community Mental

Health Centers Act. This Act provided for the establishment and governance on county government. The Mental Health Reform Act of 1990 reaffirmed the principles and values of a locally controlled mental health system.

A CMHC can only be created by action of the Board of County Commissioners. County government serves two principal roles with respect to CMHCs: determining and establishing the governing structure for CMHCs; and providing county financial support for CMHCs.

The CMHCs also have a substantial partnership with state government. Among the state's role in the public mental health system is licensure of CMHCs, contracting with CMHCs for services, statewide oversight and focus on target populations.

In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system, with its local governing boards, is funded in large part with state and county funds. Consequently, service delivery decisions are made at the local level, closest to the residents that require mental health treatment.

As the local Mental Health Authorities for community-based mental health services in Kansas, CMHCs provide the primary linkages between and among service agencies and transition from child to adult services. The CMHCs serve as the gatekeepers to state mental health hospital treatment by screening all referrals to state hospitals.

Meeting the Mental Health Needs of Kansans

During the period from 1970 to 1997, the state hospital average daily census declined by more than 80 percent. Many of these former hospital patients now rely on CMHCs for mental health services to maintain their ability to live in their own community.

The number of severe and persistent mentally ill (SPMI) adults served by CMHCs has grown from 7,775 in FY92, to just under 13,000 in FY02. The same trend has occurred for children/adolescents with a serious emotional disturbance (SED), having served 6,034 in FY92, compared to just under 13,000 in FY02. In FY02, CMHCs also served over 46,000 adults and over 16,000 children/adolescents who were not a part of the target populations.

The CMHCs have played a critical role in accomplishing significant bed reductions in state hospitals, declining from 1,003 in FY90 to 376 in FY02.

In FY90, the average length of stay (ALOS) for children/adolescents was 220 days, compared to 43 days at Rainbow Mental Health Facility (RMHF) and 91 days at Larned State Hospital (LSH) in FY02. For adults, the ALOS was 108 days in FY90, compared to 27 days at RMHF, 69 days at Osawatomie State Hospital (OSH), and 43 days at LSH for FY02.

Accountability

First and foremost, CMHCs are accountable to their County Commission authorized boards. The CMHCs are further accountable to state and federal government. Some examples include: CMHC licensing rules and regulations; participating CMHC contracts; Medicaid and Medicare rules and regulations; Quality Enhancement staff; and other periodic audits and studies on CMHC functioning.

CMHC Consolidation Discussion

Impact on County Local Control

The CMHCs are created by several statutes and have a variety of forms of governance. Two are county operated and happen to be the largest CMHCs in the system. The remaining Centers are either quasi-governmental or non-profits. Each has their own local governing board. This is a serious issue of local responsibility and local control.

If the state mandates consolidation to replace the intra-local agreements that formed the CMHCs, the system is likely to have a lot of counties drop their funding for those services.

Taking local control away from counties to determine CMHC designation would be a major step backwards for the Kansas mental health system. Taking the local communities out of the decision-making loop could seriously compromise the current level of voluntary county dollars that are in the system – totaling $20 million. CMHC funding is dependent upon a critical linkage of county, state and federal funds. The potential to save money or draw down any additional federal dollars as a result of consolidation is unclear. Yet we do know that the loss of county revenue will impact our ability to provide core services as well as continue to meet the needs of the uninsured.

A CMHC cannot exist by law unless a county resolves to create it, designate it, or create it as a department of the County. Since state law does not allow the state to create CMHCs, mergers would have to be voluntary.

One of the many strengths of the Kansas system is that the scope and size of a CMHC is largely driven by the community and that in Kansas. While the state targets its resources to the CMHCs to the target populations, local counties may contribute funds for diverse services provided in their community. Although we are looking at means to pull down some federal funds, there is no direct state reimbursement for administration.

The CMHC catchment areas were developed over 30 years ago through intra-governmental agreements locally. Whatever the efficiencies may or may not be, they will not cover the loss of county funding that will follow realignment or consolidation.

What Are We Trying to Fix?

We believe there is no substitute for locally run and locally governed CMHCs.

- Consumer satisfaction surveys are at an all-time high.
- State hospital utilization is within contractual obligations.
- Consumer status reports reflect very positive consumer outcomes, such as independent living.
- The centralized services offered through The Consortium are already saving the state and CMHCs money.
- CMHCs negotiate their contracts as a group.
- CMHCs plan policy issues as a group.
- CMHCs are actively involved in the stakeholder groups and advocacy groups.
- CMHCs manage data as a group.
- Service volume in the CMHCs has increased.
- Kansas is seen as a leader in the field. Other systems look to our system and ask "how do you do that?"

Our Own Efforts to Explore and Achieve Efficiencies

We are currently exploring opportunities for consolidating some business functions within the CMHCs. As we look around, technology has changed so much that geography no longer limits how or where many things occur. While we recognize that 29 CMHCs developing 29 separate ways of doing something is not the most efficient way of doing business, this is not the history in Kansas.

While CMHCs are consistently reviewing their functions, we believe there is no link to cost savings in consolidation of CMHCs because fewer CMHCs do not correlate to fewer client services or a need for fewer case managers, therapists, offices, etc.

Conclusion and Recommendations

In these critical financial times facing state government, it is important that you know that CMHCs are part of the solution. The state mental health average expenditure per SPMI adult was less than $4,700 in FY02; and for children and adolescents, less than $1,800. In addition, the average annual cost of serving a child or adolescent on the SED Waiver is $16,800. Consider those costs and compare them to the annual cost for meeting the needs of an adult in a state hospital setting - $70,000; or a child or adolescent in a state hospital setting - $149,000; or even Level 6 care for juvenile offenders - up to $77,000. Community-based services are most definitely a good value.

While we have 29 licensed CMHCs, we also have services available in over 120 locations throughout the state. We are very concerned about any proposed system changes that makes it harder for persons to readily access services. Persons with mental illness and their families should

not be asked to travel further to access services. Among the greatest barriers to accessing services is transportation.

There is no evidence as to how much can be actually saved by a merger of CMHCs. It is possible that merging some counties or CMHCs could even create additional costs as some branch offices are in county owned facilities. A merger of CMHCs without good planning would cause major disruptions to service which would lead to immediate higher costs in hospitalizations.

Rather than letting a current budget crisis lead to hasty changes to a system that has taken years to develop, we should instead continue to engage in thoughtful planning for its future. Unless you want to reduce services to client, we believe that eliminating or consolidating a group of CMHCs will not create funding efficiencies large enough to be noticed in the public mental health system.

There needs to be a thoughtful planning process which includes opportunity for input from stakeholders of our system. This is a complex system, unique in each community served and somewhat fragile at this point due to the fiscal restraints.

The Association understands and appreciates the need and also the opportunity to participate in the periodic review of service delivery systems and the best use of public dollars. Any new approach to the system should, at the very least, ensure:

- Continued support of our local partners in county government;
- Continued services for all persons with mental illness;
- Current levels of funding from local, state and federal government sources are preserved; and
- The CMHC service system is strengthened by any changes.

Thank you for the opportunity to appear before you today.

5-5

Association of Community Mental Health Centers of Kansas, Inc.
720 SW Jackson, Suite 203, Topeka, KS 66603
Telephone (785) 234-4773 Fax (785) 234-3189
Web Site: www.acmhck.org

March 3, 2003

The Honorable Stan Clark, Chairman
Medicaid Reform Task Force
Statehouse, Room 449-N
Topeka, KS 66612

Dear Senator Clark:

I would like to express my appreciation to you for allowing The Association of Community Mental Health Centers of Kansas, Inc., the opportunity to share our thoughts and concerns with you concerning the Kansas Medicaid program as it relates to the populations served by Community Mental Health Centers (CMHCs).

As I understand it, the Task Force asked for additional information concerning the total number of individuals served by CMHC as well on the various services provided by CMHCs. Enclosed you will find the following:

1. Listing of CMHCs and their satellite offices;
2. Total numbers served by CMHC for FY 2002 – adults;
3. Total numbers served by CMHC for FY 2002 – children and adolescents;
4. An excerpt from the Performance Partnership Block Grant Application for FY2003-2004 (page 57) which outlines basic and specialized CMHC services for adults;
5. An excerpt from the Performance Partnership Block Grant Application for FY2003-2004 (pages 126-127) which outline basic and specialized CMHC services for children and adolescents.

Thank you for the opportunity to provide you with this follow-up information. If you have any questions, please feel free to contact me.

Sincerely,

Michael J. Hammond
Interim Executive Director

cc: Dan Hermes
Stuart Little
David Johnson

Randy Class, President, Wichita | Keith Rickard, President Elect, Leavenworth | Kermit George, Vice President, Hays | Everett (Jake) Jacobs, Secretary, Manhattan | Brenda Mills, Treasurer, Topeka | Melvin Goering, Member at Large, Newton | Patricia Murray, Past President, Salina | Michael Hammond, Interim Executive Director

Community Mental Health Centers

AREA MENTAL HEALTH CENTER

1111 EAST SPRUCE STREET
GARDEN CITY, KS 67846-5999

PHONE#: (620) 275-0625	FAX#: (620) 275-7908

WEBSITE: www.areamhc.org

EXECUTIVE DIRECTOR: RIC DALKE

ASSOCIATE OFFICES:

GARDEN CITY OFFICE
1111 EAST SPRUCE
GARDEN CITY, KS 67846-5999
(620) 276-7689 FAX (620) 276-6117

SATELLITE OFFICES:
LAKIN
SYRACUSE

DODGE CITY OFFICE
2101 W. HIGHWAY 50 BYPASS
P.O. BOX 1376
DODGE CITY, KS 67801-1376
(620) 227-8566 FAX (620) 225-5824

SATELLITE OFFICES:
BUCKLIN
CIMARRON
JETMORE

ULYSSES OFFICE
404 N. BAUGHMAN P.O. BOX 757
ULYSSES, KS 67880-0757
(620) 356-3198 FAX (620) 356-3101

SATELLITE OFFICES:
ELKHART
JOHNSON CITY

SCOTT CITY OFFICE
210 W. 4TH
SCOTT CITY, KS 67871-1205
(620) 872-5338 FAX (620) 872-2879

SATELLITE OFFICES:
DIGHTON
LEOTI
TRIBUNE

COMMUNITY SUPPORT SERVICES
222 S. MAIN, P.O. BOX 477
GARDEN CITY, KS 67846-0477
(620) 275-9434 FAX (620) 275-1448

COMMUNITY SUPPORT SERVICES
3000 N 14TH PO BOX 370
DODGE CITY, KS 67801-0370
(620) 227-5040 FAX (620) 227-7306

INPATIENT SERVICES
BEHAVIORAL HEALTH SERVICE
ST. CATHERINE HOSPITAL
410 EAST WALNUT
GARDEN CITY, KS 67846-5672
(620) 272-2500 FAX (620) 272-2508

BUSINESS OFFICE
1111 EAST SPRUCE
GARDEN CITY, KS 67846-5999
(620) 275-0625 FAX (620) 275-7908

COUNTIES SERVED:

FINNEY	FORD	GRANT	HAMILTON	GRAY
GREELEY	HODGEMAN	KEARNY	LANE	MORTON
SCOTT	STANTON	WICHITA		

5-8

BERT NASH COMMUNITY MENTAL HEALTH CENTER

200 MAINE STREET, SUITE A
LAWRENCE, KS 66044

PHONE#: (785) 843-9192	FAX#: (785) 843-0264
WEBSITE: www.bertnash.org	EMERGENCY#: (785) 843-9192

EXECUTIVE DIRECTOR: DAVID E. JOHNSON
EMAIL: djohnson@bertnash.org

OPERATIONS DIRECTOR: THOMAS PETRIZZO, JD, MSW

SATELLITE OFFICES:

314 EAST 8TH STREET
EUDORA, KS 66025
(785) 843-9192
(OUTREACH)

814 HIGH STREET
BALDWIN, KS 66006
(785) 843-9192
(OUTREACH)

COUNTY SERVED:

DOUGLAS

5-9

CENTER FOR COUNSELING AND CONSULTATION SERVICES

5815 BROADWAY
GREAT BEND, KS 67530

PHONE#: (620) 792-2544	FAX#: (620) 792-7052
1 (800) 875-2544	

EXECUTIVE DIRECTOR: DWIGHT YOUNG, MBA, LCP

<u>SATELLITE OFFICES</u>: (CALL MAIN OFFICE FOR HOURS AND APPOINTMENTS)

LARNED
LYONS
STAFFORD

<u>COUNTIES SERVED</u>:

BARTON
PAWNEE
RICE
STAFFORD

5-10

CENTRAL KANSAS MENTAL HEALTH CENTER

809 ELMHURST
SALINA, KS 67401

PHONE#: (785) 823-6322	FAX#: (785) 823-3109
EMAIL: ckmhc@ckmhc.org	EMERGENCY#: (785) 823-6324

EXECUTIVE DIRECTOR: PATRICIA MURRAY, LSCSW

SATELLITE OFFICES:

(ALL APPOINTMENTS SCHEDULED THROUGH (785) 823-6322)

ABILENE
ELLSWORTH
HERINGTON
LINCOLN
MINNEAPOLIS

COUNTIES SERVED:

DICKINSON
ELLSWORTH
LINCOLN
OTTAWA
SALINE

5-11

COMCARE OF SEDGWICK COUNTY

635 NORTH MAIN
WICHITA, KS 67203

PHONE#: (316) 660-7600	FAX#: (316) 383-7925
EMERGENCY#: (316) 660-7500	TTY#: (316) 267-0267
WEBSITE: www.sedgwickcounty.org/comcare	**CENTRALIZED INTAKE: (316) 660-7540**

EXECUTIVE DIRECTOR: MARILYN COOK
EMAIL: mcook@sedgwick.gov

SATELLITE OFFICES:

ADDICTION TREATMENT SERVICES
(316) 660-7550

CENTER CITY
HOMELESS PROJECT
(316) 660-7800

COMMUNITY SUPPORT SERVICES
(316) 660-7700

OUTPATIENT SERVICES
(316) 660-7675

FAMILY AND CHILDREN
COMMUNITY SERVICES
(316) 660-9600

CRISIS INTERVENTION SERVICES
GENERAL NUMBER: (316) 660-7525
24 HOUR: (316) 660-7500

COUNTY SERVED:

SEDGWICK

5-12

COMMUNITY MENTAL HEALTH CENTER OF CRAWFORD COUNTY

911 EAST CENTENNIAL
PITTSBURG, KS 66762

PHONE#: (620) 231-5141	FAX#: (620) 231-1152
EMERGENCY#: (620) 232-7283	

ADMINISTRATOR: RICHARD PFEIFFER, LMSW

DIRECTOR: DAVID BOYD, LMLP, DIRECTOR OF MENTAL HEALTH SERVICES
EMAIL: david@cmhccc.org

COUNTY SERVED:

CRAWFORD

5-13

COWLEY COUNTY MH AND COUNSELING CENTER

22214 D STREET
WINFIELD, KS 67156

PHONE#: (620) 442-4540 or (620) 221-9664	FAX#: (620) 442-4559
EMAIL: ccmhcc@hit.net	EMERGENCY#: (620) 442-4554 or (620) 221-9686

EXECUTIVE DIRECTOR: LINDA YOUNG
EMAIL: youngl@onemain.com

COUNTY SERVED:

COWLEY

5-14

FAMILY CONSULTATION SERVICES*

560 NORTH EXPOSITION
WICHITA, KS 67203

PHONE#: (316) 264-8317	FAX#: (316) 264-0347
EMERGENCY#: (316) 263-3770	

EXECUTIVE DIRECTOR: RANDALL M. CLASS, LSCSW

SATELLITE OFFICES:

PLANEVIEW - COLVIN
(316) 688-9343

COUNTY SERVED:

SEDGWICK

*AN AFFILIATE OF COMCARE OF SEDGWICK COUNTY

5-15

FAMILY LIFE CENTER INC.

201 WEST WALNUT
COLUMBUS, KS 66725

PHONE#: (620) 429-1860	FAX#: (620) 429-1041
EMAIL: famlife@columbus-ks.com	EMERGENCY#: 1-866-634-2301

EXECUTIVE DIRECTOR: SCOTT JACKSON, MA

SATELLITE OFFICES:

BAXTER SPRINGS OUTPATIENT
445 EAST 11TH
BAXTER SPRINGS, KS 66713
(620) 856-2184 FAX (620) 856-5215

GALENA OUTPATIENT
719 EAST 7TH
GALENA, KS 66739
(620) 783-5744 FAX (620) 783-5077

COMMUNITY SUPPORT PROGRAM
723 EAST 7TH
GALENA, KS 66739
(620) 783-1994 FAX (620) 783-2464

JUVENILE JUSTICE SERVICES
445 EAST 11TH
BAXTER SPRINGS, KS 66713
(620) 856-5355 FAX (620) 856-5215

CHILDREN SERVICES & PARENT SUPPORT SERVICES
720 EAST 6TH
GALENA, KS 66739
(620) 783-2900 FAX (620) 783-2901

COUNTY SERVED:

CHEROKEE

5-16

FAMILY SERVICE & GUIDANCE CENTER OF TOPEKA, INC. *

ADMINISTRATION
325 SW FRAZIER
TOPEKA, KS 66606

PHONE#: (785) 232-5005	FAX#: (785) 232-0160
WEBSITE: www.fsgctopeka.com	Email: fsgc@fsgctopeka.com
EMERGENCY#: (785) 232-5005 (ALL LOCATIONS)	

CEO: BRENDA MILLS
EMAIL: bmills@fsgctopeka.com

SATELLITE OFFICES:

PRESCHOOL
2055 CLAY
TOPEKA, KS 66604
(785) 234-5663 FAX (785) 234-4853

ADMISSIONS AND OP SERVICES
325 SW FRAZIER
TOPEKA, KS 66606
(785) 232-5005 FAX (785) 232-0160

YOUTH DEVELOPMENT PROGRAM
2029 SW WESTERN AVENUE
TOPEKA, KS 66604
(785) 232-4411 FAX (785) 232-4098

COUNTY SERVED:

SHAWNEE

* AN AFFILIATE OF VALEO BEHAVIORAL HEALTH CARE

5-17

FOUR COUNTY MENTAL HEALTH CENTER

3751 WEST MAIN
INDEPENDENCE, KS 67301

PHONE#: (620) 331-1748	FAX#: (620) 332-8540
TDD#: (620) 331-0134	EMERGENCY#: 1 (800) 499-1748

EXECUTIVE DIRECTOR: RONALD G. DENNEY, MA, LMLP
EMAIL: rdenney@fourcounty.com

BRANCH OFFICE:

813 UNION
COFFEYVILLE, KS 67337
(620) 251-8180 FAX (620) 252-2125

SATELLITE OFFICES:

CEDAR VALE
(620) 758-2248

FREDONIA
(620) 378-4455

HOWARD
(620) 374-2370

NEODESHA
(620) 325-2611

SEDAN
(620) 725-3115

COUNTIES SERVED:

CHAUTAUQUA
ELK
MONTGOMERY
WILSON

COMMUNITY SERVICES:

3751 WEST MAIN
INDEPENDENCE, KS 67301
(620) 331-3131 FAX (620) 332-8590

CRISIS DIVERSION SERVICES:
3751 WEST MAIN
INDEPENDENCE, KS 67301
(620) 331-5151 FAX (620) 332-8540

5-18

FRANKLIN COUNTY MENTAL HEALTH CENTER

204 EAST 15TH STREET
OTTAWA, KS 66067

PHONE#: (785) 242-3780	FAX#: (785) 242-6397
EMAIL: fcmhc@ott.net	EMERGENCY#: (785) 242-3781

EXECUTIVE DIRECTOR: DIANE ZADRA DRAKE, MN, ARNP

COUNTY SERVED:

FRANKLIN

5-19

THE GUIDANCE CENTER

818 NORTH 7TH STREET
LEAVENWORTH, KS 66048-1422

PHONE#: (913) 682-5118	FAX#: (913) 682-4664

EXECUTIVE DIRECTOR: KEITH RICKARD
EMAIL: krickard@nekmhgc.org

SATELLITE OFFICES:

ATCHISON
1301 N. 2ND STREET
ATCHISON, KS 66002
(913) 367-1593 FAX (913) 367-1627

LEAVENWORTH (COMMUNITY SUPPORT SERIVCES)
2301 10th AVE.
LEAVENWORTH, KS 66048
(913) 682-6953 FAX (913) 682-0132

OSKALOOSA
1102 WALNUT
P.O. BOX 127
OSKALOOSA, KS 66066
(785) 863-2929 FAX (785) 863-2972

COUNTIES SERVED:

ATCHISON
JEFFERSON
LEAVENWORTH

5-20

HIGH PLAINS MENTAL HEALTH CENTER

208 EAST 7TH STREET
HAYS, KS 67601-4199

PHONE#: (785) 628-2871	FAX#: (785) 628-1438
WEBSITE: www.highplainsmentalhealth.com	EMERGENCY#: (785) 628-2871 or 1 (800) 432-0333

INTERIM EXECUTIVE DIRECTOR: WALT HILL
EMAIL: walt@hpmhc.com

BRANCH OFFICES:

COLBY BRANCH OFFICE
750 S. RANGE
COLBY, KS 67701
(785) 462-6774 FAX (785) 462-3690

GOODLAND BRANCH OFFICE
723 MAIN
GOODLAND, KS 67735
(785) 899-5991 FAX (785) 899-2533

NORTON BRANCH OFFICE
211 S. NORTON
NORTON, KS 67654
(785) 877-5141 FAX (785) 877-5142

OSBORNE BRANCH OFFICE
121 WEST MAIN
OSBORNE, KS 67473
(785) 346-2184 FAX (785) 346-2487

PHILLIPSBURG BRANCH OFFICE
783 7TH STREET
PHILLIPSBURG, KS 67661
(785) 543-5284 FAX (785) 543-5285

OTHER LOCATIONS:

WOODHAVEN
(CSS PROGRAM)
1412 EAST 29TH
HAYS, KS 67601
(785) 625-2400

WESTSIDE ALTERNATIVE SCHOOL
(CBS PROGRAM)
323 WEST 12TH
HAYS, KS 67601
(785) 623-2416

ONE DAY A WEEK OFFICES:

ATWOOD
RAWLINS CO HEALTH CTR
ATWOOD, KS 67730
(785) 462-6774

HOXIE
SHERIDAN CO HEALTH COMPLEX
HOXIE, KS 67740
(785) 462-6774

OBERLIN
DECATUR CO HEALTH DEPT
OBERLIN, KS 67749
(785) 877-5141

SMITH CENTER
SMITH CO MEMORIAL HOSP
SMITH CENTER, KS 66967
(785) 346-2184

QUINTER
GOVE COUNTY MEDICAL CENTER
QUINTER, KS 67752
(785) 628-2871

COUNTIES SERVED:

CHEYENNE	DECATUR	ELLIS	GOVE	GRAHAM
LOGAN	NESS	NORTON	OSBORNE	PHILLIPS
RAWLINS	ROOKS	RUSH	RUSSELL	SHERIDAN
SHERMAN	SMITH	THOMAS	TREGO	WALLACE

5-21

HORIZONS
MENTAL HEALTH CENTER

1715 EAST 23RD AVENUE
HUTCHINSON, KS 67502-1188

PHONE#: (620) 665-2240	FAX#: (620) 665-2276

CRISIS MANAGEMENT SERVICE (CALL 24 HOURS)
HUTCHINSON# (620) 665-2299
CALL TOLL FREE 1 (800) 794-0163 (CRISIS MANAGEMENT ONLY)

CEO: MICHAEL A. TRUMAN

MEDICAL DIRECTOR: BRUCE E. KLOSTERHOFF, M.D.

BRANCH OFFICES:

BARBER COUNTY AREA OFFICE
102 SOUTH MAIN
P.O. BOX 212
MEDICINE LODGE, KS 67104-0212
(620) 886-5057 FAX (620) 886-3473

KINGMAN COUNTY AREA OFFICE
760 WEST D, SUITE 1
P.O. BOX 227
KINGMAN, KS 67068-0227
(620) 532-3895 FAX (620) 532-3710

HARPER COUNTY AREA OFFICE
125 NORTH JENNINGS
P.O. BOX 296
ANTHONY, KS 67003-0296
(620) 842-3768 FAX (620) 842-5881

PRATT COUNTY AREA OFFICE
101 EAST 8TH
PRATT, KS 67124-2867
(620) 672-2332 FAX (620) 672-3162

COUNTIES SERVED:

BARBER HARPER KINGMAN PRATT RENO

5,22

IROQUOIS CENTER FOR HUMAN DEVELOPMENT INC

610 E. GRANT ST.
GREENSBURG, KS 67054

PHONE#: (620) 723-2272 TOLL FREE#: (888) 877-0376	FAX#: (620) 723-3450
CRISIS#: (620) 723-2656	

EXECUTIVE DIRECTOR: C. SHELDON CARPENTER, LMLP, LCP
EMAIL: csheldon@yahoo.com

SATELLITE OFFICES:

ASHLAND
COLDWATER
KINSLEY
MINNEOLA

COUNTIES SERVED:

CLARK
COMANCHE
EDWARDS
KIOWA

5-23

JOHNSON COUNTY MENTAL HEALTH CENTER

6000 LAMAR, SUITE 130
MISSION, KS 66202

PHONE#: (913) 831-2550	FAX#: (913) 826-1608
WEBSITE: www.jocoks.com/mentalhealth	EMERGENCY#: (913) 384-3535

EXECUTIVE DIRECTOR: DAVID WIEBE, LSCSW
EMAIL: wiebe@jocoks.com

SATELLITE OFFICES:

OLATHE OFFICE
1125 WEST SPRUCE
OLATHE, KS 66061
(913) 782-2100 FAX (913) 782-1186

COMMUNITY SUPPORT SERVICES
6440 NIEMAN ROAD
SHAWNEE, KS 66203
(913) 962-9955 FAX (913) 962-7843

FAMILY FOCUS (CHILDREN'S SERVICES)
1125 WEST SPRUCE
OLATHE, KS 66061
(913) 782-2100 FAX (913) 782-1186

ADOLESCENT CENTER FOR TREATMENT
301 NORTH MONROE STREET
OLATHE, KS 66061
(913) 782-0283 FAX (913) 782-0609

ADULT DETOXIFICATION UNIT
8000 WEST 127TH STREET
OVERLAND PARK, KS 66213
(913) 897-6101 FAX (913) 897-6802

COUNTY SERVED:

JOHNSON

5-24

KANZA MENTAL HEALTH AND GUIDANCE CENTER

909 SOUTH SECOND STREET
P.O. BOX 319
HIAWATHA, KS 66434

PHONE#: (785) 742-7113	FAX#: (785) 742-3085
AFTER HOURS EMERGENCY#: (785) 742-2131	

CHIEF EXECUTIVE OFFICER: BILL D. PERSINGER, JR.
EMAIL: bpersinger@ksmhc.org

SATELLITE OFFICES:

HOLTON (785) 364-4536
KICKAPOO INDIAN RESERVATION
SABETHA
SENECA
TROY

FOR APPOINTMENTS IN SATELLITE OFFICES: 1) CALL HOLTON DIRECTLY, 2) ALL OTHER SATELLITES, CALL HIAWATHA NUMBER.

COUNTIES SERVED:

BROWN
DONIPHAN
JACKSON
NEMAHA

5-25

LABETTE CENTER FOR MENTAL HEALTH SERVICES INC.

1730 BELMONT
P.O. BOX 258
PARSONS, KS 67357

PHONE#: (620) 421-3770 or (620) 421-3771	FAX#: (620) 421-0665

WHEN OFFICE IS CLOSED -
EMERGENCY#: (620) 421-4880 (24 HOURS)
LABETTE COUNTY MEDICAL CENTER

ADMINISTRATOR: MATTHEW M. ATTEBERRY, LSCSW
EMAIL: matteberry@lcmhs.com

COMMUNITY SUPPORT PROGRAM
(620) 421-9402 OR (620) 421-9476

SATELLITE OFFICE:

OSWEGO
(620) 795-2733

COUNTY SERVED:

LABETTE

5-26

MENTAL HEALTH CENTER OF EAST CENTRAL KANSAS

1000 LINCOLN
EMPORIA, KS 66801

PHONE#: (620) 343-2211	FAX#: (620) 342-1021
WEBSITE: www.mhceck.org	EMERGENCY#: (620) 343-2626 AFTER HOURS CALL TOLL FREE (866) 330-3310

EXECUTIVE DIRECTOR: JOHN RANDOLPH, Ph.D.
EMAIL: jrandolph@mhceck.org

SATELLITE OFFICES:

ALMA
BURLINGTON
COTTONWOOD FALLS
COUNCIL GROVE
EUREKA
OSAGE CITY

COUNTIES SERVED:

CHASE
COFFEY
GREENWOOD
LYON
MORRIS
OSAGE
WABAUNSEE

5-27

MIAMI COUNTY MENTAL HEALTH CENTER

401 NORTH EAST STREET
PAOLA, KS 66071

PHONE#: (913) 557-9096	FAX#: (913) 294-9247

EXECUTIVE DIRECTOR: BOB CURTIS
EMAIL: bcurtis@mcmhc.net

COUNTY SERVED:

MIAMI

5-28

PAWNEE MENTAL HEALTH SERVICES

P.O. BOX 747
MANHATTAN, KS 66505-0747

PHONE#: (785) 587-4361 | FAX#: (785) 587-4377

EMERGENCY#: 1 (800) 609-2002 (ALL OFFICES)

EXECUTIVE DIRECTOR: EVERETT "JAKE" JACOBS

SATELLITE OFFICES:

BELLEVILLE OFFICE
REPLUBLIC COUNTY HOSPITAL
BELLEVILLE, KS 66935
(785) 527-2549

CLAY CENTER OFFICE
532 LINCOLN
CLAY CENTER, KS 67432
(785) 632-2108

JUNCTION CITY OFFICE
814 CAROLINE AVENUE
JUNCTION CITY, KS 66441
(785) 762-5250 FAX (785) 762-2144

MARYSVILLE OFFICE
1017 BROADWAY
MARYSVILLE, KS 66508
(785) 562-3907

WASHINGTON OFFICE
321 C STREET, SUITE 102
P.O. BOX 95
WASHINGTON, KS 66968
(785) 325-3252

BELOIT OFFICE
207-5 NORTH MILL
BELOIT, KS 67420
(785) 738-5363

CONCORDIA OFFICE
210 W 21ST STREET
CONCORDIA, KS 66901
(785) 243-8900 FAX (785) 243-8933

MANKATO OFFICE
114 EAST MAIN
MANKATO, KS 66956
(785) 378-3898

ST. MARYS OFFICE
503 EAST HWY 24
ST. MARYS, KS 66536
(785) 437-6233

COUNTIES SERVED:

CLAY, MARSHALL, RILEY, CLOUD, MITCHELL, WASHINGTON, GEARY, POTTAWATOMIE, JEWELL, REPUBLIC

5-29

PRAIRIE VIEW INC.

1901 EAST 1ST STREET
BOX 467
NEWTON, KS 67114

PHONE#: (316) 284-6400	FAX#: (316) 284-6491
WEBSITE: www.pvi.org	EMERGENCY#: (316) 284-6400

CHIEF EXECUTIVE OFFICER: MELVIN GOERING
EMAIL: goeringmm@pvi.org

SATELLITE OFFICES:

MARION
(620) 382-3701

McPHERSON
(620) 245-5000

COUNTIES SERVED:

HARVEY
MARION
McPHERSON

5-30

SOUTH CENTRAL MENTAL HEALTH COUNSELING CENTER, INC.

2365 WEST CENTRAL
EL DORADO, KS 67042

PHONE#: (316) 321-6036	FAX#: (316) 321-6336
EMERGENCY#: ENTERPRISE 20357	

EXECUTIVE DIRECTOR: KEN TAYLOR

SATELLITE OFFICES:

ANDOVER
(316) 733-5047 FAX: (316) 733-5060

AUGUSTA
(316) 775-5491 FAX: (316) 775-5442

COUNTY SERVED:

BUTLER

5-31

SOUTHEAST KANSAS MENTAL HEALTH CENTER

304 NORTH JEFFERSON
P.O. BOX 807
IOLA, KS 66749

PHONE#: (620) 365-8641	FAX#: (620) 365-8642
EMERGENCY#: 1-888-588-6774	

EXECUTIVE DIRECTOR: ROBERT F. CHASE
EMAIL: rchase@sekmhc.org

OFFICES:

CHANUTE
(620) 431-7890

FORT SCOTT
(620) 223-5030

GARNETT
(785) 448-6806

IOLA
(620) 365-5717

PLEASANTON
(913) 352-8214

HUMBOLDT
(620) 473-2241

OUTREACH OFFICE:

YATES CENTER
(620) 365-5717

COUNTIES SERVED:

ALLEN
ANDERSON
BOURBON
LINN
NEOSHO
WOODSON

5-32

SOUTHWEST GUIDANCE CENTER

P.O. BOX 2945
LIBERAL, KS 67905-2945

PHONE#: (620) 624-8171	FAX#: (620) 624-0114

E-MAIL: swguide@swk .net

EXECUTIVE DIRECTOR: JIM KARLAN, LCP, LMLP, CBHE
EMAIL: jkarlan@yahoo.com

SATELLITE OFFICES:

HUGOTON
(316) 544-8511

MEADE
(316) 873-2112

SUBLETTE
(316) 675-2686

COUNTIES SERVED:

HASKELL
MEADE
SEWARD
STEVENS

S-33

SUMNER MENTAL HEALTH CENTER

1601 W. 16TH STREET
P.O. BOX 607
WELLINGTON, KS 67152-0607

PHONE#: (620) 326-7448	FAX#: (620) 326-6662
EMERGENCY#: 1 (800) 369-8222	

CHIEF EXECUTIVE OFFICER: GREGORY G. OLSON, MS

COUNTY SERVED:

SUMNER

5-34

VALEO BEHAVIORAL HEALTH CARE

ADMINISTRATION OFFICE
5401 WEST 7TH STREET
TOPEKA, KS 66606

PHONE#: (785) 273-2252	FAX#: (785) 273-2736

CHIEF EXECUTIVE OFFICER: TOM ZABROWSKI
EMAIL: tomz@cjnetworks.com

MENTAL HEALTH & SUBSTANCE ABUSE SERVICES OFFICE

(785) 233-1730 FAX (785) 233-0085

AFFILIATED AGENCIES:

BREAKTHROUGH INC
(785) 232-6807

COMMUNITY SERVICE OFFICE
(785) 232-7214

FAMILY SERVICE AND GUIDANCE CENTER
(785) 232-5005

ST. FRANCIS HOSPITAL & MEDICAL CENTER
(785) 295-8380

STORMONT-VAIL REGIONAL MEDICAL CENTER
(785) 354-6000

COUNTY SERVED:

SHAWNEE

5-35

WYANDOT CENTER FOR COMMUNITY BEHAVIORAL HEALTHCARE, INC.

3615 EATON STREET
P.O. BOX 3228
KANSAS CITY, KS 66103-0228

PHONE#: (913) 831-0024	FAX#: (913) 831-1300
WEBSITE: www.wyandotcenter.org	EMAIL: cullumber_e@wmhci.org
EMERGENCY#: (913) 831-1773	

EXECUTIVE DIRECTOR: PETER W. ZEVENBERGEN

SATELLITE OFFICES:

BONNER SPRINGS
420 N. PARK
BONNER SPRINGS, KS 66012
(913) 441-1400 FAX (913) 441-1463

MEADOWLARK
1223 MEADOWLARK LANE
KANSAS CITY, KS 66102
(913) 287-0007 FAX (913) 287-0354

WASHINGTON WEST
7840 WASHINGTON AVE.
KANSAS CITY, KS 66112
(913) 328-4600 FAX (913) 328-4604

WASHINGTON EAST
1300 N. 78TH STREET
KANSAS CITY, KS 66112
(913) 831-9500

COUNTY SERVED:

WYANDOTTE

5-36

TOTAL NUMBERS SERVED BY CMHC FOR FY 2002

	Total Adults	Non-SPMI	SPMI
Area MHC	2989	2456	533
Bert Nash	2570	2111	459
Center for C & C	1925	1835	90
Central Kansas	2117	1877	240
COMCARE	5013	3491	1522
Cowley County	1330	1098	232
Crawford County	947	676	271
Family Consult. Servc	891	887	4
Family Life	557	374	183
Fam. Serv. & Guid. C	128	115	13
Four County	2207	1628	579
Franklin County	949	805	144
The Guidance Center	1689	1285	404
High Plains	3495	2804	691
Horizons	2700	2149	551
Iroquois	389	256	133
Johnson County	4966	3707	1259
Kanza	974	812	162
Labette	934	728	206
MHC East Central KS	1761	1116	645
Miami County	916	782	134
Pawnee	5229	4755	474
Prairie View	3024	2477	547
S. Central MH Couns	1120	975	145
Southeast KS	1957	1488	469
Southwest Guid. Cntr	570	417	153
Sumner	405	260	145
Valeo	4782	3366	1416
Wyandot	2662	1767	895
Adults total	**59196**	**46497**	**12699**

TOTAL NUMBERS SERVED BY CMHC FOR FY 2002

	Children Total	Non-SED	SED
Area MHC	1539	1245	294
Bert Nash	1079	597	482
Center for C & C	367	294	73
Central Kansas	1211	736	475
COMCARE	1212	402	810
Cowley County	883	545	338
Crawford County	655	139	516
Family Consult. Serv(	2102	1872	230
Family Life	746	244	502
Fam. Serv. & Guid. C	2594	1291	1303
Four County	1098	485	613
Franklin County	450	302	148
The Guidance Center	893	543	350
High Plains	1345	558	787
Horizons	1318	717	601
Iroquois	177	134	43
Johnson County	2042	907	1135
Kanza	720	553	167
Labette	686	348	338
MHC East Central KS	940	360	580
Miami County	385	288	97
Pawnee	1852	1265	587
Prairie View	1195	736	459
S. Central MH Couns.	663	560	103
Southeast KS	935	427	508
Southwest Guid. Cntr	214	111	103
Sumner	320	210	110
Valeo			
Wyandot	1583	552	1031
Children total	**29204**	**16421**	**12783**

and recovery center for the consumers of the area. The Kansas City, Kansas metro area includes two CMHCs, and representatives from each are on the task force, in addition 42% of the members are also consumers of mental health services.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Kansas has twenty-seven (27) Community Mental Health Centers (CMHCs), with two (2) affiliates. The Community Support Programs of the CMHCs generally organize services for the targeted population at the local level for adults with SPMI. Case management is the core service.

This network of CMHCs has a combined staff of over 2,000 providing mental health services to every county in Kansas. Together they form an integral part of the total mental health system in Kansas. The independent, locally operated CMHCs are dedicated to fostering a quality, freestanding system of services and programs for the benefit of citizens needing mental health care and treatment. CMHCs initiate and maintain close cooperative working relationships with other groups, organizations, and individuals having similar interests and goals.

Treatment and services

As licensed comprehensive CMHCs, these agencies offer the following required basic services for adults:

* Outpatient
* 24-hour emergency services
* Consultation and Education
* Screening
* Aftercare
* Case Management
* Medication Management
* Attendant Care

Specialized Services include:

* Observation/Stabilization
* Respite Care
* In-Home Family Therapy
* Drop-In Services for persons with severe and persistent mental illness
* Vocational Services for persons with severe and persistent mental illness
* Homeless Projects
* Residential Programs
* Social Detox for Alcohol and Drug Abuse Services
* Intermediate Residential Care for Alcohol and Drug Treatment
* Half-Way Houses for Alcohol and Drug Services
* Early Parenting Programs for Children
* Child Abuse Treatment Programs
* Parent Education Classes
* Psychosocial treatment groups
* Deaf and Hard of Hearing programs

health services for young children who experience or are at risk for SED. Funding was to be utilized for new initiatives and services and not to supplant any current activities.

CMHCs who had an existing early childhood program could apply for grant funding but needed to indicate how the new funding builds or expands the existing program. Incorporating a mental health component into an existing non-CMHC community based early childhood program was also allowed. Programs were developed in collaboration with parents and other agencies and/or systems involved with young children such as regular and special education, Head Start, public health departments, Interagency Coordinating Councils (the agencies responsible for coordinating birth to 3 services), the local Child Welfare office, etc. Programs are community based, allow family involvement, provide parent support and outreach services, and track program outcomes.

COMMUNITY MENTAL HEALTH CENTER SERVICES

Services for children in the targeted population are generally organized at the local level by the Community Based Services Programs of the Community Mental Health Centers for children/adolescents with SED. Case management is the foundation of the home and community based service delivery model for children. Case management builds upon the strengths of children and their families to coordinate services that create a strong network of support. Case management tasks include case coordination, resource acquisition, parenting support and education, finding crisis services, creating new services, providing ongoing assessment of children to monitor progress, and includes intensive home-based work with the child and child's family.

As licensed comprehensive Community Mental Health Centers, CMHCs offer the following required basic services for children and adolescents:

A. Outpatient Clinical Services
B. 24 -hour emergency services
C. Consultation and Education
D. Screening
E. Aftercare
F. Case Management
G. Medication management

In addition to providing the required services above, all Community Mental Health Centers offer an array of community based mental services to children and adolescents with severe emotional disturbance. Case management is the core service of a community based treatment approach. Other services may include but are not limited to:

- Home-based Family Therapy
- Partial Hospitalization
- Attendant Care
- Respite Care
- Wraparound Services
- Psycho-social Rehabilitation Programs
- Parent Support and Education Services.

5-40

All licensed CMHCs statewide also provide at least one specialized mental health service for children and adolescents. Specialized Services may include:

* Observation/Stabilization
* Independent Living Skills
* Transitional Services for Adolescents
* Respite Care
* Drop-In Services for persons with serious emotional disturbance
* Vocational Services for persons with serious emotional disturbance
* Residential Programs
* Social Detox for Alcohol and Drug Abuse Services
* Intermediate Residential Care for Alcohol and Drug Treatment
* Parenting Support Services
* Mental Health Consultation to School Systems
* Therapeutic Classrooms/School Base Mental Health Programs
* Early Parenting Programs for Children
* Preschool Day Treatment Programs
* Children's Day Hospital
* Child Abuse Treatment Programs
* Parent Education Classes
* Crisis Services
* Crisis Stabilization Services
* Alcohol and Drug Treatment Services
* Therapeutic Foster Care
* Compeer Services
* Multi Systemic Therapy Programs
* Other specialized services focusing on areas such as anger management, self-awareness, sexual abuse treatment, etc.

Most of the programs are quite limited in the number of children they can serve and not all 29 CMHCs and affiliates have all the services listed above. However, through the Children's Mental Health Home and Community-Based Services Waiver and the Family Centered System of Care, MHSAPTR continues to work towards enhancing and expanding community based programming in CMHCs statewide.

Priorities for children and adolescents with SED and their families are similar. For both children and adults those who receive substantial amounts of public funds or services are targeted for the case management services. Therefore, case managers in this program will be working with the most challenging and functionally limited individuals.

Kansas plans to maintain provision of case management services to each adult with SPMI and each child with SED who receives substantial amounts of public funds or services in fiscal year 2000. In addition to the priorities for case management services outlined in the Standards (see above), further assurances case management is provided to all such individuals is included in the Contract Establishing a Participating Mental Health Center. This contract with MHSAPTR requires each participating CMHC to "provide appropriate and needed case management and other community

700 SW Jackson, Suite 803, Topeka, KS 66603-3737 phone 785/235-5103, tty 785/235-5190, fax 785/235-0020 interhab@interhab.org www.interhab.org

March 11, 2003

TO: House Social Services Budget Committee and
Senate Select Committee on Medicaid

FR: Tom Laing, Executive Director, InterHab
RE: Proposal to mandate consolidation of CDDO areas

This committee, like its counterparts in the Senate, is considering a proposal to establish a legislative consolidation mandate for the oversight of the service and support system for Kansans with developmental disabilities.

We welcome legislative interest and inquiry into the nature of how services are organized, performed and overseen in Kansas. We recommend against any major overhaul of the system in this legislative session, given the modest time that is being allotted to such proposals. We propose that the committee choose instead to take at least this summer's interim session as an opportunity to explore:

(1) the motivation for consolidation,
(2) the outcomes that would be sought for persons with disabilities and their families, and
(3) the cost of such major system changes.

I will focus on three of our major concerns.

1. The Local/State partnership works well, and should not be "fixed".
2. The savings that have been highlighted this proposal are inaccurate.
3. Consolidation is not needed, and would harm consumers and families.

<u>Why discourage local support?</u>

For more than thirty years, counties have done a good job of identifying and assisting the CDDOs they have designated in their areas. Counties contribute more than 14 million voluntarily raised property tax dollars each year to help assure that local services are available. To eliminate their role, and thereby erase any formal duty on their part, would almost certainly reduce their incentive to support these essentially state sponsored programs. Simply stated, eliminating the county role will reduce the county financial assistance which is equal to roughly14% of non-federal government funding in the system. That is a significant amount of funding to jeopardize. We see no constructive

purpose to be served by weakening such a successful history as is represented by this state/local partnership.

Penny-wise and pound-foolish?

The current system spends less than 3% of the state's investment on local management of CDDO areas. Anyone who suggests that such a meager investment is bad for the system hasn't considered the alternative, i.e. less and less oversight over the expenditure of $200 million for vulnerable Kansans would be a grave mistake.

Simply stated, with an already stripped-down oversight system at the state level, whose interests are served by further weakening community oversight? Will the rights and the concerns of consumers and families be acknowledged by anyone? Or will their interests, and their concerns, be ignored?

The question has to be asked, why would anyone want such an outcome?

How much consolidation is a good thing?

Currently, 94 of Kansas 105 counties operate in multi-county CDDO areas that they themselves voluntarily formed. Of the remaining 11 counties, four of them are the State's largest counties, Sedgwick, Shawnee, Johnson and Wyandotte counties. Of those four, three are operated by the counties themselves. The historic willingness of county commissioners to voluntarily consolidate in the vast majority of Kansas counties suggests the need for further consolidation isn't as pressing as proponents have indicated.

If the consolidation is fully examined, it will easily be seen that many families and consumers will be required to go further to access services, an outcome that would impact most heavily on non-urbanized areas.

Consolidation as an efficiency matter only passes the "efficiency test" if the needs of the persons and families served are ignored; because, make no mistake about it, it is not efficient for persons served to have to travel farther or deal with more remote bureaucracies to secure answers to their questions and access to services.

Finally, to whom should we turn to make the system more efficient?

One need only look at the service dollars for persons served and know that the source of ideas regarding efficiency is local leadership, not state leadership. State services exceed 125,000 dollars per year/per person and local services cost less than one third of that amount.

It is hard to imagine, given the track record of state services versus local services, that placing administrative and operational controls in state hands is going to save money.

Summary:

Proponents of this proposal seem to be saying:

We are willing to risk losing the counties' money.
We are willing to have less oversight for services to vulnerable persons.
We are willing to risk making the system less accessible for persons and families we serve.

We oppose such proposals.

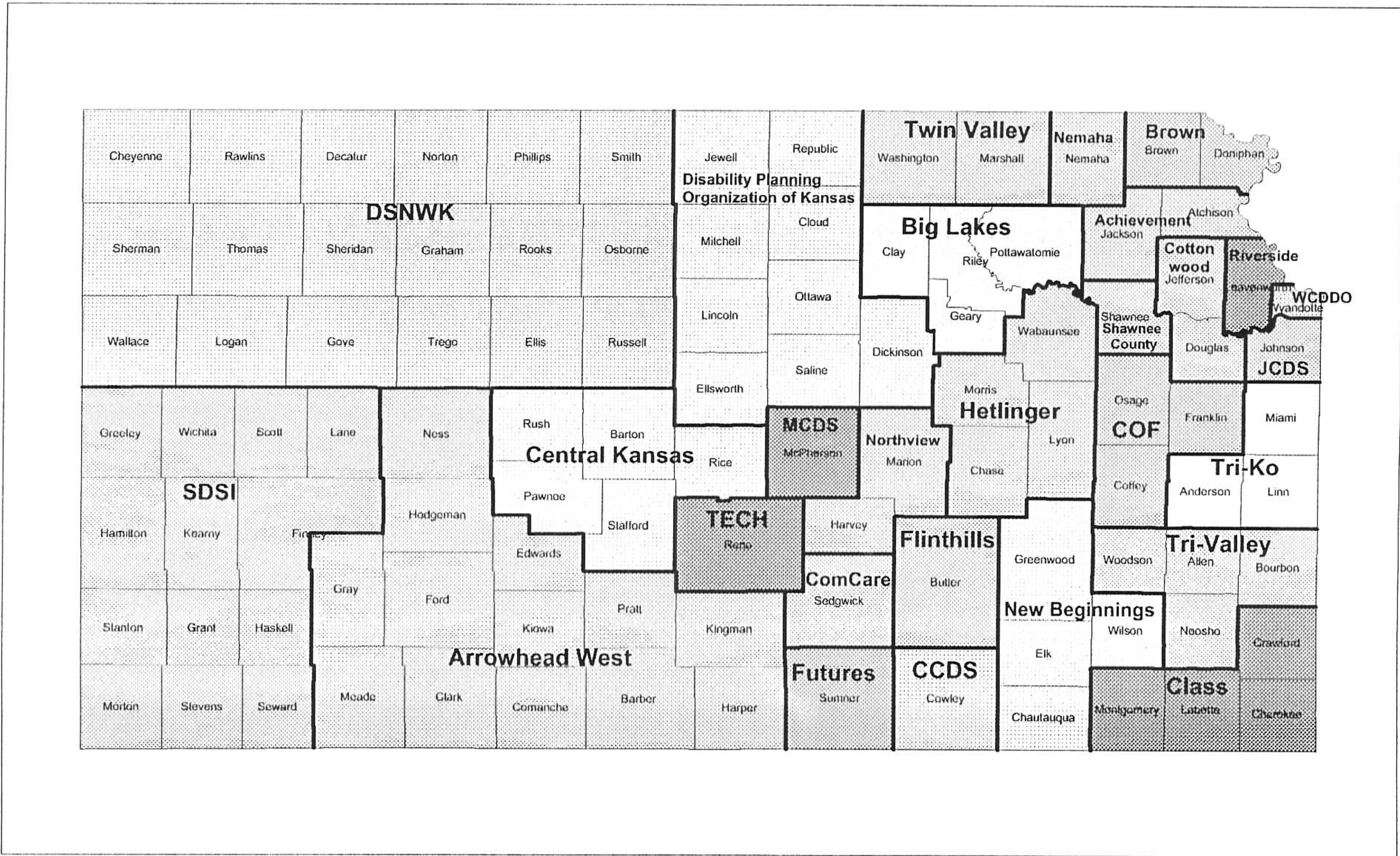
We appreciate and make good use of county financial support.

We believe strong local oversight assures that basic health and safety concerns are addressed for vulnerable persons.

We believe the system should be accessible to the target population. .

We urge you to shelve this proposal, or at a minimum, direct your attention to it during an interim session, when facts and ideas can be more deliberately prepared, reviewed and discussed.

Kansas CDDO's



Date of Map: July 8, 2002

Written Testimony
House Social Services Budget Subcommittee
March 11, 2003
Submitted by Randall Allen, Executive Director
Kansas Association of Counties

Chairman Landwehr and members of the subcommittee, I appreciate the opportunity to submit written testimony in support of an appropriation in the State FY 04 budget to provide for the burial of indigent decedents. For the past several years, the State budget has included funds for the burial of indigent decedents where the persons received prior financial assistance from SRS and where there are no property assets to defray the expense. In FY 02, this expense totaled $457,471, and the annual cost from FY 1998 to FY 2002 has not fluctuated a lot.

We understand that the FY 03 appropriation for this purpose was transferred from the SRS budget to the KDHE budget and that an inter-agency agreement was adopted for SRS to continue administration of the program. The KAC has no position one way or another about which State department administers the program but we urge the State to continue this modest program in FY 2004 for the following reasons:

1) If funds are not appropriated, the financial burden for this program will fall to counties, pursuant to K.S.A. 22a-215. This, in and of itself, is probably not a budget-killer for most counties. However, with the loss of $96 million in State revenue sharing funds to local governments in FY 04 along with the new costs which will be borne by local governments due to implementation of various state fee structures, defunding of this program by the State would further aggravate an already bad situation. The result of most state budget cuts has been and will be either higher local property taxes or loss of services.

2) In addition to our concern about shifting an expense of nearly $500,000 annually to county property taxpayers as an unfunded mandate, we submit that the State Department of Social and Rehabilitation Services has an appropriate role in the burial of indigent decedents since the SRS (*not the counties*) has the means to determine whether a decedent was receiving income assistance. As such, off-loading this budget problem to counties when the State, not counties, has responsibility for the social welfare system, seems illogical in a practical sense, however tempting it is as a short-term budget remedy.

We urge the subcommittee to recommend an appropriation for the indigent burial program even if it means increasing a fee at the state level (e.g. death certificates) to offset the cost. Thank you for your consideration of our comments.

The Kansas Association of Counties, an instrumentality of member counties under K.S.A. 19-2690, provides legislative representation, educational and technical services and a wide range of informational services to its member counties. Inquiries concerning this testimony should be directed to Randall Allen or Judy Moler by calling (785) 272-2585.

6206 SW 9th Terrace
Topeka, KS 66615
785•272•2585
Fax 785•272•3585
email kac@ink.org