MINUTES

LEGISLATIVE BUDGET COMMITTEE

August 26-27, 2010
Room 548-S—Statehouse

Members Present

Representative Ray Merrick, Vice-chairperson
Senator Laura Kelly
Senator John Vratil
Representative Bill Feuerborn
Representative Jeff Whitham
Representative Kevin Yoder

Member Absent

Senator Jay Emler, Chairperson

Staff Present

Alan Conroy, Kansas Legislative Research Department
J. G. Scott, Kansas Legislative Research Department
Leah Robinson, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Reagan Cussimanio, Kansas Legislative Research Department
Dylan Dear, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Lauren Douglass, Kansas Legislative Research Department
Cody Gorges, Kansas Legislative Research Department
Aaron Klaassen, Kansas Legislative Research Department
Estelle Montgomery, Kansas Legislative Research Department
Michael Steiner, Kansas Legislative Research Department
Jarod Waltner, Kansas Legislative Research Department
Jim Wilson, Office of the Revisor of Statutes
Jill Wolters, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Daniel Yoza, Office of the Revisor of Statutes
Melinda Gaul, Chief of Staff, Senate Ways and Means Committee
Shirley Jepson, Committee Assistant

Conferees

John Dieker, Vice-President, Bombardier Learjet
Don Pufahl, Bombardier Learjet
Alan Young, Bombardier Learjet
Don Jordan, Secretary, Kansas Department of Social and Rehabilitation Services
Roy Menninger, President, Kansas Mental Health Coalition
Rick Cagan, Executive Director, National Alliance on Mental Illness–Kansas Disability Rights Center of Kansas
Jason Hooper, President, KVC Hospitals, LLC
Lois Clendening, Service Line Director, Behavioral Health, Via Christi Hospital, Wichita
Mike Hammond, Executive Director, Association of Community Mental Health Centers of Kansas
David Wiebe, Executive Director, Johnson County Community Mental Health Center
Walt Hill, Executive Director, High Plains Mental Health Center
Howard "Spenser" McCurry, consumer
Barbara Langner, Medicaid Director, Kansas Health Policy Authority
Major General Tod Bunting, Adjutant General
Janice Harper, Adjutant General's Department
Scott Brunner, Chief Financial Officer, Kansas Health Policy Authority
Dale Dennis, Deputy Commissioner, Department of Education, Topeka, USD 501
Frank Harwood, Chief Operations Officer
Shelia Smith, Assistant Director, Special Education, Lawrence School District
Ray Dalton, Deputy Secretary, Disability and Behavioral Health Services, Kansas Department of Social and Rehabilitation Services
Martin Kennedy, Secretary, Kansas Department on Aging
Roger Werholtz, Secretary, Kansas Department of Corrections
Bill Thornton, Secretary, Kansas Department of Commerce
Jim Garner, Kansas Department of Labor
Jeremy Hill, Director, W. Frank Barton School of Business, Center for Economic Development and Business Research
Stan Ahlerich, President, Kansas, Inc.

Thursday, August 26
Morning Session

The meeting was called to order at 10:00 a.m. by Representative Merrick, Vice-chairperson, in the absence of Chairperson Emler.

Year-End Expenditures and Current Year Receipts Update

J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department (KLRD), presented a preliminary overview of Actual FY 2010 Resources, Demands, and Balances of the State General Fund (SGF) (Attachment 1). Mr. Scott noted that actual receipts for FY 2010 were $5.192 billion, or 1.9 percent, below estimates. Actual expenditures for FY 2010 were $142.0 million less than the total approved by the 2010 Legislature, but $138.6 million budgeted for FY 2010 was shifted to FY 2011. This shifting related primarily to the decision to delay state aid payments to school districts in June 2010. The aid will be paid in July 2011.

Alan Conroy, Director, KLRD, presented an overview of SGF receipts for FY 2010 (Attachment 2). Mr. Conroy explained that total receipts to the SGF in FY 2010 were $98.6 million, or 1.9 percent, below the final adjusted estimate, largely due to lower-than-estimated individual income taxes. Total SGF receipts in FY 2010 were below SGF receipts in FY 2009 by $396.5 million, or 7.1 percent.

Mr. Conroy presented an update on SGF receipts for July, FY 2011 (Attachment 3) and noted that total receipts for July, the first month of FY 2011, were $10.0 million, or 2.4 percent, below the April 16, 2010, consensus revenue estimate. Retail sales and individual income taxes fell below the estimate by more than $1.0 million for this first month of FY 2011.

Mr. Scott presented an update on the congressionally approved extension of elements of the *American Recovery and Reinvestment Act (ARRA) of 2009* (Attachment 4). The extension will provide two funding sources to the states, an extension of the enhanced Federal Medicaid Assistance Percentage (FMAP) and additional funding for education jobs. The bill extends the FMAP enhancement from January 1, 2011, to June 30, 2011, at a reduced rate of 3.2 percent for January through March of 2011 and 1.2 percent from April through June of 2011. The current fiscal impact of the increased Medicaid funding is $90.2 million to the state. The bill also includes an estimated $92.7 million for Kansas education jobs funding; however, it would require a maintenance of effort on the part of the state.

Learjet Plant Expansion

John Dieker, Vice-President, Bombardier Learjet, presented an overview of the Bombardier Learjet operations in Wichita (Attachment 5). Assisting Mr. Dieker in the presentation were Don Pufahl and Alan Young. Mr. Dieker reported on the expansion of the Wichita facility for the Learjet 85 aircraft program, which will begin in the 4th quarter of 2010. The Learjet 85 is an upper-mid-sized plane designed to meet the needs of a growing customer base. The various parts for the construction of the aircraft will be made at other Bombardier Learjet plants across the country and around the world, which would then be shipped to the Wichita plant for assembly. The employees at the Wichita facility will be highly skilled employees. Presently, Learjet has approximately 2,100 employees in Kansas and plans to increase that number to 4,000 full-time employees. Mr. Dieker acknowledged the approval by the State Finance Committee on August 6, 2010, allowing Learjet to issue bonds in the amount of $27 million for the expansion project. Repayment of the bonds will be made over a seven-year period with funding provided through withholding taxes of new and current employees.

Some members of the Committee expressed concern that the state is assisting large companies through the issuance of bonds, and noted there might be a need to put more emphasis on assisting more small businesses throughout the state.

Review Policy of State Mental Health Hospitals to Cut Off Voluntary Admissions

Estelle Montgomery, KLRD, presented background and current information on the State Mental Health Hospitals Voluntary Admissions Policy (Attachment 6). Ms. Montgomery explained that the Department of Social and Rehabilitation Services (SRS) temporarily suspended voluntary admissions to the three Kansas mental health hospitals: Osawatomie State Hospital, Rainbow Mental Health Facility, and Larned State Hospital—in May 2010 and July 2010. The agency reported that all three of these facilities were full beyond licensed capacities and the agency did not have additional resources to service persons seeking voluntary admission. Ms. Montgomery stated that

when the state hospitals are full, the community mental health centers are expected to find placement alternatives for people who otherwise would be admitted.

The Committee requested information on the amount spent per day on contracted services.

Don Jordan, Secretary, SRS, presented information on the "Brief Delays in Voluntary Admissions to State Mental Health Hospitals" (Attachment 7). The Secretary stated that on those occasions, there was a lack of facilities and lack of staff to accommodate the admissions. Other factors included safety of the patients and staff, fire rules, restrictions on size of patient rooms, number of patients in a room, and restrictions against beds in the hallways. The Secretary noted that SRS works with community mental health centers when overcrowding occurs to accommodate admissions and keep individuals safe. Other actions taken by SRS included initiation of an agreement with Via Christi Hospital in Wichita for the state to pay for uncompensated care by the hospital. There was also the opening of 11 beds at Larned State Hospital to assist with the overcrowding.

Secretary Jordan noted that the agency will be requesting additional appropriations from the 2011 Legislature to assist with renovations for additional beds at Larned State Hospital. The Committee discussed possible solutions, including expansion of state hospitals or agreements with private facilities. The Secretary indicated that some patients, particularly involuntary admissions, are not suitable for placement in a private facility because of safety concerns.

The Committee requested additional information on patient length of stay at the mental health facilities.

The meeting was recessed at 11:30 a.m.

Afternoon Session

The meeting reconvened at 1:30 p.m.

Roy Menninger, President, Kansas Mental Health Coalition, presented testimony on Admissions to State Mental Health Hospitals (Attachment 8). Dr. Menninger noted that the issue of overcrowding at the state's mental health hospitals is not a new issue, but has become more critical with budget cuts, staffing cuts, and increased admissions because of increased population. Dr. Menninger made the following recommendations:

- No further budget cuts be made to mental health services;
- State hospitals should be expanded and the state should assist community services with adequate staffing;
- Establish funding for local private mental health inpatient beds throughout the state, to encourage development of public-private partnerships for mental health inpatient beds for youth and adults.

Additional testimony concerning the issue of overcrowding at the state's mental health hospitals was received from:

- Rick Cagan, Executive Director, National Alliance on Mental Illness-Kansas (Attachment 9);

- Nick Woods, System Change Coordinator, Disability Rights Center of Kansas (Attachment 10); and

- Jason Hooper, President, KVC Hospitals, Inc. (Attachment 11).

Lois Clendening, Service Line Director, Behavioral Health, Via Christi Hospitals Wichita, Inc., also testified (Attachment 12). Ms. Clendening stated that Via Christi Hospital takes both voluntary and involuntary patients, noting that the hospital has the capacity to admit additional patients from around the state. Ms. Clendening noted the importance of providing care in the local community in order for family members to be involved in the patients' care and reduce the cost. While state mental health hospitals cannot take patients with acute physical medical conditions, Via Christi is able to take patients with both physical and mental health concerns. Ms. Clendening stated that Via Christi is willing to take mental health patients from the state on a routine basis; however, the facility would not be able to take an extremely violent patient because of safety concerns. Responding to a question from the Committee, Ms. Clendening noted the hospital currently has 11 patients that have been referred from the state.

SRS provided a report on Community Hospital Licensed Inpatient Psychiatric Beds (Attachment 13). Because the Committee questioned some of the numbers on the report, SRS noted that they would double check the numbers for accuracy with the Department of Health and Environment (KDHE), the agency which supplied the numbers.

Mike Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, also appeared before the Committee (Attachment 14). Mr. Hammond felt that it is important to address the issue and provide for a solution to alleviate future problems.

Other testimony was received from:

- David Wiebe, Executive Director, Johnson County Community Mental Health Center (Attachment 15);

- Walter Hill, Executive Director, High Plains Mental Health Center (Attachment 16); and

- Howard "Spence" McCurry, Consumer (Attachment 17).

Ray Dalton, Deputy Secretary, SRS, responded to Committee questions concerning health insurance payments, noting that a patient's health insurance is the first payee for services, with the state being the last payee. Secretary Jordan stated that it is important to address the overcrowding with a long-term strategy for the mental health care population, as well as address provisions of the new federal health care act.

Update of Medicaid and State Children's Health Insurance Program Eligibility Processing Delays and Funding

Barbara Langner, Medicaid Director, Kansas Health Policy Authority (KHPA), presented an "Update on the Medicaid State Children's Health Insurance Program (SCHIP) Eligibility Processing Delays and Funding" (Attachment 18). Ms. Langner stated that the backlog in processing applications for the Medicaid and SCHIP programs has been caused by an increase in the length of time needed to process the applications because of additional requirements. The current budget does not allow for additional staff. Currently, the Clearinghouse staff is only able to process current applications and does not have the time to address the backlog. KHPA has received a letter from the Centers for Medicare and Medicaid Services (CMS) indicating that the agency needs to take corrective action to address the processing time. Ms. Langner noted there is a concern that the backlog could result in a violation of federal processing time requirements and a loss of federal funds.

KHPA has responded with a three-pronged approach to resolve the application backlog:

- Implementation of system modifications to hasten the application processing over the next six months;
- Adoption of CMS-approved eligibility policy options to simplify the eligibility determination process; and
- Continuation of attempts to seek financial resources from multiple sources to increase application processing capacity, including private funding from philanthropic foundations, requesting budget enhancement, and seeking a favorable Children's Health Insurance Program Preauthorization Act (CHIPRA) bonus payment decision.

Ms. Langner stated that KHPA has received notice of an approved CHIPRA payment of $1.2 million. The KHPA Board has endorsed the application of those funds to eliminate the backlog at the Clearinghouse; however, funding for the Clearinghouse in FY 2012 is not expected to be sufficient to keep up with the high volume of applications. KHPA will include a request in its FY 2012 budget for additional resources for the Clearinghouse.

The meeting was recessed at 3:30 p.m.

Friday, August 27
Morning Session

The meeting reconvened at 9:00 a.m.

Disaster Relief

Major General Tod Bunting, Adjutant General, provided an update on disaster relief, including information on how a disaster is handled by state agencies, issues arising if current funding falls short, current status of outstanding disasters, and estimated total state disaster match requirements

(Attachment 19). Major General Bunting stated that the agency anticipates it will need an additional $27.4 million to address current state disasters for the remainder of FY 2011, mainly for utility infrastructure and for flooding in southeast Kansas.

Responding to a question from the Committee, Janice Harper, Adjutant General's Office, explained that small projects are paid for directly up front. Bills on larger projects are paid for as they are presented by the contractors. The agency pays both the state and federal share in one payment.

Medicaid Funding for Schools

Amy Deckard, KLRD, presented background information and an update on Medicaid Reimbursement of Attendant Care Services (Attachment 20). Ms. Deckard stated that effective July 1, 2010, KHPA discontinued reimbursement for attendant care services to schools under the Medicaid School Based Services program. This change was made as a result of an interpretation made by CMS, indicating that payment could not be made to school districts, unless the Kansas Medicaid program also covered these services in non-school settings.

A report prepared by KLRD on "Total Medicaid Expenditures for Special Education and Attendant Care by School District for FY 2008, FY 2009 and FY 2010" was distributed to the Committee (Attachment 21).

Scott Brunner, Chief Financial Officer, KHPA, presented additional comments on Medicaid funding for schools. Mr. Brunner noted that the state plan was presented to CMS in early 2009. Since that time, KHPA has been working with CMS to negotiate the final outcome. KHPA received word from CMS in March or April 2010 that there was a problem with the payments to school districts for attendant care services, with a final notification from CMS at the end of May, that these payments would not be allowed. KHPA then alerted school districts to this decision from CMS in the middle of June 2010. Responding to a question from the Committee, Mr. Brunner indicated that the effect of the action, based on estimates, would be an underpayment of approximately $5 million-$10 million to school districts. KHPA continues to work with CMS to find a solution to the problem.

Frank Harwood, Chief Operations Office, Lawrence Public Schools, and Shelia Smith, Assistant Director of Special Education, Lawrence Public Schools, presented testimony (Attachment 22). Mr. Harwood noted the difficulty in receiving the notice so late (June 17, 2010), is that the reimbursement for attendant care services will be discontinued at such a late date in the school budgeting process for FY 2011. Mr. Harwood stated that the Lawrence Public Schools will continue to provide the attendant care services as needed by their students; however, the district will need to shift funding from other educational programs.

Additional testimony was received from:

- Jennifer Barnhart, Director of Special Education, Topeka Unified School District 501 (Attachment 23);

- Dr. Rod Allen, Paola School District (Attachment 24). Dr. Allen suggested that the implementation of the changes be delayed until the FY 2012 budget year in order for school districts to have time to adjust to the new data collection and realign their budgets; and

- Dr. Bill Craig, Chief Executive Officer, Lakemary Center (Attachment 25). Dr. Craig stated that the Lakemary Center provides a statewide resource for children with the challenging combination of developmental disability and significant

psychiatric and behavioral disorders. A central component of the successful treatment is the specialized aides in the school who work is funded through the Medicaid service called Attendant Care. The services provided to children with an Individualized Educational Plan (IEP) are required by law. Dr. Craig noted that one-fifth of their total school budget comes from funds for attendant care with the removal of these services creating a budget crisis.

The Committee requested a listing of all school districts with the impact of the new ruling by district. The Committee also requested that KHPA research the possibility of holding school districts harmless for the 2010-2011 school year.

Update on Home and Community-Based Waivers

Amy Deckard presented an "Update on the Actions by the 2010 Legislature regarding Home and Community-Based Waivers" (Attachment 26).

Ray Dalton, Deputy Secretary, SRS, provided information on Home and Community-Based Services Waivers (Attachment 27), including the following:

- Developmental Disability (DD) Waiver. An additional $3.3 million from the State General Fund was allocated to the DD waiver for FY 2011. At this time, there are 2,444 people on the waiting list receiving no waiver services and another 1,047 people receiving some services, but who are waiting for additional services. To avoid further overspending, SRS eliminated oral health services on January 1, 2010, and temporary respite care services on February 1, 2010.

- Physical Disability (PD) Waiver. As of August 1, 2010, there were 2,286 individuals on the PD Waiver waiting list. Steps have been taken to avoid overspending by eliminating oral health services, limiting service, and changing the crisis criteria.

- Traumatic Brain Injury (TBI) Waiver. This program is considered a rehabilitation program and consumers are expected to transition off the program or to another program. Changes in the program to avoid overspending include elimination of oral health services; limiting personal services to ten hours per day unless there is a determination of a crisis situation; limiting assistive services to crisis situations only, with approval by the program manager; and moving third year continuation of service review to a program manager, as opposed to a committee. There is no waiting list for this program.

- Technology Assisted (TA) Waiver. Designed to serve children ages 0-22 years who are medically fragile and technology dependent, requiring intense medical care. There is no waiting list for this program.

- Serious Emotional Disturbance (SED) Waiver. During FY 2010, $48,448,927 was paid through the SED waiver to service a total of 6,021 children.

- Autism Waiver. The target population for the autism waiver is children with autism spectrum disorders (ASD), including autism, Aspergers' Syndrome, and other pervasive development disorders. This waiver was implemented on January

1, 2008. There is a waiting list of 247 children at this time. The total expenditure for the waiver in FY 2010 was $743,673.

Mr. Dalton noted that the SRS Fee Fund balance was used to fill the gap between available SGF and waiver spending, and allocated to HCBS waivers. The fund is now depleted and SRS will be $11 million short for FY 2012.

Mr. Dalton provided an update on the Money Follows the Person (MFP) Grant, a federally funded grant for Kansas with targeted population including persons currently residing in nursing facilities and intermediate care facilities for people with mental retardation (ICFs/MR). He also discussed Executive Order 10-01, regarding the Kansas Neurological Institute and Parsons State Hospital. He indicated that SRS has been working with the Executive Order Advisory Group to make recommendations on the downsizing of the facilities.

The Committee expressed concern that the cost of services in the private sector are not included. The Committee also felt that there should be more involvement on the part of KHPA with regard to the waivers.

Martin Kennedy, Secretary, Department on Aging, presented an update on Home and Community-Based Waivers for the Frail Elderly (HCBS-FE) (Attachment 28). Secretary Kennedy noted that oral health services, sleep cycle services, comprehensive support, assisted technology, and telehealth services have been discontinued in order to control expenses. The agency anticipates a $7.0 million shortfall during the current fiscal year. The Committee suggested that options be explored for underwriting the funding of the oral health program.

Additional testimony on the effects of the budget cuts to the Home and Community-Based Waivers was received from:

- Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association (Attachment 29);
- Tom Laing, Executive Director, InterHab (Attachment 30); and
- Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas (SILCK) (written only) (Attachment 31).

The meeting was recessed at 11:55 a.m.

Afternoon Session

Update on Corrections - Stockton Facility

Roger Werholtz, Secretary, Kansas Department of Corrections (KDOC), presented an update on the Stockton facility (Attachment 32). Secretary Werholtz informed the Committee that the Stockton facility will reopen on September 1, 2010, and will be filled to capacity with 128 inmates. The Secretary noted that the prison population will still be 237 over capacity after the opening of Stockton. At present, there are no inmates housed outside the state.

Responding to questions from the Committee, Secretary Werholtz stated that there is no mechanism in place at this time, which gives KDOC the authority to release inmates early. At this time, KDOC is in the process of developing recommendations to present to the Governor and the Legislature concerning prison capacity.

Kansas Economy

Bill Thornton, Secretary, Department of Commerce, presented an update on the state of the Kansas Economy (Attachment 33). Mr. Thornton stated that the goal of the Department is to encourage job creation and capital investment in Kansas through the recruitment of out-of-state firms, the expansion of existing Kansas companies, and the creation of new companies. Responding to a question from the Committee concerning FY 2010 recruitment results, Secretary Thornton stated that the jobs created and payroll figures are projected numbers associated with the expectation that the jobs will materialize.

Jim Garner, Secretary, Department of Labor, presented an Update on Kansas Economic Data (Attachment 34). Mr. Garner reported that the state, at 6.9 percent unemployment, is sufficiently below the national unemployment rate of 9.7 percent. Secretary Garner stated that there are some positive signs of growth in the construction industry; professional and business services; trade, transportation and utilities; mining and logging; manufacturing; and financial activities. Currently, the state is paying approximately $10.0 million in unemployment benefits per week. To date, the Secretary reported that it has been necessary to borrow $88.2 million from the U.S. Treasury to pay unemployment benefits. As a part of ARRA, no interest will accrue on the loan until January 2011. Responding to a question from the Committee, Secretary Garner stated that unemployment taxes are collected on the first $8,000 of salary; consequently, the state has already received the bulk of unemployment taxes at this time. It is anticipated that the state may need to borrow additional funds from the federal government during the fourth quarter of 2010. Mr. Garner stated that interest will begin accruing on the federal loan on January 1, 2011, with the first payment due September 1, 2011.

Jeremy Hill, Director, W. Frank Barton School of Business, Center for Economic Development and Business Research, presented testimony on the Kansas Economy. Mr. Hill projected that unemployment will remain relatively high, with a forecast of slow recovery from the recession.

Stan Ahlerich, President, Kansas, Inc., presented testimony on Indicators of the Kansas Economy (Attachment 35). Mr. Ahlerich stated that the recession is worldwide and projects that it will last for a considerable period of time with a slow recovery. Mr. Ahlerich stated that the recession was caused by consumer debt, commercial debt, and national debt. He indicated that the world economy is very unstable at this time and said that the state needs to position itself to welcome industry and business to the state, with a mix of large and small businesses, and needs to create an environment to attract opportunities and jobs.

The meeting was adjourned at 3:45 p.m. The next meeting of the Committee will be October 14-15, 2010.

Prepared by Shirley Jepson
Edited by Leah Robinson

Approved by the Committee on:

October 14, 2010
(Date)

LEGISLATIVE BUDGET COMMITTEE
GUEST LIST
DATE: August 26, 2010

NAME	REPRESENTING
John Kirk	DOB
Amy Penrod	DOB
Kris Mecray	Kennedy & Assoc.
Michelle Bullis	Cap. Strategies
Barbara Belcher	Merck
Melissa Wangemann	KAC
Dick Koerth	KDWP
Jim Conant	KDOR
Barb Conant	KDOA
Lois Weeks	SRS
Mike Hammond	Hein Law Firm
Colin Thomasset	ACMHCK
Bernd Koops	Hein Law Firm
Matt Casey	GBA
David Klepper	KC STAR
JP Small	Bombardier Learjet
Don Pufahl	Bombardier Learjet
Alan Young	Bombardier Learjet
John Dieker	Bombardier Learjet
Rachel Whitten	Kansas Reporter

LEGISLATIVE BUDGET COMMITTEE
GUEST LIST
DATE: August 27, 2010

NAME	REPRESENTING
Kevin Keatley	Kansas Association of Counties
Janice Harper	Adjutant General's Dept.
Angee Morgan	" " "
Tod Bunting	" " "
Frank Harwood	Lawrence Public Schools
Shelia Smith	"
Rob Merkey	Kennedy & Assoc.
Bernd Koops	Hein Law Firm
Michelle Butler	Cap. Strategies
Jennifer Crow	USD 501
Mark Tallman	KASB
Martin Kennedy	KDOA
T. Laing	InterHab
Jeremy Hill	WSU- CEDBR
Brendan Yorkey	DOB
MIKE GATTO	KDOC
Charles Simmons	KDOC
Roger Werholtz	KDOC
JEREMY BARCLAY	KDOC
DENNIS WILLIAMS	KDOC
Stuart Little	Community Correction Assoc.
Megan Bottenberg	KDOL
Jim Garner	KDOL

LEGISLATIVE BUDGET COMMITTEE
GUEST LIST
DATE: __August 27, 2010_____

NAME	REPRESENTING
Sean Miller	Capitol Strategies
J.P. SMALL	STOCKTON, CITY OF
Gene Meyer	Kansas Reporter

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 • FAX (785) 296-3824

kslegres@klrd.ks.gov http://www.kslegislature.org/klrd

August 26, 2010

To: Legislative Budget Committee

From: J.G. Scott, Chief Fiscal Analyst
Leah Robinson, Principal Fiscal Analyst

Re: Actual FY 2010 Resources, Demands, and Balances of the State General Fund – Preliminary

Based on final action of the 2010 Legislature, the Kansas Legislative Research Department estimated that the June 30, 2010 State General Fund unencumbered cash balance would be a negative $67.8 million. This amount was based on: the April 2010 consensus revenue estimates, as adjusted for legislation; and the expenditures approved by the 2010 Legislature. As shown in Table I, the actual ending balance was a negative $24.4 million, or approximately $43.4 million above the estimate. It should be noted, however, that the FY 2010 data contained in this report are preliminary and are subject to revision by the Division of Accounts and Reports.

Actual receipts were $5.192 billion, which was $98.6 million, or 1.9 percent, below the estimated amount.

Actual FY 2010 expenditures were $142.0 million less than the total approved by the 2010 Legislature. However, $138.6 million budgeted for FY 2010 has "shifted" and is now authorized to be spent in FY 2011. Net underspending was $3.3 million.

Table II identifies the major items of underspending and shifting revealed by the Research Department's analysis of FY 2010 State General Fund appropriations accounts, including reappropriations to FY 2011. Significant underspending occurred within the Board of Regents and the state universities ($1.4 million, primarily related to lower than budgeted expenditures for debt service), and the Department of Administration ($1.1 million, primarily in capital improvement debt service expenditures); and the Adjutant General ($0.5 million, almost exclusively for capital improvement debt service expenditures).

Significant shifting of expenditures from FY 2010 to FY 2011 includes $132.0 million in the budget of the State Department of Education, largely related to the decision to delay state aid payments from June (FY 2010) to July (FY 2011); $2.0 million in the Board of Regents and the state universities, primarily related to expenditures for the Southwest Kansas Access project, and a number of grant and scholarship programs); $1.4 million in the budgets of the Department of Social and Rehabilitation Services and the state hospitals, primarily in operating expenditures); and $1.0 million in the budgets of the legislative branch agencies, related to operating expenditures.

TABLE I
State General Fund
Comparison of Revised Budget Estimates with Actual Resources and Demands for FY 2010
(Totals May Not Add Due to Rounding)

	Dollars in Thousands		
	Revised Budget	Actual	Difference
Unencumbered Cash Balance, June 30, 2009	$ 51.2	$ 51.2	$ 0.0
Receipts	5,291.0	5,192.4	(98.6)
Total Resources	$ 5,342.2	$ 5,243.6	$ (98.6)
Expenditures and Encumbrances	5,410.0	5,268.0	(142.0)
Unencumbered Cash Balance, June 30, 2010	$ (67.8)	$ (24.4)	$ 43.4

TABLE II
Underspending and Shifting of Expenditures
(Amounts in Thousands)

Underspending:

Board of Regents and Postsecondary Education		
Postsecondary Education Infrastructure Debt Service	$	5,486
School of Pharmacy Expansion Debt Service		509
Southwest Kansas Access		350
University of Kansas Operating Expenditures		348
Kansas State University Operating Expenditures		279
University of Kansas Medical Center Oper. Exp.		276
Community College Operating Grant		261
Wichita State University Operating Expenditures		177
KSU-Extension and Ag. Research Program Oper. Exp.		131
Pittsburg State University Operating Expenditures		91
Fort Hays State University Operating Expenditures		90
Emporia State University Operating Expenditures		84
Postsecondary Aid for Vocational Education		84
Tuition Waivers		43
Municipal University (Washburn) Operating Grant		30
KSU-Veterinary Medical Center Operating Expenditures		28
R.O.T.C. Scholarship Reimbursement		27

Postsecondary Education Operating Grant		(6,991)		
All Other		62		
Subtotal – Board of Regents and Postsecondary Ed.			$	1,365
Department of Administration				
Statehouse Renovation Debt Service	$	911		
Capitol Complex Rehabilitation and Repair		159		
KPERS Bonds Debt Service		17		
All Other		14		
Subtotal – Department of Administration			$	1,101
Department on Aging*			$	680
Department of Social and Rehabilitation Services and Hosp.*			$	(680)
Adjutant General				
Training Center Debt Service	$	343		
Armory Debt Service		149		
Subtotal – Adjutant General			$	492
Department of Corrections and Correctional Facilities				
Day Reporting State Match	$	431		
Debt Service Payments		215		
Local Jail Payments		152		
Central Administration		(49)		
Norton Correctional Facility		(245)		
Medical and Mental Health Programs		(265)		
Subtotal – Department of Corrections and Facilities			$	240
Department of Education			$	63
Juvenile Justice Authority and Juvenile Correctional Facilities			$	37
All Other			$	14
TOTAL - Underspending			**$**	**3,312**

Shifting of Expenditures:

Department of Education				
KPERS School Employer Contributions	$	53,047		
Supplemental General State Aid		46,098		
General State Aid		32,667		
Special Education Aid		148		
Teaching Excellence Scholarships		36		
Operating Expenditures		1		
Subtotal-Department of Education			$	131,998
Board of Regents and Postsecondary Education				
Southwest Kansas Access	$	445		
Nursing Student Scholarships		298		
Teacher Scholarships		283		
University of Kansas Medical Center Operating Exp.		209		
Fort Hays State University Wetlands Center		169		
Nursing Education Grant		166		
R.O.T.C. Tuition Reimbursement		93		
Military Service Scholarships		87		
State Scholarship Program		54		
Vocational Scholarships		49		
KUMC Cancer Center		42		
Nursing Facilities and Supplies		30		
All Other		30		
Subtotal – Board of Regents and Postsecondary Educ.			$	1,955
Department of Social and Rehabilitation Services and Hosp.				
State Operations	$	1,379		
All Other		1		
Subtotal – Department of SRS and Hospitals			$	1,380
Legislative Agencies			$	1,011

1-4

Department of Corrections and Correctional Facilities			
Medical and Mental Health Care Contract	$ 258		
Central Administration	223		
Norton Correctional Facility Operating Expenditures	235		
Winfield Correctional Facility Operating Expenditures	24		
Offender Programs	22		
All Other	28		
Subtotal-Department of Corrections and Facilities		$	790
Department on Aging			
Medicaid Assistance-Money Follows the Person	$ 169		
Senior Care Act	77		
Nursing Facilities Regulation – State and Federal	54		
Administration	47		
Administration - Medicaid	43		
All Other	19		
Subtotal – Department on Aging		$	409
Board of Indigents' Defense Services			
Capital Defense	$ 161		
Operating Expenditures	108		
Subtotal – Board of Indigents' Defense Services		$	269
Department of Health and Environment			
Aid to Local Units	$ 138		
Aid to Local Units – Primary Health	34		
Immunization Programs	26		
All Other	5		
Subtotal – Department of Health and Environment		$	203
Department of Wildlife and Parks			
State Parks Ongoing Rehabilitation	$ 67		
Reimbursement for Licenses for Disabled Veterans	39		
Reimbursement for Licenses for National Guard Members	11		
Reimbursement of Permits for National Guard Members	7		
All Other	1		
Subtotal – Department of Wildlife and Parks		$	125

Department of Administration			
Facilities Management	$ 57		
Policy Analysis Initiatives	48		
All Other	1		
Subtotal – Department of Administration		$	106
Juvenile Justice Authority and Juvenile Correctional Facilities		$	66
Adjutant General		$	49
Attorney General		$	48
School for the Blind		$	42
Judicial Branch		$	40
Human Rights Commission		$	39
Health Policy Authority		$	23
Sentencing Commission		$	20
Department of Revenue		$	18
Commission on Veterans' Affairs		$	15
Offices of the Governor and Lieutenant Governor		$	6
Department of Commerce		$	4
Historical Society		$	3
Department of Agriculture		$	3
Kansas Bureau of Investigation		$	2

Department of Labor	$	2
Kansas Highway Patrol	$	2
All Other	$	4
TOTAL – Shifting of Expenditures to FY 2011	**$**	**138,632**

*$680,000 was transferred from the Department on Aging to the Department of Social and Rehabilitation Services pursuant to provisions of "Money Follows the Person."

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 ◆ FAX (785) 296-3824

kslegres@klrd.ks.gov http://www.kslegislature.org/klrd

July 19, 2010

To: Legislative Budget Committee

STATE GENERAL FUND RECEIPTS

FY 2010

The Legislative Research Department recently received from the Division of Accounts and Reports information on the total State General Fund (SGF) receipts from FY 2010.

Total receipts to the SGF were $98.6 million, or 1.9 percent, below the final adjusted estimate (which includes any legislation enacted after the Consensus Revenue estimate). Taxes only in FY 2010 were $101.9 million, or 2.0 percent, below the adjusted estimate – most notably, in lower-than-estimated individual income taxes.

Tax sources that exceeded the estimate by more than $1.0 million were retail sales ($12.0 million, or 0.7 percent); corporate franchise ($7.5 million, or 21.9 percent); and insurance premiums ($1.6 million, or 1.3 percent).

Tax sources falling below the adjusted estimate by more than $1.0 million were individual income ($91.8 million, or 3.7 percent), corporation income ($25.1 million, or 10.0 percent), financial institutions income ($3.5 million, or 17.4 percent), severance ($2.1 million, or 2.5 percent), and liquor enforcement ($1.7 million or 3.0 percent).

Of particular note is the shortfall in individual income taxes. Withholding receipts for salaried individuals declined 1.3 percent in FY 2010, compared to a positive growth rate of 1.6 percent in FY 2009 and 6.2 percent in FY 2008. Estimated income tax payments, largely from self-employed individuals, in FY 2010 fell 19.5 percent, compared to a decline of 14.2 percent in FY 2009 and positive growth of 12.1 percent in FY 2008.

Interest receipts exceeded the estimate by $1.6 million, or 7.1 percent. Net transfers and agency earnings both exceeded the estimate by $0.9 million.

Total SGF receipts in FY 2010 were below total SGF receipts in FY 2009 by $396.5 million, or 7.1 percent. Tax receipts only for FY 2010 were below FY 2009 tax receipts only by $422.4 million, or 7.8 percent.

A Certificate of Indebtedness of $700 million was discharged or redeemed by the State General Fund prior to the end of the fiscal year, as required by law. The redemption took place on June 24, 2010.

H:\02clerical\ANALYSTS\ADC\50791.wpd

Legislative Budget Committee
Date 8-26/27-2010
Attachment 2

STATE GENERAL FUND RECEIPTS
FY 2010
(dollar amounts in thousands)

	Actual	FY 2010			Percent increase relative to:	
	FY 2009	Estimate*	Actual	Difference	FY 2009	Estimate
Property Tax:						
Motor Carriers	$ 29,257	$ 24,000	$ 24,993	$ 993	(14.6)%	4.1%
Income Taxes:						
Individual	$ 2,682,000	$ 2,510,000	$ 2,418,208	$ (91,792)	(9.8)%	(3.7)%
Corporation	240,258	250,000	224,940	(25,060)	(6.4)	(10.0)
Financial Inst.	26,192	20,000	16,515	(3,485)	(36.9)	(17.4)
Total	$ 2,948,450	$ 2,780,000	$ 2,659,663	$ (120,337)	(9.8)%	(4.3)%
Estate Tax	$ 22,530	$ 9,000	$ 8,396	$ (604)	(62.7)%	(6.7)%
Excise Taxes:						
Retail Sales	$ 1,689,516	$ 1,640,000	$ 1,652,037	$ 12,037	(2.2)%	0.7%
Comp. Use	235,026	205,000	205,540	540	(12.5)	0.3
Cigarette	107,216	99,000	99,829	829	(6.9)	0.8
Tobacco Prod.	5,728	6,300	6,352	52	10.9	0.8
Cereal Malt Bev.	2,089	2,100	1,989	(111)	(4.8)	(5.3)
Liquor Gallonage	18,215	18,200	17,953	(247)	(1.4)	(1.4)
Liquor Enforce.	53,794	56,500	54,827	(1,673)	1.9	(3.0)
Liquor Drink	9,141	9,100	8,930	(170)	(2.3)	(1.9)
Corp. Franchise	41,720	34,000	41,462	7,462	(0.6)	21.9
Severance	124,249	84,000	81,870	(2,130)	(34.1)	(2.5)
Gas	73,814	41,400	39,988	(1,412)	(45.8)	(3.4)
Oil	50,436	42,600	41,882	(718)	(17.0)	(1.7)
Total	$ 2,286,693	$ 2,154,200	$ 2,170,788	$ 16,588	(5.1)%	0.8%
Other Taxes:						
Insurance Prem.	$ 119,590	$ 118,800	$ 120,375	$ 1,575	(0.7)%	1.3%
Miscellaneous	1,794	1,800	1,655	(145)	(7.7)	(8.1)
Total	$ 121,384	$ 120,600	$ 122,030	$ 1,430	(0.5)%	1.2%
Total Taxes	$ 5,408,314	$ 5,087,800	$ 4,985,870	$ (101,930)	(7.8)%	(2.0)%
Other Revenue:						
Interest	$ 64,199	$ 23,000	$ 24,629	$ 1,629	(61.6)%	7.1%
Transfers (net)	35,582	127,731	128,586	855	--	0.7
Agency Earnings and Misc.	80,879	52,500	53,365	865	(34.0)	1.6
Total	$ 180,660	$ 203,231	$ 206,579	$ 3,348	14.3%	1.6%
TOTAL RECEIPTS	$ 5,588,974	$ 5,291,031	$ 5,192,449	$ (98,582)	(7.1)%	(1.9)%

* Consensus estimate as of April 16, 2010 as subsequently adjusted for legislation enacted after that date. A Certificate of Indebtedness of $700 million was redeemed or repaid, as required by law, before the end of the fiscal year. The redemption was made on June 24, 2010.

NOTES: Details may not add to totals due to rounding.

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 ◆ FAX (785) 296-3824

kslegres@klrd.ks.gov http://www.kslegislature.org/klrd

August 16, 2010

To: Legislative Budget Committee

STATE GENERAL FUND RECEIPTS
JULY, FY 2011

For the first four months of FY 2011, estimates of State General Fund (SGF) receipts are based upon the consensus estimates of April 16, 2010 and as adjusted for 2010 legislation enacted after that date.

Total receipts for July, the first month of FY 2011, were $10.0 million, or 2.4 percent, below the estimate. The component of total SGF receipts from taxes only was $2.5 million, or 0.7 percent, below the estimate. The estimated total receipts for July were $408.6 million, while actual receipts were $398.6 million.

There was only one tax source – insurance premiums – that exceeded the estimate by more than $1.0 million for July. Insurance premium receipts were $1,020,000 above the estimate.

Tax sources that fell below the estimate by more than $1.0 million were retail sales ($2.3 million, or 1.5 percent) and individual income ($1.8 million, or 1.0 percent). It should be noted that although the state retail sales and use tax rate temporarily increased from 5.3 percent to 6.3 percent effective July 1, most of the increased sales and use tax receipts from the higher rate will not be reflected until the August monthly receipt report is issued in early September.

Interest and agency earnings were $1.0 million and $1.2 million, respectively, below the estimate. Net transfers were $5.3 million less than anticipated.

Total SGF receipts for July of FY 2011 are $66.6 million, or 20.1 percent, above FY 2010 for the same period. Tax receipts only for the same period were above FY 2010 by $35.4 million, or 10.4 percent. However, it is important to note that $31.0 million in tax refunds that should have been paid in FY 2009 were delayed until July 2010, to help ensure the State General Fund ended the fiscal year with a positive balance. Excluding the delayed tax refunds, total receipts would be $35.6 million, or 9.8 percent, above total receipts for the same period in FY 2010. Tax receipts only (excluding the delayed tax refunds) would be $4.4 million, or 1.2 percent, above the same period in FY 2010.

The report excludes the July 1 deposit to the SGF of $700 million, pursuant to the issuance of a Certificate of Indebtedness. This certificate will be discharged prior to the end of the fiscal year.

STATE GENERAL FUND RECEIPTS

July, FY 2011

(dollar amounts in thousands)

	Actual	FY 2011			Percent increase relative to:	
	FY 2010	Estimate*	Actual	Difference	FY 2010	Estimate
Property Tax:						
Motor Carriers	$ 268	$ 100	$ 52	$ (48)	(80.7)%	(48.3)%
Income Taxes:						
Individual	$ 150,144	$ 180,000	$ 178,209	$ (1,791)	18.7%	(1.0)%
Corporation	7,386	5,000	4,757	(243)	(35.6)	(4.9)
Financial Inst.	(1,227)	(700)	(694)	6	(43.5)	(0.9)
Total	$ 156,302	$ 184,300	$ 182,273	$ (2,027)	16.6%	(1.1)%
Estate Tax	$ 152	$ 400	$ 152	$ (248)	0.2%	(61.9)%
Excise Taxes:						
Retail Sales	$ 146,259	$ 148,000	$ 145,734	$ (2,266)	(0.4)%	(1.5)%
Comp. Use	19,930	22,000	22,732	732	14.1	3.3
Cigarette	9,263	8,000	8,321	321	(10.2)	4.0
Tobacco Prod.	579	600	600	0	3.7	0.1
Cereal Malt Bev.	212	200	183	(17)	(13.6)	(8.4)
Liquor Gallonage	1,716	1,800	1,812	12	5.6	0.7
Liquor Enforce.	4,798	5,000	4,673	(327)	(2.6)	(6.5)
Liquor Drink	746	750	754	4	1.0	0.5
Corp. Franchise	1,232	700	958	258	(22.3)	36.8
Severance	3,328	7,750	7,886	136	137.0	1.8
Gas	2,081	3,500	3,488	(12)	67.6	(0.3)
Oil	1,247	4,250	4,398	148	252.7	3.5
Total	$ 188,063	$ 194,800	$ 193,653	$ (1,147)	3.0%	(0.6)%
Other Taxes:						
Insurance Prem.	$ (3,687)	$ (600)	$ 420	$ 1,020	(111.4)%	--
Miscellaneous	107	150	100	(50)	(6.4)	(33.3)
Total	$ (3,580)	$ (450)	$ 520	$ 970	(114.5)%	--
Total Taxes	$ 341,205	$ 379,150	$ 376,650	$ (2,500)	10.4%	(0.7)%
Other Revenue:						
Interest	$ 1,804	$ 2,300	$ 1,303	$ (997)	(27.8)%	(43.4)%
Transfers (net)	(15,013)	22,435	17,093	(5,342)	--	(23.8)
Agency Earnings and Misc.	4,020	4,700	3,549	(1,151)	(11.7)	(24.5)
Total	$ (9,189)	$ 29,435	$ 21,944	$ (7,491)	--	(25.4)%
TOTAL RECEIPTS	$ 332,017	$ 408,585	$ 398,594	$ (9,991)	20.1%	(2.4)%

* Consensus estimate as of April 16, 2010, as subsequently adjusted for legislation enacted after that date. Excludes a Certificate of Indebtedness of $700 million, that must be redeemed prior to the end of the fiscal year.

NOTES: Details may not add to totals due to rounding.

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 • FAX (785) 296-3824

kslegres@klrd.ks.gov http://www.kslegislature.org/klrd

August 26, 2010

To: Legislative Budget Committee

From: J.G. Scott, Chief Fiscal Analyst

Re: Act of 2009 Extension

In August, the Congress approved and the President signed an extension of the American Recovery and Reinvestment Act (ARRA) of 2009. The extension will provide two funding sources to states, an extension of the enhanced Federal Medicaid Assistance Percentage (FMAP) and additional funding for education jobs.

ARRA FMAP Extension

The bill extended the enhanced FMAP from January 1, 2011 to June 30, 2011, though at a reduced rate. The current enhanced rate is a base increase of 6.2 percent and the extension is 3.2 percent for January through March of 2011 and 1.2 percent from April through June of 2011. The bill does maintain the base Medicaid match rate at the highest level attained from FY 2008 to FY 2011 and continues the unemployment bonuses. The estimated federal base rate for Kansas for FY 2011 is 59.05 percent, down from 60.38 percent in FY 2010.

States do have to apply within 45 days from the date of the bill signing (September 24, 2010) in order to receive the increased Medicaid funding. The current fiscal impact to the State of Kansas is estimated to be an additional $90.2 million. The FMAP extension affects the Medicaid program ($85.1 million), Medicaid clawback ($4.4 million) and foster care program ($0.6 million).

The FY 2011 state budget includes enhanced Medicaid funding that was estimated at $131.0 million. This estimate did not include the stepped down base adjustment, but maintained the increase at 6.2 percent.

Education Jobs

The bill also includes an estimated $92.7 million for Kansas education jobs funding. There also is a maintenance of effort that is required. For FY 2011, the State must either maintain expenditures at the FY 2009 level or at the same percentage of education expenditures to total expenditures as FY 2010. Another option is available if the tax collections for calendar year 2009 were less than tax collections for calendar year 2006. If this is the case, the State can either maintain expenditures at the FY 2006 level or at the same percentage of education expenditures to total expenditures as FY 2006.

Kansas qualifies under the last option and is maintaining expenditures at the FY 2006 level. The bill requires that both K-12 education and higher education be included in the maintenance of effort, but funding can be distributed only to K-12 to support school-level

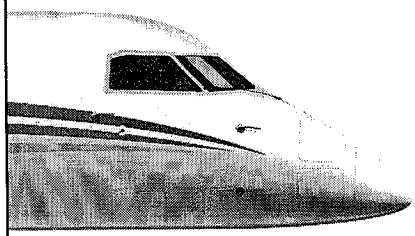
Legislative Budget Committee
Date 8-26/27-2010
Attachment 4

State General Fund budget for K-12 education is $85.9 million above the required maintenance of effort, which would require at least $6.8 million to be distributed to the school districts.

Summary

Kansas is estimated to receive a total of $182.9 million in additional federal funds. If Kansas simply meets the maintenance of effort for the education jobs, there would be a total of $176.1 million available to the State General Fund and $6.8 million available to the local school districts. The FY 2011 approved budget includes a total of $131.0 million that was anticipated in enhanced funding, creating an estimated $45.1 million in unanticipated federal funding.

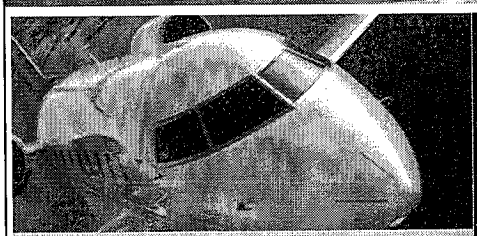
Bombardier Learjet

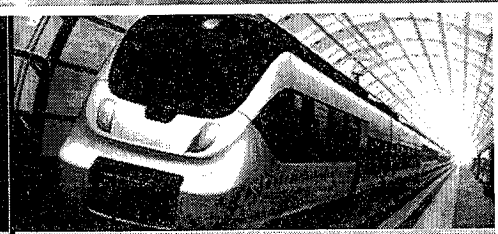


August 26, 2010

BOMBARDIER

Bombardier Inc. – A diverse company





Aerospace

F10 revenues: $9.4 billion
48% of total revenues
Backlog: $16.8 billion*
Employees: 28,900*

Transportation

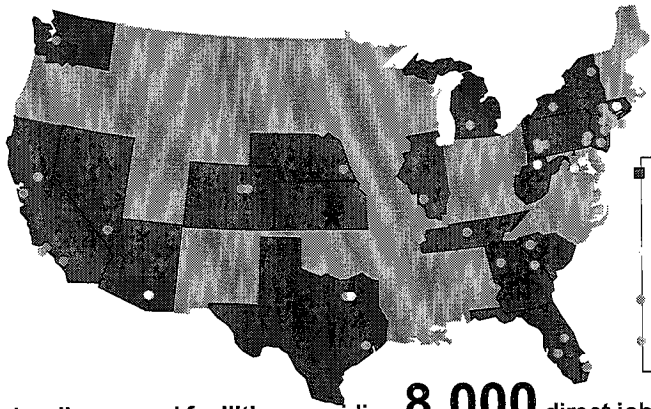
F10 revenues: $10 billion
52% of total revenues
Backlog: $27.1 billion*
Employees: 33,800*

*As at January 31, 2010

BOMBARDIER

Legislative Budget Committee
Date 8-26/27-2010
Attachment 5

Bombardier Coast-to-Coast in the US

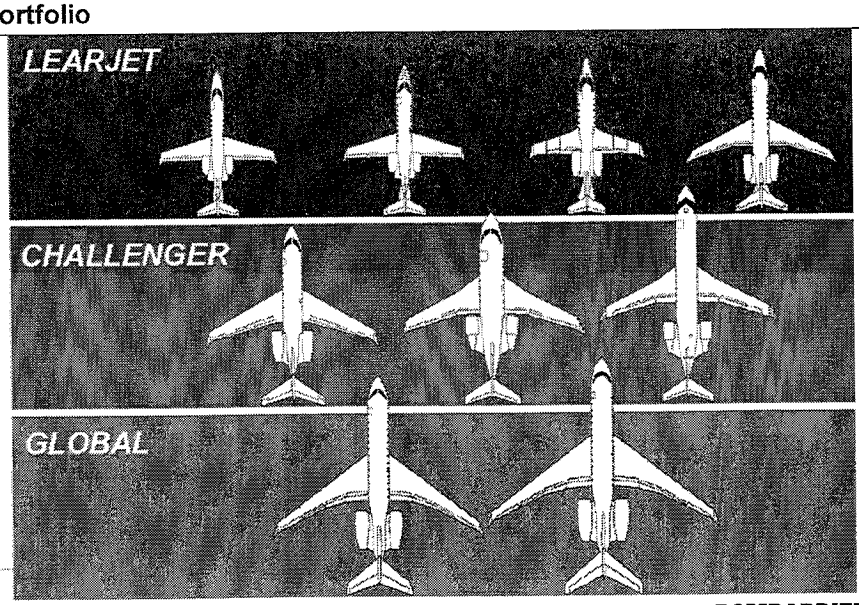


39 Bombardier-owned facilities providing **8,000** direct jobs

in **21** States and D.C. plus **10** Authorized Service Facilities

BOMBARDIER

Bombardier Business Aircraft has the Industries Broadest Product Portfolio

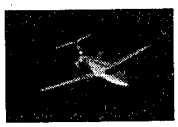


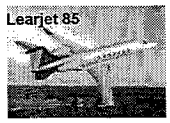
BOMBARDIER

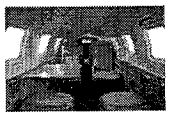
4

5-2

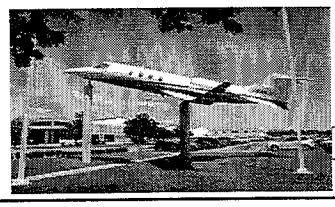
Bombardier Learjet Products and Facility



- Wichita, Kansas facility (Over 2100 employees)
  - Learjet Operations and Headquarters
  - Bombardier Aircraft Services (BAS)
  - Bombardier Flight Test Center (BFTC)
  - Learjet Customer Service & Support (CS&S)
  - Bombardier Parts Logistics & CRC (PL)
- Coming Soon, ***LEARJET 85***
  - Final Assembly
  - Interior Completions
  - Flight Testing
  - Customer Delivery

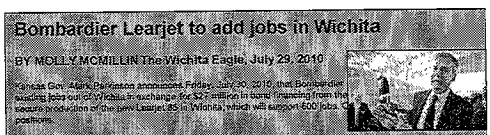



5

Market conditions

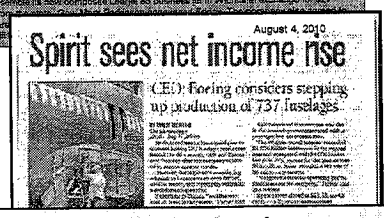

LEARJET TO ADD JOBS IN WICHITA

The Learjet 85 assembly site will support 500 jobs, 300 of them new positions


Bombardier Learjet to add jobs in Wichita

BY MOLLY MCMILLIN The Wichita Eagle, July 29, 2010

Parkinson announces $27 mil for Bombardier Learjet


August 4, 2010

Spirit sees net income rise

CEO: Boeing considers stepping up production of 737 fuselages


Hawker sales, deliveries fall in 2nd quarter


Sunday, August 1, 2010 – Wichita Eagle

Aviation sees growth in law enforcement

High-tech cameras help planes play a larger role

Hawker reiterates its plans

BY MOLLY McMILLIN The Wichita Eagle, August 5, 2010

Hawker Beechcraft CEO Bill Boisture says the company's actions are part of an internal process called "Project Challenge," aimed to position the business for the future.Hawker Beechcraft's top executive reiterated to Wall Street analysts that the company is considering alternate U.S. locations for some of its Wichita-based manufacturing.The actions are part of t... Challenge," aimed to position the busin... CEO Bill Boisture said on a conference ... financial results. "We do believe it is ne... company to be profitable in a smaller m... finalize these and other facilities footpri... months.Project Challenge focuses on f... on core and noncore tasks, supply cha... initiatives, Boisture said.

Aviation looks to Latin America

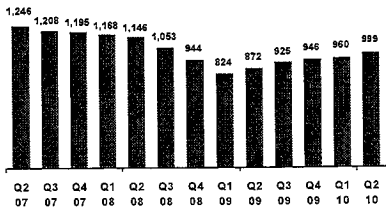
BY MOLLY McMILLIN - The Wichita Eagle, August 3, 2010

Wichita planemakers are turning toward Latin America next week to help sell business aircraft. They will display products at the Seventh Annual Latin America Business Aviation Conference and Exhibition at the Congonhas Airport in Sao Paulo, Brazil. The show runs Aug. 12-14 and typically attracts more than 13,000 people. Latin American countries are poised to play an important part in the economic recuperation of general aviation, said aviation consultant Brian Foley. Historically, Latin America has been the third-largest market for corporate aircraft and is where 12 percent of the world's 30,600 business jets and turboprops are based. Jets outnumber turboprops by two-to-one in North America and Europe.

5-3

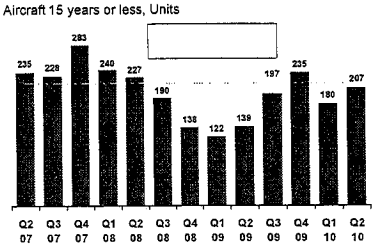
Business Jet leading indicators still challenging

US BUSINESS JET UTILIZATION
All business jets, Thousands departures and landings



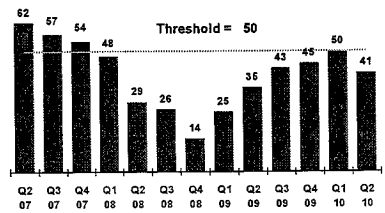
Source: FAA website

INDUSTRY PRE-OWNED AIRCRAFT SALES
Aircraft 15 years or less, Units



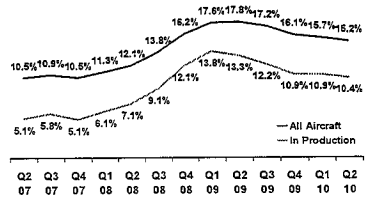
Source: AMSTAT

UBS BUSINESS JET MARKET CONDITIONS INDEX
Brokers and dealers confidence, 100-point scale



Source: UBS

INDUSTRY PRE-OWNED INVENTORY
Percentage (%) of fleet



Source: JETNET

BOMBARDIER

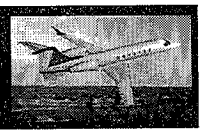
7

We are continuing to invest in our future

Business Aircraft

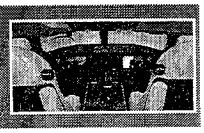
Learjet 85

- First F.A.R. Part 25 composite business jet
- Larger, more comfortable stand-up cabin than any existing aircraft in its class
- Entry into service scheduled for 2013



Global Vision Flight Deck

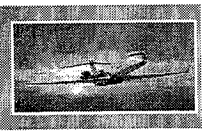
- Improved avionics system
- Increased situational awareness and comfort
- Superior design aesthetics in the cockpit
- Entry into service scheduled for 2012



Commercial Aircraft

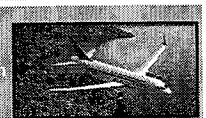
CRJ1000 NextGen

- *CRJ1000 NextGen* aircraft provides up to 14% lower operating economics than in production competing aircraft
- Entry into service scheduled for the second half of this year



CSeries

- Optimized design with 15% lower operating economics than in production competing aircraft
- First product specifically designed for this segment in the last 20 years
- Entry into service scheduled for 2013

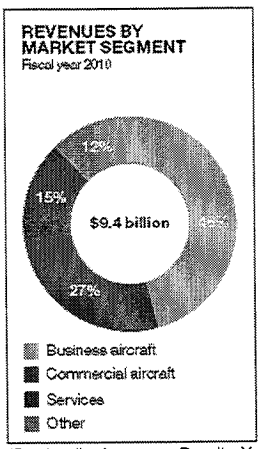


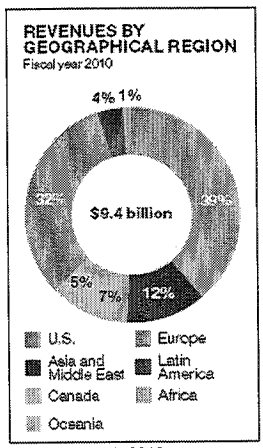
BOMBARDIER

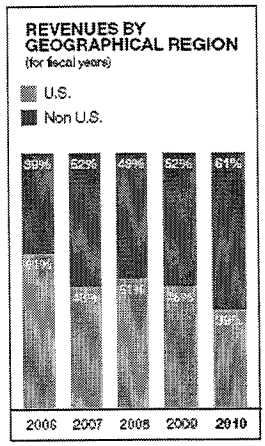
8

5-4

BA TODAY: A WORLD LEADER







*Bombardier Aerospace Results, Year ended January 31, 2010

Business aircraft accounts for almost half of BA's revenues. Non-US revenues have shown significant growth over the past 5 years.

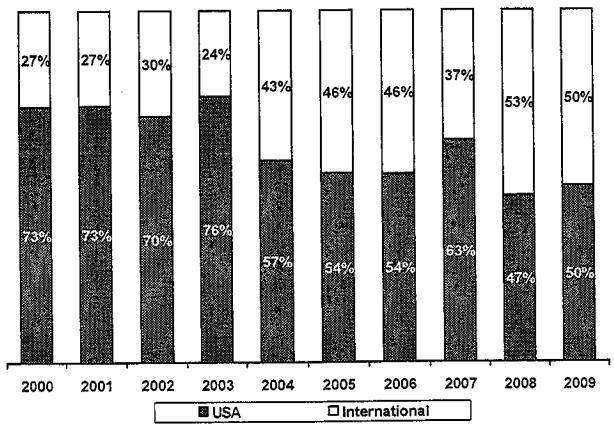
BOMBARDIER

9

Geographic Split of Learjet Deliveries

USA & INTERNATIONAL DELIVERIES

Percent. Learjet gross deliveries, fiscal years 2000 – 2009



From 2000 to 2009, the proportion of Learjet deliveries destined to international customers increased from 27% to 50% respectively.

Source: Bombardier internal sources

BOMBARDIER

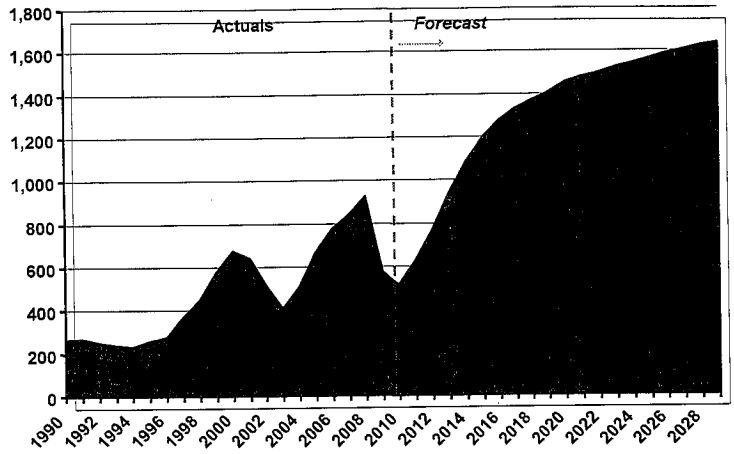
10

5-5

26,000 business aircraft deliveries expected over 20 years

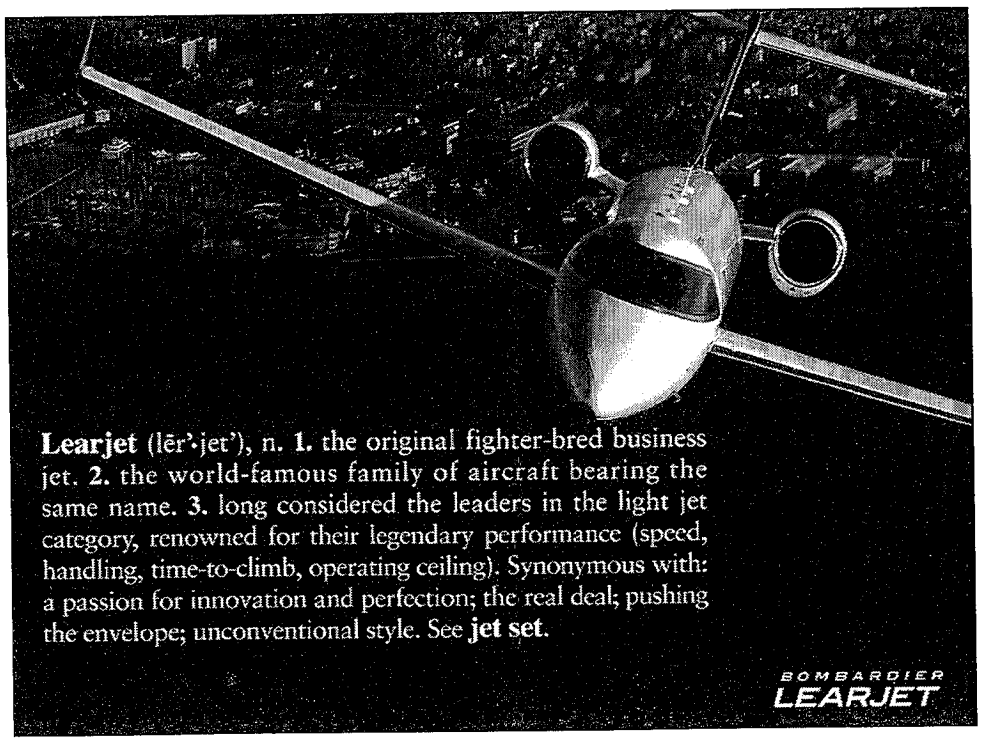
INDUSTRY BUSINESS JET DELIVERIES
Units, 1990-2029

	2010-19	2020-29	2010-29
Total	10,500	15,500	26,000



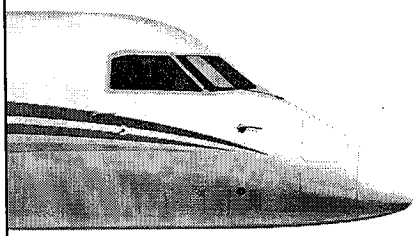
BOMBARDIER
11

Source: GAMA, Business Aircraft Market Forecast



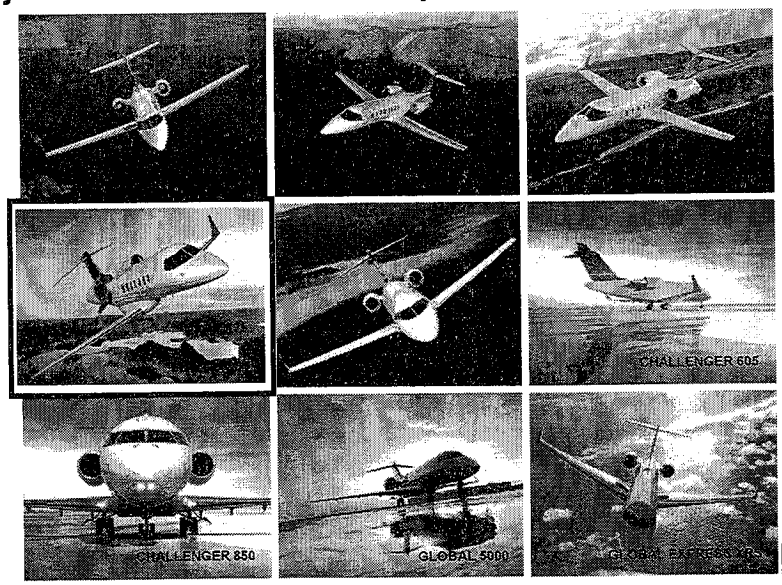
5-6

Learjet 85 Program Overview



BOMBARDIER

Learjet 85 fills the void in a comprehensive product portfolio

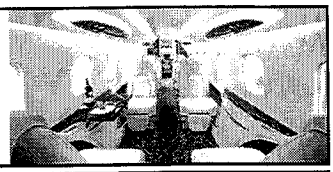


Learjet 85 meets the growing needs of our customer base

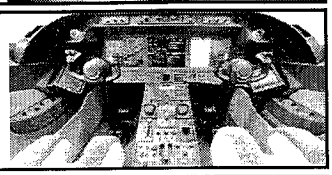
5-7

Why *Learjet 85* ?

Superior Cabin
- Largest cabin with double club configuration in its segment
- Largest windows in a *Learjet*
- Next generation cabin interiors



Superior Technology
- State-of-art avionics derived from *Global Vision Flight* deck
- Latest green engine technology
- Value added baseline equipment



Superior Performance
- Best climb performance
- Best range-to-speed ratio
- Low direct operating cost

The *Learjet 85* will redefine the midsize category in all three key areas of design.

BOMBARDIER

15

Learjet 85 Progress Summary

Program is now in the Detail Design Phase

Technology Readiness testing progressing as planned

System design, installation and integration on target

Improving design for maintainability

Significant portion of composite tooling underway

Mexico factory build complete for production start-up

FAA concurrence to Mexico parts conformity achieved

Wichita final assembly facility readiness plan in place

Second world mock-up tour ongoing

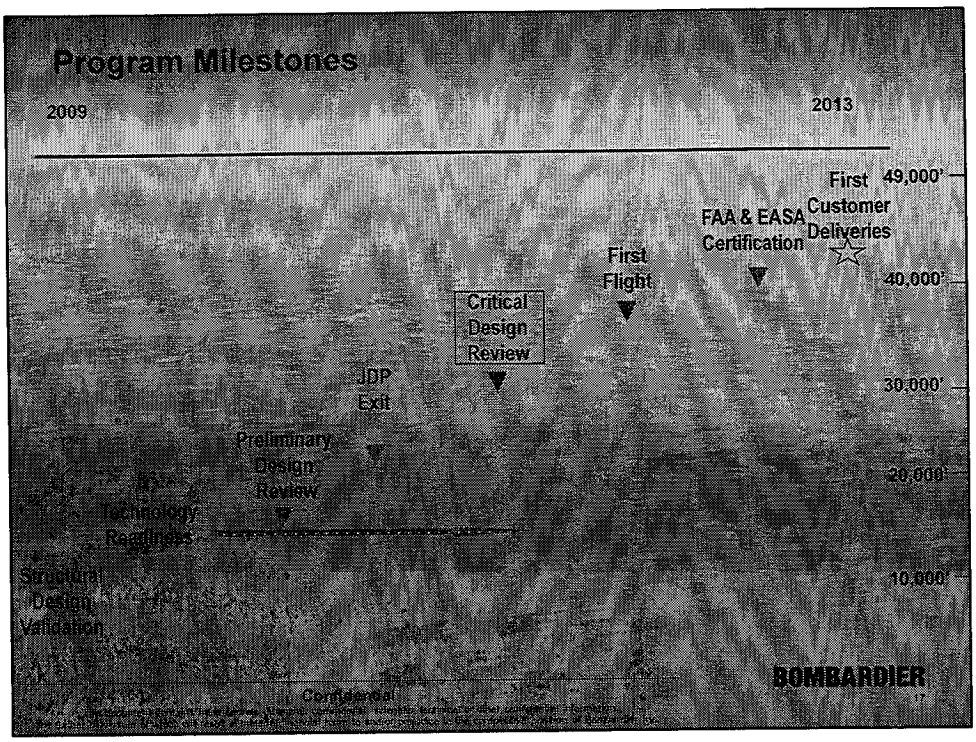
Pressure Barrel Manufacturing Validation Unit (MVU) completed

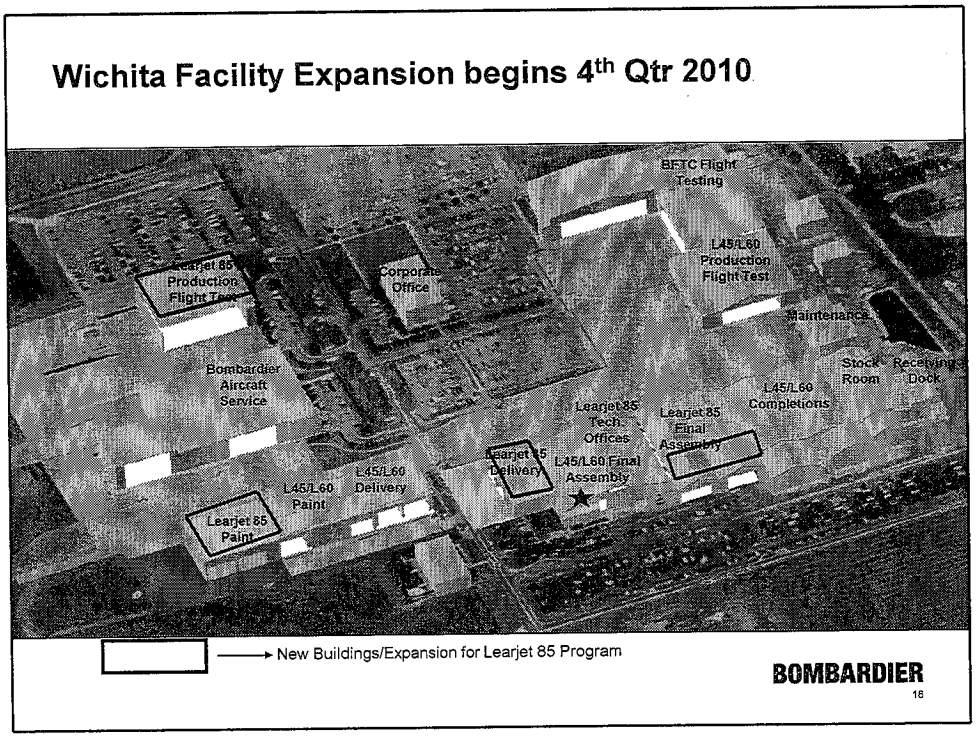
The program is progressing on schedule

BOMBARDIER

16

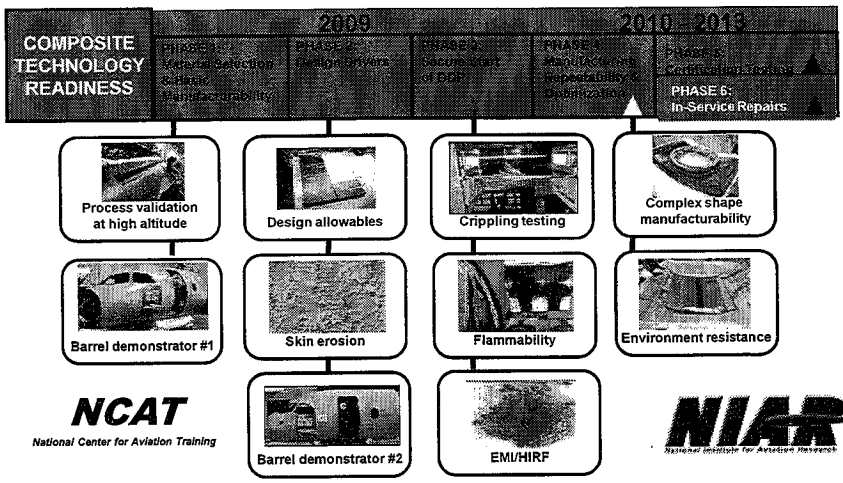
5-8


Program Milestones
2009
2013
First Customer Deliveries
49,000'
FAA & EASA Certification
First Flight
40,000'
Critical Design Review
JDP Exit
30,000'
Preliminary Design Review
20,000'
Technology Readiness
Structural Design Validation
10,000'
Confidential
BOMBARDIER


Wichita Facility Expansion begins 4th Qtr 2010
BFTC Flight Testing
L45/L60 Production Flight Test
Learjet 85 Production Flight Test
Corporate Office
Maintenance
Bombardier Aircraft Service
Stock Room
Receiving Dock
L45/L60 Completions
Learjet 85 Tech. Offices
Learjet 85 Final Assembly
Learjet 85 Delivery
L45/L60 Final Assembly
L45/L60 Delivery
L45/L60 Paint
Learjet 85 Paint
New Buildings/Expansion for Learjet 85 Program
BOMBARDIER
16

5-9

Composite Technology Readiness



NCAT
National Center for Aviation Training

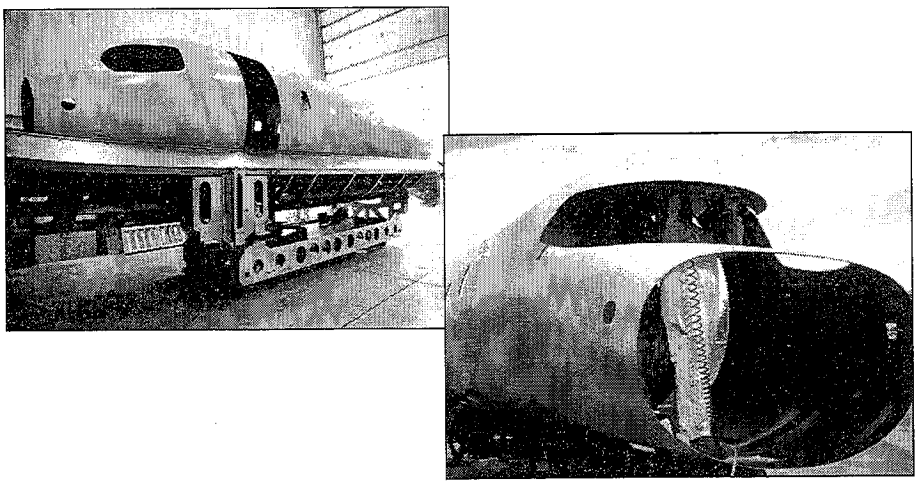
NIAR
National Institute for Aviation Research

Technology Readiness is a parallel learning and testing activity to validate the implementation of new technologies on the platform

BOMBARDIER

19

Pressure Fuselage Manufacturing Validation Unit



BOMBARDIER

20

5-10

Summary

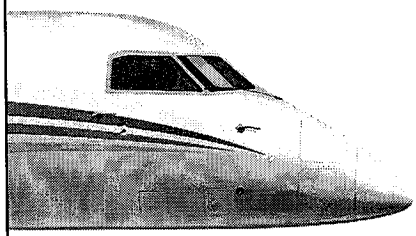
- The Learjet 85 is uniquely positioned to be the segment leader for the upper mid-size category, providing an integrated product plan in a comprehensive Bombardier product line-up.
- The clean sheet design, incorporating latest technologies, is defining the future of Learjet for strong viability in the future as a market leading producer of business jet aircraft.
- Technology Readiness is a parallel learning and testing activity to product development, to implement new proven technologies to the platform. NIAR / NCAT are critical to this activity.
- The Learjet 85 Program continues to plan with full company support and a solid focus on execution.

BOMBARDIER

21

5-11

Learjet Inc.
- Kansas "Economic Revitalization and Reinvestment Act" Funding -



BOMBARDIER

Learjet and the State of Kansas

Learjet Investment In Kansas

- Employees equal approx 2,100 in Kansas
- Average annual gross Kansas compensation of ~$170M
- Kansas State Tax Withholding ~$7M per year
- Investing in New Development with ~$600M in Kansas
- Learjet spends approx $150M* with Suppliers located in Kansas – this is prior to potential suppliers selected on New Development Programs

Criteria "Economic Revitalization and Reinvestment Act"

- ✓ > $150M average annual gross Kansas compensation
- ✓ > $50K average annual gross compensation per Kansas employee
- ✓ > $500M real and tangible property invested in Kansas
- ✓ > $500M to invest in eligible aviation project in Kansas
- ✓ > Employ up to 4,000 full-time employees in Kansas

✓ Learjet Meets

Application Process

- Received State Finance Committee approval Friday, August 6, 2010

* Based on 2007 spending levels and does not include new program levels

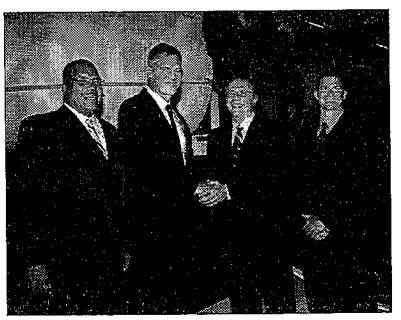
BOMBARDIER

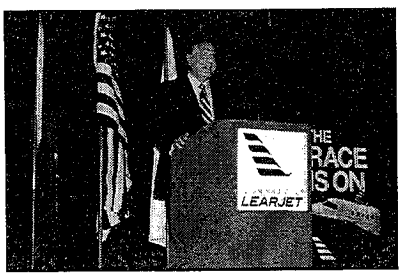
24

5-12

July 30, 2010 – Wichita, Kansas

BOMBARDIER
25

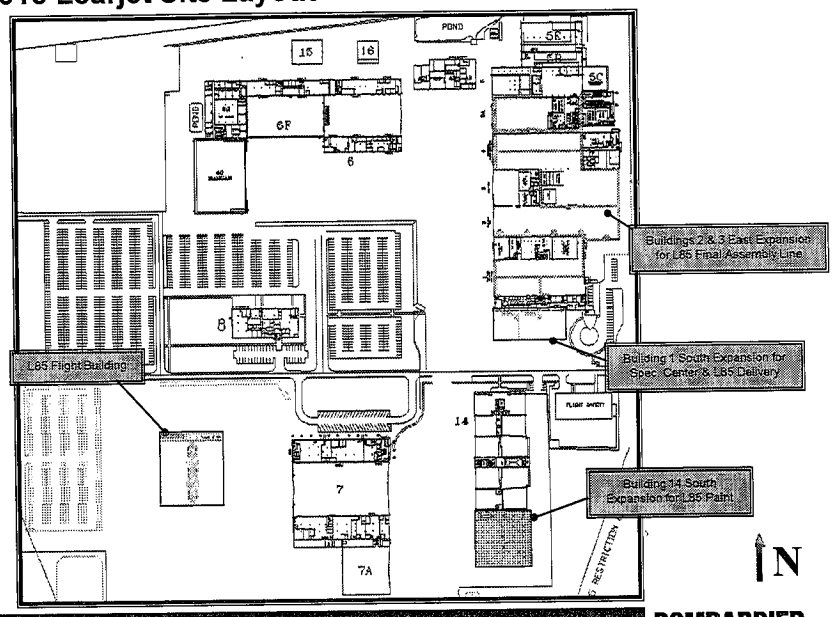




BOMBARDIER
26

5-13

2010-2013 Learjet Site Layout

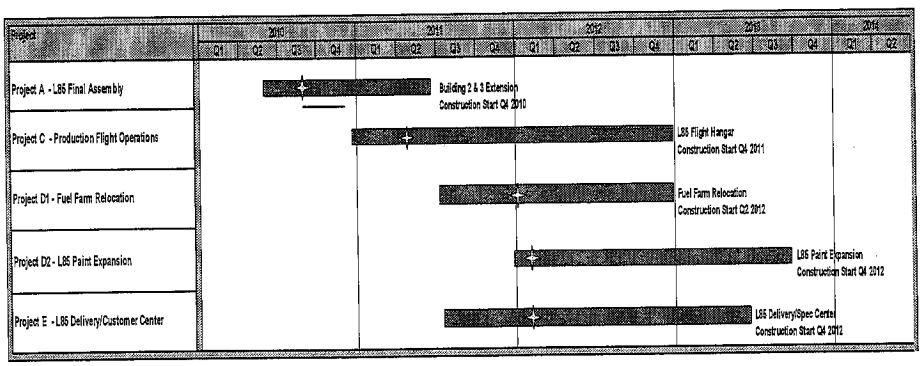


$27M State Funding Allocated To Site Expansion

BOMBARDIER

27

Learjet Site – Capital Expansion Plan



BOMBARDIER

28

5-14

Thank you for the State of Kansas' partnership with Bombardier.

Questions?

BOMBARDIER

29

5-15

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 ◇ FAX (785) 296-3824

kslegres@klrd.ks.gov http://www.kslegislature.org/klrd

August 26, 2010

To: Legislative Budget Committee

From: Estelle Montgomery, Fiscal Analyst

Re: State Mental Health Hospitals Voluntary Admissions Policy

In May 2010 and July 2010, the Department of Social and Rehabilitation Services (SRS) temporarily suspended voluntary admissions to the three Kansas mental health hospitals. The hospitals continued to accept people ordered to the facilities by the courts or escorted by police. Voluntary admissions require a referral by one of the state's 27 community mental health centers and involve adults who must have the capacity to consent to care, have a treatment facility that agrees the person is in need of services offered by a facility and are mentally ill as defined by law and medical understanding. When the hospitals are full, the community centers are expected to find placement alternatives for people who otherwise would be admitted. According to SRS, all three facilities were full beyond licensed capacities and the agency did not have additional resources to serve persons seeking voluntary admissions.

Past Discussions

During the 2005 Interim Legislative Budget Committee meetings, the Secretary for the Department of Social and Rehabilitation Services (SRS), presented information on state mental health hospital admissions. The Committee was informed that the number of Kansans turning to the public mental health service system for services increased by 21.1 percent between FY 2000 and FY 2004. However, the rate of admissions was stated to be similar to rates across the country. A number of factors contributed to the increase in admissions, but the Secretary highlighted the decline in the number of private psychiatric hospital beds available in Kansas, the number of new patients who are unknown to the community public mental health system and the increased number of people with serious mental illness accessing public services. The Secretary's testimony also discussed treatment challenges at the hospitals which included patients who have a co-occurring diagnosis such as substance abuse, serious physical conditions or functioning issues that require more intensive hospital treatment. The Secretary added that increased admissions were coming at a time when hospitals were struggling to meet budget allocations due primarily to higher drug costs, utility bills and outside medical expenses. The Secretary stated to be managing shortfalls internally by shifting money and holding staff positions vacant. However, the Secretary warned that with the increases in admissions, holding vacancies open could cause longer stays, inadequate care and endanger the safety of staff and patients. The Committee requested additional information on allocations for each Community Mental Health Centers (CMHCs) for admissions and the number of placements.

The 2006 Interim Legislative Budget Committee discussed census, admissions and capacity issues at the three state mental health hospitals. The Secretary for the Department of Social and Rehabilitation Services (SRS) stated that admissions had increased over the last several years, especially at Osawatomie, and this increase had forced hospitals to ma

Legislative Budget Committee
Date 8-26/27-2010
Attachment 6

available resources. In addition, the Secretary indicated that the hospitals have began reviewing treatment methods and practices to ensure patients are as stabilized as possible before re-entering the community to prevent readmission. The Secretary reviewed the ongoing discussions and ideas occurring between SRS and the CMHCs to address the census when it reached certain levels. Suggestions from conferees to address the shortage of inpatient beds included adding state hospital beds, regionalized inpatient services with day hospitals; and better utilization of community hospitals for acute care with adequate reimbursement. Another major topic of discussion, intertwined with the discussion of state hospital admissions, was the continuum of services to Kansans with mental illness. A number of conferees suggested that an intermediate level of care was needed between community services and state hospital care. The Committee recommended additional hearings to identify concerns relating to mental health issues, funding to open the an additional 30-bed Crisis Stabilization Unit at Osawatomie State Hospital, and funding to allow SRS to enter into contractual arrangements with local hospitals who have the capacity to provide acute care inpatient services.

Overview

In the early 1990s the Kansas Mental Health Reform Act began. Just prior to Mental Health Reform, approximately 1,000 beds existed within four mental health hospitals. Community Mental Health Centers (CMHCs) became the gatekeepers for admissions to mental health hospitals through a screening process which determined the need for inpatient treatment or diversion to community services. This led to increased collaboration with the Mental Health Centers and emphasized short, intensive treatment in the inpatient setting.

Currently, Kansas operates three mental health hospitals (Topeka State Hospital closed in 1997). Osawatomie State Hospital, Rainbow Mental Health Facility and Larned State Hospital serve persons experiencing serious symptoms of severe mental illness. Only persons who have been determined to be a danger to themselves or others and generally exhibit symptoms that community providers cannot treat safely and effectively are referred to these facilities. Once severe symptoms are stabilized, they can successfully return home with supports provided by their CMHCs.

Rainbow Mental Health Facility provides psychiatric services to adults patients from five counties. In FY 2001, administrative services for Rainbow were consolidated with Osawatomie State Hospital to save resources. The two hospitals currently have a shared administrative team, including the superintendent, who oversees both facilities. In FY 2008, Rainbow ceased treatment of adolescents and children and began admitting adults only. Until June 2007, Rainbow provided treatment to children and adolescents with serious emotional disturbances. Beginning July 2007, Kaw Valley Behavioral Healthcare, Inc. (KVC) began serving the youth who would have otherwise been referred to Rainbow.

Osawatomie State Hospital serves adults from 46 counties who require inpatient psychiatric treatment or non-medical detoxification for substance abuse. No services are offered for children or adolescents. Certain support services are provided to Osawatomie Correctional Facility and Rainbow Mental Health Facility. Osawatomie operates a 30-bed Crisis Stabilization Unit and three Acute Care Units. The Crisis Stabilization Unit serves individuals who may be stabilized in a short period of time and returned to the community within 14 days or less. The Acute Care Units have a target length of stay of 30 days or less. The 2007 Legislature added $3.0 million, all from the State Institutions Building Fund, to remodel an existing building that would allow the opening of an additional 30-bed Crisis Stabilization Unit for FY 2009. The 2008 Legislature also added $1.5 million, all from the State General Fund, and 49.0 FTE for the last half of FY 2009 for operations. Due to FY 2009 through FY 2011 budget reductions, the Department of Social and Rehabilitation Services opened the remodeled 30-bed Crisis Stabilization Unit but simply moved people from an existing 30-bed unit that was then

closed. The shift avoided the need for an additional $1.5 million in FY 2010 for six months of operations for the additional unit. Currently, SRS estimates opening the 30-bed unit in FY 2011 would require $3,399,523 from the State General Fund.

Larned State Hospital provides psychiatric treatment and limited detox facilities to adults from the 59 western counties of the state. The State Security Hospital serves the entire state as a secure setting for criminal forensic patients during evaluation and treatment, and non-forensic patients with severe behavioral problems who may be transferred from other hospitals. The Sexual Predator Treatment Program provides treatment for convicted sex offenders who have completed their prison sentences and have been civilly committed under the Kansas Sexual Predator Law because of an ongoing danger to the community. In FY 2010, SRS closed the Inpatient Psychiatric Treatment Unit for Youth located on the Larned campus and contracted these services to Kaw Valley Behavioral Healthcare, Inc. in Hays, Kansas. When the Inpatient Psychiatric Treatment Unit for Youth was moved the Adult Civil Psychiatric Services was relocated to the building complex and 10 beds were opened in FY 2011.

Current Voluntary Admissions Status

In May 2010 and July 2010, the Department of Social and Rehabilitation Services (SRS) temporarily suspended voluntary admissions to the three Kansas mental health hospitals. In past situations and when funding allowed, the Department of Social and Rehabilitation Services would privately contract with Kaw Valley Behavioral Healthcare, Inc. to provide state mental health hospital level of care and treatment for children and adolescents for $510-$550 per day. In addition, SRS has a temporary arrangement with Via Christi to serve adults from Sedgwick County who have been determined to need state hospital level care and treatment. The daily rate for this temporary arrangement is approximately $765 per day. SRS anticipates that a longer term, more permanent arrangement with a private psychiatric hospital to provide this level of care and treatment could potentially be obtained at a lower rate such as those paid to Kaw Valley Behavioral Healthcare. SRS estimated that FY 2010 Medicaid daily reimbursement rates for the same services at state mental health hospitals range between $337-$508 per day.

During times of delayed voluntary admissions, persons seeking voluntary inpatient treatment can receive extensive community based mental health services to meet their immediate need from CMHCs to ensure they are safe and receive needed mental health treatment. This often includes 24 hour one to one or, in extreme circumstances, two or three to one crisis support provided by both professional clinical and paraprofessional mental health staff. This can be provided in the persons' own homes or in one of the many crisis settings operated by CMHCs around the state.

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Legislative Budget
August 26, 2010

Brief Delays in Voluntary Admission to State Mental Health Hospitals

Don Jordan, Secretary

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

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Brief Delays in Voluntary Admissions to State Mental Health Hospitals

Joint Committee on Legislative Budget

Chairman Emler and members of the Committee, thank you for the opportunity to present information regarding recent delays in voluntary admissions to the State Mental Health Hospitals.

Twice in recent months SRS had to delay voluntary admissions to its state mental health hospitals' (SMHHs) civil psychiatric programs for short periods of time. At these times the SMHHs continued to accept involuntary admissions. The SMHHs operate with real physical and staffing constraints that limit the number of persons they can safely and effectively serve at any one time. Extremely high census jeopardizes patient and staff safety, threatens licensing and accreditation, and can exceed the maximum number of patients the state Fire Marshal allows. The difficult decision to delay voluntary admissions was only made when the census at all three SMHHs simultaneously reached levels beyond which it was too dangerous to accept any more voluntary admissions.

The exact census that might trigger a delay in voluntary admissions is not a precise number. It depends on many factors such as the acuity of the patients in the facility, the mix of male and female patients, and the day of the week. (Many more admissions than discharges occur over the week-end.) SRS leadership consulted closely with the SMHH superintendents regarding these issues before making the difficult decision to delay voluntary admissions.

The three SMHHs - Osawatomie, Rainbow Mental Health Facility, and Larned - admitted 4,256 persons for civil psychiatric treatment in FY 2010. The SMHHs are budgeted to serve the following number of persons at any one time:

Hospital	Budgeted Census
Osawatomie State Hospital (OSH)[1]	176
Rainbow Mental Health Facility (RMHF)	50
Larned State Hospital Psychiatric Services Program (LSH PSP)[2]	79
TOTAL	**305**

With this high number of admissions, there are many times when hospitals are over their budgeted census. (See Attachment A) Occasionally a hospital has reached extremely high census, well above its budgeted census, and it is no longer safe to accept more voluntary admissions. Generally, when this has occurred, admissions have been diverted to

[1] The Legislature approved funds to open an additional 30 bed unit at OSH for six months. SRS recommended cutting these funds and not opening this unit as part of recent budget reductions. The Legislature accepted SRS' recommendation. If the unit were opened additional funds would be needed to operate it for a full year.
[2] LSH has recently increased its operating capacity to 90. This, however, did not increase its budgeted capacity.

other SMHHs whose census is not at critical levels. Until recent months this solution has kept SMHHs census manageable.

In mid-May all three SMHHs began experiencing extremely high census at the same time. Census reached a point where it was no longer safe to voluntarily admit more people to any of the SMHHs. As a result it was not possible to divert persons from one state mental health hospital to another. At this point SRS, unfortunately, had no choice but to delay voluntary admissions beginning with an announcement on May 19th. The delay continued until May 26th. During this time the SMHHs continued to accept involuntary admissions. Below are the census levels at the SMHHs while this delay of voluntary admissions was occurring.

Hospital	Budgeted Census	Census on May 19th	Census on May 26th
OSH	176	187	176
RMHF	50	58	48
LSH PSP	79	87	89
TOTAL	**305**	**332**	**313**

The following immediate actions were taken to address the health and safety of the persons whose voluntary admission to a SMHH might be delayed:

- Community Mental Health Centers (CMHCs) were asked to keep people where they were if they were in safe locations, like local community hospital psychiatric service programs, until the SMHHs' census lowered.
- CMHCs were also asked to do all they could to provide needed services to those seeking voluntary admission who may not be admitted immediately. This included providing crisis services both in place and in crisis beds they may already have; providing crisis case management; and making extensive use of attendant care, psychosocial rehabilitation, CPST, and peer support around the clock if needed.
- SRS directed its Medicaid Community Mental Health Managed Care Organization, Kansas Health Solutions, to grant all reasonable requests for exceptions to Medicaid limits, and to provide extraordinary assistance with creative wrap-around plans for persons who are Medicaid eligible.

Immediately thereafter the following actions were taken to reduce the likelihood of needing to delay voluntary admissions:

- SRS initiated its agreement to pay Via Christi for uncompensated care provided to persons from Sedgwick County that COMCARE determined would have otherwise been placed at OSH. Via Christi agreed to accept persons they believed they could effectively service when OSH's census was too high to accept more voluntary patients.
- LSH PSP immediately opened an additional 11 beds in the space previously used for children's services.[3] LSH at first staffed the additional 11 beds by paying overtime to existing employees. Soon thereafter, LSH was given authority to hire permanent employees to staff their expanded bed capacity.

[3] As a result of a competitive bid, SRS entered into an agreement with KVC Behavioral Healthcare to provide inpatient psychiatric services to children and adolescents who would have otherwise been served at LSH. The program, called Wheatland Psychiatric Hospital, is located in Hays, Kansas.

- SRS and Prairie View established an agreement whereby SRS would pay Prairie View for providing uncompensated inpatient psychiatric hospital care for persons diverted to their facility from LSH PSP when it was experiencing extremely high census. Soon thereafter SRS, Prairie View, and three other CMHCs agreed to expand this agreement to the other CMHC's catchment areas.
- SRS and Prairie View arranged for their agreement to apply to persons from Sedgwick County when their admissions to OSH were being diverted and Via Christi was full.

In mid-July census was once again extremely high at all three SMHHs and diversions were insufficient to meet the need. So once again SRS was unfortunately forced to delay voluntary admissions to all SMHHs. Census at that time was as follows:

Hospital	Budgeted Census	Census on July 16th	Census on July 20th
OSH	176	187	179
RMHF	50	51	48
LSH PSP	79	90	84
TOTAL	**305**	**328**	**311**

We are very thankful for the hard work and cooperation of the state mental health hospitals, CMHCs, local inpatient psychiatric programs, and other community providers. They have gone above and beyond the call during these difficult times. Not only have all areas of the system stepped up and served people who needed inpatient treatment, but they have worked hard to successfully and timely discharge people when they are ready to return home. As a result of everyone's hard work these instances of delayed voluntary admissions have been relatively short and, to our knowledge, no serious incidents have occurred.

Like you, we are concerned that there are limits to the community and inpatient mental health service systems. We are carefully examining recent admissions data and have begun discussions with the Association of Community Mental Health Centers of Kansas regarding what more can be done to reduce the risk of future delays of voluntary admissions. We are committed to working collaboratively in finding positive ways to keep these episodes to an absolute minimum. We appreciate your support in these efforts.

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Attachment A

Osawatomie State Hospital							
State Fiscal Year	Admissions	Average Daily Census	High Census	Low Census	Days Over Census	Per Cent Days Over Census	Average Length of Stay
2005	1,943	167	193	136	74	20%	31
2006	2,016	166	198	134	81	22%	29
2007	1,969	170	199	150	100	28%	28
2008	2,181	169	195	145	64	17%	25
2009	2,042	169	195	145	82	23%	30
2010	2,193	172	197	142	123	34%	29

Rainbow Mental Health Facility							
State Fiscal Year	Admissions Adult & Youth	Average Daily Census Adult Only	High Census Adult Only	Low Census Adult Only	Days Over Census	Per Cent Days Over Census	Average Length of Stay Adult Only
2005	671	24	40	3	76	21%	21
2006	664	26	41	10	52	14%	21
2007	671	30	40	20	19	5%	23
2008	810*	44	56	32	36	10%	19
2009	875	42	55	24	27	7%	17
2010	840	49	61	37	131	36%	22

* Stopped admitting children and adolescents. All children and adolescents are now served at KVC STAR.

Larned State Hospital Psychiatric Services Program							
State Fiscal Year	Admissions Adult & Youth	Average Daily Census Adult & Youth	High Census Adult Only	Low Census Adult Only	Days Over Census Adult Only	Percent Days Over Census Adult Only	Average Length of Stay Adult Only
2005	990	72	84	52	2	.5%	49
2006	1,064	81	86	59	31	8%	25
2007	1,097	82	92	56	34	9%	27
2008	1,177	94	102	71	259	71%	33
2009	1,071	86	99	63	141	39%	30
2010	1,223*	93	108	72	302**	83%	44

Note:

*Youth Services Closed May 6, 2010.

**Effective May 21, 2010, Psychiatric Services Program (PSP) capacity changed from 79 to 90, although the budgeted census remains at 79. The number above reflects days over our budgeted census of 79. There were 296 days or 81% of days over capacity.

KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

Testimony presented to the Legislative Budget Committee

by Roy Menninger, MD
August 26, 2010

I appreciate this opportunity to revisit the bed crisis afflicting the Kansas Mental Health hospitals.

SUMMARY POINTS:

- This crisis is not a new issue. I reference our expressions of concern in 2009 (Menninger, Feb. 11, 2009 testimony) and again this year (Campbell, Feb. 12, 2010 testimony) with allusions to the problem in 2006 and 2007.
- Supplemental funding for expansion was wiped out over the past 2 years: Reduced by ~$700,000 in FY 2010 and $1.6 million in FY2011. Needed expansion at Larned SH is on hold. The rehabbed unit at Osawatomie SH is ready—but unstaffed. Hospital operating budgets were cut.
- Staffing needs at all 3 hospitals are now critical as a result of "artificial shrinkage" to reduce operating expenses.[1]
- Steady increase in number of civil admissions: from 2,469 in 2002 to 3,988 in 2009 – a 60% increase in 7 years[2]
- These circumstances overwhelmed the hospitals, confronting them with the unacceptable prospect of having to admit more patients than they could manage, with Osawatomie SH 34%, Rainbow MHF 36%, and Larned SH 83% days over budgeted census in 2009.[3]. This led to the regrettable but unavoidable decision to decline ("delay") admission of voluntary patients in May until beds became available.

CONSEQUENCES:

- Damaged the mental health safety net, especially for indigent or low income people who have no insurance.
- Increased pressure on community services even as their budgets have been severely curtailed.[4]
- Role of hospitals shifted from longer-term care of hard-to-treat patients to providing short-term acute services.

RECOMMENDATIONS:

- **At all costs, we urge you to resist efforts to make further cuts in the mental health service system.**
- **Support adequate funding for both the state hospitals and the community services (the Community Mental Health Clinics) – needed expansion and especially for more adequate staffing**
- **Establish funding for local private mental health in-patient beds throughout the state to encourage development of public-private partnerships for MH inpatient beds for youth and adults.**

NOTES:

1 - Osawatomie SH has around 55 unfilled positions of a total of 441. Rainbow had 15 of 122 positions unfilled. These numbers represent a dramatic increase over those of 2008, when Osawatomie had only 20-25 positions open, and Rainbow 8-10. Absent requisite funding in the face of continued cuts in funding for basic expenses, further staff cuts to provide necessary funds will unquestionably negatively impact the quality of treatment. (Campbell, p. 2, Feb. 12, 2010 testimony)

2 -

Civil Psychiatric Services Admissions								
State Hospital	**FY02**	**FY03**	**FY04**	**FY05**	**FY06**	**FY07**	**FY08**	**FY09**
LSH	819	836	929	990	1,064	1,097	1,176	1,071
OSH	1,137	1,371	1,570	1,943	2,016	1,969	2,181	2,042
RMHF	513	588	715	671	664	671	810	875
Total	**2,469**	**2,795**	**3,214**	**3,604**	**3,744**	**3,737**	**4,167**	**3,988**
Percent Change		13%	15%	12%	4%	0%	12%	-4%

Note: In FY08 RMHF began serving only adults

Source: SRS

Legislative Budget Committee
Date 8-26/27-2010
Attachment 8

3 -

OSH Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2005	73	20%
FY 2006	81	22%
FY 2007	100	28%
FY 2008	64	17%
FY 2009	82	23%
FY 2010	123	34%

Source: SRS

RMHF Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2007	19	5%
FY 2008	36	10%
FY 2009	27	7%
FY 2010	131	36%

Source: SRS

LSH Psychiatric Services Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2006	31	8%
FY 2007	34	9%
FY 2008	259	71%
FY 2009	141	39%
FY 2010	302	83%

Source: SRS

4 –

Highlights of funding reductions sustained by the CMHC system:

1. $20 million reduction in Mental Health Reform grants since FY 2008 – a 65 percent reduction.
2. $7.8 million all funds in Medicaid rate reductions during FY 2010 as a result of the 10% rate reduction.
3. $3.1 million in MediKan funding in FY 2010 – a 45 percent reduction.
4. $560,000 SGF in Community Support Medication Program funding during FY 2010 – a 53 percent reduction.

ATTACHMENTS:

Amy Campbell – Testimony to the Senate Ways and Means Subcommittee on SRS State Hospitals, Feb. 12, 2010
Roy Menninger MD – Testimony to the House Social Services Budget Committee, Feb. 11, 2009
Roy Menninger MD et al. – letter to Don Jordan, Secretary of SRS, May 26, 2010

* * * * *

For More Information, Contact:

Kansas Mental Health Coalition
c/o Amy A. Campbell, Lobbyist
P.O. Box 4103, Topeka, KS 66604
785-969-1617; campbell525@sbcglobal.net

c/o Roy W. Menninger, MD, Chair
85 SW Pepper Tree Lane, Topeka, KS 66611-2072
785-266-6100, fx: 785-266-9004, roymenn@sbcglobal.net

A

8-2

KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

P.O. Box 4103, Topeka, KS 66604

To: Don Jordan, Secretary of SRS

From: Roy W. Menninger MD, Kansas Mental Health Coalition
Amy Campbell, Kansas Mental Health Coalition
Mike Hammond, Association of CMHCs of Kansas
Rocky Nichols, Disability Rights Center of Kansas
Rick Cagan, NAMI Kansas
Susan Crain Lewis, Mental Health Association of the Heartland

Date: May 26, 2010

cc: Governor Mark Parkinson

RE: Cutting Off Voluntary Admissions to State Psychiatric Hospitals

As advocates for Kansans with mental health needs, we were surprised and concerned to receive your May 19, 2010, memo regarding the elimination of the option of Kansans in crisis to admit themselves voluntarily to state psychiatric hospitals. This news is troubling, considering that SRS's September 2005 *Protocol for Managing State Mental Heath Hospitals Census* stated SRS's intent to "work together on a continuous basis" to prevent these things from happening. That didn't happen in this instance. We are calling upon SRS and the State of Kansas to work proactively to quickly reinstate voluntary admissions to the state's psychiatric hospitals.

There are essentially only two front doors to state psychiatric hospitals for Kansans with mental illness – voluntary or involuntary admissions. The SRS action locks one of the two front doors. If Kansans cannot voluntarily admit themselves to a state psychiatric hospital, then their only choice is to endure a worsening of their psychotic episode, decompensate further, and to put themselves or others at risk of harm or even death. In that event, it may be necessary for a court to order them to be admitted involuntarily to the hospital. However, by that time they may have spiraled out of control and would be significantly harder to treat successfully. Alternatively, they may have ended up in a jail or prison, at a much higher cost to both taxpayers and the person in need of treatment.

We are also troubled by the timing of the announcement and the lack of action to fix this during the Legislative session. The Kansas Legislature adjourned only seven days prior to the agency's abrupt announcement of this decision. Why was SRS not beating down the door of the Governor's Office and the Kansas Legislature while the Mega/Omnibus budget bill was being finalized? Why was SRS not loudly sounding alarms to ensure that funding was appropriated to prevent this terrible outcome? In the agency's sudden May 19 announcement, it states that this issue had worsened "especially over the past several weeks." If SRS knew that this was a problem for the past several weeks, why didn't the agency take advantage of this unprecedented opportunity when the budget was written for all intents and purposes by only one chamber? Why didn't the agency seek these funds at the end of the session to avert this crisis?

We would also like to express our concerns about the failure of the state psychiatric hospitals, particularly Larned State Hospital (LSH), to follow the Protocol referenced above. Furthermore, even if the Protocol were followed in spirit, as it was at Osawatomie State Hospital (OSH) , it failed to prevent this crisis it was intended to avert. Our understanding of the Protocol is that SRS would take proactive steps to avoid this outcome. These include, among other things, the utilization of referrals, transfers, and discharges to lighten the burden on the State's mental health care system and render suspension of admissions unnecessary.

As per the spirit of the Protocol, partners such as the Disability Rights Center, NAMI Kansas, the Kansas Mental Health Coalition and others should have been notified that the state psychiatric hospitals were "approaching capacity defined by predetermined "trigger points." This is in stark contrast to a memo dated May 19 which informs us that voluntary admissions will stop on May 19. Notice of these measures on their effective date is essentially notice after that fact. That is not acceptable. We request that you work to reverse this unfortunate policy.

As mental health advocates, we are committed to the accessibility of much needed mental health services for all Kansans. We have a responsibility to ask on behalf of Kansans with disabilities whether the Protocol was improperly implemented, lacked necessary resources and support, or simply failed.

From our perspective, the agency's action increases the burden on our specific organizations and our clients. It also increases the liability of the State of Kansas. It is important to remember that the availability of hospitalization, voluntary or involuntary, is a safety net for both patients and society. Without the option of voluntary admission, would-be patients who would have sought and obtained necessary treatment are at risk of receiving no help at all, may have to be eventually admitted involuntarily, or may harm themselves or others. As an inevitable result, both the people in crisis and society at large are exposed to the increased costs and consequences of untreated mental illness.

To best serve our clients during this time, our organizations need to know what measures SRS is taking to immediately address this serious problem. We need to know what services and supports are being put in place to provide the intensive care needed for individuals who meet clinical criteria for voluntary admission, yet are denied admission to the hospital. We need to know what steps are being taken to relieve overcrowding and the implications for patients who are currently in the state psychiatric hospitals, for their families, and for the Community Mental Health Centers.

For several years, our organizations have repeatedly pointed out to the previous administration, the current administration, SRS, and even the Legislature that the public mental health system is near a breaking point. Mental Health Reform funds – funds used to keep people out of our State Hospitals – have been cut by $20 million. That reduction is the result of across-the-board cuts over the past few years. Three years ago, we successfully lobbied the Legislature to appropriate funding to open a new 30 bed unit at OSH and the staffing for it. SRS, as part of its response to the demand that its budget be cut, chose to cut those funds and not open the unit. We believe we would not be in this predicament had that unit been opened up.

Temporarily, the administration needs to find resources to purchase local acute care psychiatric inpatient services from hospitals wherever possible to reduce pressure on the state psychiatric hospitals. This summer and fall, the administration needs to open up the OSH unit that the Legislature funded to renovate and staff. That will bring an additional 30 beds on line. The administration needs to put $500,000 towards the remaining 11 beds at LSH that are off line, and bring them online. There were savings from privatizing the adolescent unit at LSH. Rather than investing those savings into more adult inpatient resources, SRS absorbed those savings in the hospital budgets and we gained nothing from the savings. Finally, transitional housing and crisis stabilization beds need to be developed and funded.

We remain frustrated that these necessary solutions and the needed resources to implement them have been repeatedly sought yet continue to be overlooked or ignored by policymakers. We will continue to speak out about those options and the need to implement them.

For Information, Please Contact:
Amy A. Campbell
Kansas Mental Health Coalition
P.O. Box 4103
Topeka, KS 66604
785-969-1617 campbell525@sbcglobal.net

KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

Testimony presented to the Senate Ways and Means Subcommittee on SRS State Hospitals

by Amy A. Campbell
February 12, 2010

Thank you for the opportunity to address your committee today on behalf of the Kansas Mental Health Coalition. **And thank you for your continuing recognition of the crisis faced by Kansas Mental Health Hospitals and enabling us to discuss it with you.**

KMHC has long expressed concern about the adequacy of the state's inpatient psychiatric resources - the safety net for all in our state whose mental health needs require the comprehensive and specialized tertiary care that hospitals should provide. The mental health system is a web of varied services and supports. The inadequacy of any part of the system will negatively affects the provision of vital services to consumers and their families.

The 2006 Interim Legislative Budget Committee learned that increasing demand for inpatient services is a national phenomenon. The psychological problems of the patients coming to the state hospitals are increasingly serious, often paired with violent tendencies and serious mental health needs. Roughly 70% have co-occurring alcohol and drug addictions. They are frequently too severe to respond to 3-4 day "stabilizing" treatment. Half the time, they are individuals who have never sought community based services.

History:
Building on the Conclusions and Recommendations of the 2006 Interim Legislative Budget Committee, the 2007 Legislature ordered positive initial steps to address the inpatient crisis:

1 Supplemental funding was added to the SRS budget to open one additional 30 bed inpatient unit at Osawatomie State Hospital within the existing and available physical plan.
2 Supplemental funding of $1.9 million was added to the SRS budget to allow SRS to enter into contractual arrangements with community providers / local hospitals with the capacity to provide acute care inpatient services.
3 SRS was ordered to begin a planning process with mental health stakeholders to work together
   - to define what the future role of the State Mental Health Hospitals (SMHH) is going to be;
   - to determine the appropriate number of inpatient beds that is necessary to meet the needs of the citizens of Kansas based on the State's current population and respective population growth projections (either SMHH beds or a combination of SMHH beds and local acute care inpatient resources); and
   - to propose a plan as part of the agency's budget hearings in 2008 to the Ways and Means and Appropriations Committees that would support the needs identified in the plan.
4 Supplemental funding was added to the SRS budget to add direct care staff to Osawatomie State Hospital and Rainbow Mental Health Facility to meet the requirements of providing active treatment as ordered by the 2006 Joint Commission on Accreditation of Healthcare Organization (JCAHO) inspections. JCAHO accreditation is required for Medicaid and Medicare certification.

The expansion funding has been wiped out in the past two years – through allotment budget reductions and through legislative appropriations. Needed expansion at Larned has been put on hold. The rehabbed unit at OSH is physically ready – but not staffed. Most recently, the Governor made an allotment reduction that cut $3 million from the hospitals.

Further, the $900,000 savings earned by privatizing the Larned Children's Unit has been absorbed into the operations of the current facilities – and stretched to fund expansion at the Sexual Predators Treatment Program transition house at Osawatomie. It is our position that funds gained by closing or privatizing mental health beds should be re-allocated within the mental health system

Where We Are Today:

- According to SRS, Osawatomie and Larned continue to exceed their budgeted bed capacity regularly. The percentage of time-over-census has increased at Osawatomie to approximately 23% in FY 2009 and FY 2010 to date. Larned State Hospital saw dramatic increases to 85% in FY 2010 to date. It is a chronic problem that will continue as long as funding for staff remains at marginally adequate levels.

- Although the new 30-bed unit at OSH has been constructed, funds requested by SRS and granted by the Legislature in 2008 to open and staff the new unit for six months beginning in January 2009 were cut. SRS predicts they will exceed all physical capacity at LSH by 2012.

- Staffing needs at all 3 hospitals now are critical and at great risk of impacting the quality of treatment. They are only marginally adequate, having been severely weakened by the cost-saving strategy of "artificial shrinkage" as the only way hospitals can cover their 'other operating expenditures' (OOE) of drugs, utilities and food when those expenses exceed their allocated budget.

Osawatomie SH has around 55 unfilled positions of a total of 441. Rainbow had 15 of 122 positions unfilled. These numbers represent a dramatic increase over those of 2008, when Osawatomie had only 20-25 positions open, and Rainbow 8-10. Absent requisite funding in the face of continued cuts in funding for basic expenses, further staff cuts to provide necessary funds will unquestionably negatively impact the quality of treatment.

Insufficient staff, especially of skilled, well-trained professionals, will bring several undesirable consequences. Hospital stays will likely become shorter, producing an increased risk of premature discharges, problematic challenges for community treatment services, and subsequent recidivism. Without adequate staff, a diminished active daily treatment programs will seriously penalize patients with no other treatment alternatives.

There are some patients for whom longer-term hospitalization is the only answer: those whose disturbances are too severe or violent or disruptive to be treated in the community; those with intractable disorders who need a therapeutic environment for an extended time, for whom short-term "stabilization" is useless; those with disorders requiring specialized services not available in the community. A well-staffed hospital capable of providing these tertiary services is essential if these vitally needed services are to be available to Kansans.

KMHC Supports Research and Strategic Planning for the Future Inpatient Needs in Kansas

- Hospital to Home Initiative: KMHC supports the work being done on the Home and Hospital Initiative and its preliminary recommendations to expand access to beds in the community and to create an initiative to provide access to housing. There is more work to be done. This group should be inclusive – incorporating representatives of a broad array of stakeholders including family members of adults and children who utilize inpatient services. Further, the Team should pursue the directive of the 2007 Legislative Budget Committee and 2008 Senate Ways and Means Committee. *Background: In 2007, SRS established a work group to look comprehensively at services needed by persons with mental illness to prevent hospitalization, and to insure effective transition post hospitalization. This group is also targeting areas of need within community treatment as they affect inpatient treatment and eventual success for individuals in the community.*

KMHC Supports an Adequate Array of Psychiatric Inpatient Services

The SRS-operated state psychiatric hospitals at Osawatomie and Larned are the safety net for individuals with severe mental illness in Kansas. The state psychiatric hospitals are facing stagnant budgets, crumbling and condemned buildings, and increased patient loads. For a number of years, the Osawatomie State Hospital (OSH) has reached its' maximum capacity and is often significantly over census on a continual basis. Over the past year, Larned State Hospital (LSH) has reached its maximum capacity as well. This situation has forced the philosophy of the use of state psychiatric hospitals in Kansas to change. The utilization of state psychiatric hospitals has evolved from serving as long-term residential treatment facilities to the role of short-term acute care treatment facilities.

To help alleviate such overcrowding, in 2007, the Kansas Legislature funded SRS's budget for facility improvements at OSH to prepare for expansion with a new 30-bed adult psychiatric unit. The 2008 Legislature appropriated $1.5 million to staff the expanded unit beginning in FY 2009. That funding was lapsed in 2009. In addition, the 2008 Legislature appropriated $400,000 to plan for future construction of a new 30 bed crisis stabilization unit at LSH, which replaces 19 beds taken offline with 11 new beds. For FY 2010, it was estimated that $8.7 million is needed for the construction of the new crisis stabilization unit. Currently, the Larned Children's Unit is being privatized, and will be converted to use for adults.

Support Local Public/Private Partnerships for Mental Health Inpatient Beds (for youth and adults) Across Kansas.

As noted above, the State must maintain an adequate core safety net for individuals with severe mental illness in Kansas. The Coalition supports establishing local private mental health inpatient hospital beds across Kansas, to alleviate demand for state hospital beds. Given the continued increase in the number of individuals who present for state psychiatric hospital placement, as well as the small increase in the number of beds available—even with the minimal expansion at OSH—it is important to plan for the future needs in other areas of the state. In Kansas, the urban counties of Wyandotte, Johnson, Sedgwick and Shawnee see the majority of consumers that are impacted by the lack of psychiatric inpatient resources. In 2008, the agency requested $5 million for this purpose. By contracting with local hospitals or other providers for inpatient care, youth and adults who need acute care inpatient treatment will be able to remain closer to their families and support systems. This would also provide opportunities to develop resources in rural areas to reduce long driving distances to State Hospitals.

Specifically, for FY 2010 and FY 2011 budgets, KMHC is requesting the Legislature:

1. **Support full funding for the state psychiatric hospitals with no cuts to current staffing and operations.** Absent long term strategic planning and supportive funding, KMHC is forced to continue to support short term solutions to the current crisis of limited resources to serve mentally ill Kansans who need intensive treatment provided in an inpatient setting. KMHC is particularly concerned about budget cuts which have delayed staffing the 30 bed expansion at Osawatomie State Hospital, which was remodeled to address capacity issues and the lack of funding for the 11 new beds now available to the crisis stabilization unit at LSH when it moves into the vacated children's unit.

2. **Fund needed expansion projects.** Support adding at least $1.5 million to SRS's budget to allow a new 30-bed unit to be opened at OSH in FY 2010 and alleviate overcrowding of psychiatric residents – including full staffing. Initial estimates recommended appropriating $8.7 million for the construction of a new crisis stabilization unit at LSH in FY 2010 and alleviate overcrowding of psychiatric residents OR convert the children's unit to an adult unit and add $500,000 to fund an additional 11 beds. Please be certain that the additional $500,000 is a part of the transition of those beds.

3. **Support the privatization of the Larned Children's Unit** provided that – the privatized services offer improved quality of treatment for western Kansas, improved access for families of western and central Kansas, and the agency commits to permanence and reliability of this new resource. As with the STAR program in eastern Kansas, these inpatient services should remain a part of our statewide inpatient system. The money saved should be put back into the mental health system.

4. **Oppose Closing Rainbow Mental Health Facility**
   KMHC supports evaluation and development of regionally based inpatient services as a model for the Kansas mental health system. The 2009 Governor's Facilities Closure and Realignment Commission recommended retaining this facility and expanding the use of regionally based inpatient resources in order to reduce the need for large institutional settings in the future.

5. **Support SRS initiatives to address shortage of appropriate housing.** Lack of housing options limits individual recovery and community integration. With no housing available, individuals cannot be released from hospitalization or end up relying on homeless shelters. Federal funding should be maximized with an investment of state funds.

Thank you for your time and your consideration of these issues. We are available to meet with you at any time to discuss these and any other issues.

* * * * *

For More Information, Contact:

Kansas Mental Health Coalition
c/o Amy A. Campbell, Lobbyist
P.O. Box 4103, Topeka, KS 66604
785-969-1617; campbell525@sbcglobal.net

c/o Roy W. Menninger, MD, Chair
85 SW Pepper Tree Lane, Topeka, KS 66611-2072
785-266-6100, fx: 785-266-9004, roymenn@sbcglobal.net

KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses

Testimony presented to the House Social Services Budget Committee

by Roy W. Menninger MD, KMHC Chairman
February 11, 2009

Thank you for the opportunity to address your committee today on behalf of the Kansas Mental Health Coalition. **And thank you for your continuing recognition of the crisis faced by Kansas Mental Health Hospitals and enabling us to discuss it with you.**

KMHC has long expressed concern about the adequacy of the state's inpatient psychiatric resources - the safety net for all in our state whose mental health needs require the comprehensive and specialized tertiary care that hospitals should provide. The mental health system is a web of varied services and supports. The inadequacy of any part of the system will negatively affects the provision of vital services to consumers and their families.

The 2006 Interim Legislative Budget Committee learned that increasing demand for inpatient services is a national phenomenon. The psychological problems of the patients coming to the state hospitals are increasingly serious, often paired with violent tendencies and serious mental health needs. Roughly 70% have co-occurring alcohol and drug addictions. They are frequently too severe to respond to 3-4 day "stabilizing" treatment. Half the time, they are individuals who have never sought community based services.

Building on the Conclusions and Recommendations of the 2006 Interim Legislative Budget Committee, the 2007 Legislature ordered positive initial steps to address the inpatient crisis:

1. Supplemental funding was added to the SRS budget to open one additional 30 bed inpatient unit at Osawatomie State Hospital within the existing and available physical plan.
2. Supplemental funding of $1.9 million was added to the SRS budget to allow SRS to enter into contractual arrangements with community providers / local hospitals with the capacity to provide acute care inpatient services.
3. SRS was ordered to begin a planning process with mental health stakeholders to work together
   - to define what the future role of the State Mental Health Hospitals (SMHH) is going to be;
   - to determine the appropriate number of inpatient beds that is necessary to meet the needs of the citizens of Kansas based on the State's current population and respective population growth projections (either SMHH beds or a combination of SMHH beds and local acute care inpatient resources); and
   - to propose a plan as part of the agency's budget hearings in 2008 to the Ways and Means and Appropriations Committees that would support the needs identified in the plan.
4. Supplemental funding was added to the SRS budget to add direct care staff to Osawatomie State Hospital and Rainbow Mental Health Facility to meet the requirements of providing active treatment as ordered by the 2006 Joint Commission on Accreditation of Healthcare Organization (JCAHO) inspections. JCAHO accreditation is required for Medicaid and Medicare certification.

WHERE WE ARE TODAY:

- According to SRS, Osawatomie and Larned continue to exceed their budgeted bed capacity regularly, but the percentage of time-over-census has decreased at Osawatomie SH from 28% in FY 2007 to 16% in FY 2009 to date. At Larned SH, however, it has dramatically increased from 9% in FY 2007 to 71% in FY 2008 and stands at 42% in FY 2009 to date. It is a chronic problem that will continue as long as funding for staff remains at marginally adequate levels.

- Although the new 30-bed unit at OSH has been constructed, funds requested by SRS and granted by the Legislature last year to open and staff the new unit for six months beginning in January 2009 were not included in the Governor's budget this year and have been removed from the SRS budget for next year as well, in response to current economic strictures.

- In response to concerns expressed by the Legislature about overcrowded state hospitals last year, SRS established the Hospital and Home Initiative, a task force intended to "*research and design a plan to implement an effective array of hospital and community services that support mental health wellness and*

recovery through partnerships and data-driven strategies." This focus is based on the recognition that the hospitals are not isolated units; they are part of a complex web of services that must be considered as an integrated whole, and plans developed accordingly.

After a slow start, the Work Group has begun to make significant headway on the challenging task of long-range planning for the mental health services system and shows signs of making a significant contribution this year.

- Last year, the Legislature did add a portion of the vitally needed funding for direct care staffing that SRS sought, but it was not the entire amount requested. That deficiency has left the hospitals in serious difficulty.

- Staffing needs at all 3 hospitals now are critical and at great risk of impacting the quality of treatment. They are only marginally adequate, having been severely weakened by the cost-saving strategy of "artificial shrinkage" as the only way hospitals can cover their 'other operating expenditures' (OOE) of drugs, utilities and food when those expenses exceed their allocated budget.

  At this point, Osawatomie SH has some 60 unfilled positions – 14% of a total of 440. Rainbow has 15 of 122 positions (12%) unfilled. These numbers represent a dramatic increase over those of a year ago, when Osawatomie had only 20-25 positions open, and Rainbow 8-10. Absent requisite funding in the face of continued cuts in funding for basic expenses, further staff cuts to provide necessary funds will unquestionably negatively impact the quality of treatment.

  Insufficient staff, especially of skilled, well-trained professionals, will bring several undesirable consequences. Hospital stays will likely become shorter, producing an increased risk of premature discharges, problematic challenges for community treatment services, and subsequent recidivism. Without adequate staff, a diminished active daily treatment programs will seriously penalize patients with no other treatment alternatives.

  There are some patients for whom longer-term hospitalization is the only answer: those whose disturbances are too severe or violent or disruptive to be treated in the community; those with intractable disorders who need a therapeutic environment for an extended time, for whom short-term "stabilization" is useless; those with disorders requiring specialized services not available in the community. A well-staffed hospital capable of providing these tertiary services is essential if these vitally needed services are to be available to Kansas citizens.

In short, whatever the funding issues of unmet capital needs, the funding short-fall for staffing is even more critical and needs to be addressed.

At the time of the dramatic overhaul of the state hospital treatment programs in the 1950's, my father Dr. Will Menninger pushed for investment in people—trained staff, teachers, and specialists, not buildings. He advocated Brains Before Bricks. My uncle, Dr. Karl Menninger, echoed these sentiments, saying that with well-trained staff, patients could be well-treated in a barn. I am <u>not</u> advocating the neglect of our physical facilities; I am emphasizing the absolutely vital need for funding to hire and retain adequate staffing to provide adequate treatment. Please do not neglect this primary requirement for the mental health services Kansas needs.

Thank you for your time and your consideration of these issues. We are available to meet with you at any time to discuss these and any other issues.

* * * * *

For More Information, Contact: Kansas Mental Health Coalition

c/o Amy A. Campbell, Lobbyist
P.O. Box 4103, Topeka, KS 66604
785-234-9702, cell: 785-969-1617; fx: 785-234-9718, kmhc@amycampbell.com

c/o Roy W. Menninger, MD, Chair
85 SW Pepper Tree Lane, Topeka, KS 66611-2072
785-266-6100, fx: 785-266-9004, roymenn@sbcglobal.net

8-9

NAMI Kansas
National Alliance on Mental Illness

Legislative Budget Committee

August 26, 2010

Presented by:
Rick Cagan
Executive Director

NAMI Kansas is a statewide grassroots membership organization dedicated to improving the lives of individuals with mental illness. Our members are individuals who are living with mental illnesses and the family members who provide care and support. We provide peer support, education and advocacy on behalf of those who are affected by mental illnesses.

In order to examine the events in May which necessitated the suspension of voluntary admissions to the state mental health hospitals, it is critical that we view the state hospitals in the context of the entire public mental health system. We have testified on numerous occasions before committees of the legislature about the necessity of establishing a continuum of care which should be available on a statewide basis to provide a safe environment for the care and treatment of persons with mental illnesses. It is our hope that the Legislature would view our treatment system from this perspective since resources lacking at the community level have a direct impact on the demand for services at the state hospitals.

We believe that the following list of issues and concerns all have a bearing on the current demand for inpatient treatment services at the state hospitals. At some level, each of these issues needs to be addressed as part of a comprehensive solution.

1. There are from four to five times as many individuals with serious mental illness in our jails and prisons in Kansas than we have licensed bed capacity in our state mental health hospitals. We can either pay for adequate care through our mental health treatment system or we can continue to shift the cost to the criminal justice system as we are currently doing.
2. "Jail diversion" programs, such as police-based Crisis Intervention Teams and Mental Health Courts, are being expanded in Kansas. However, there are concerns in law enforcement circles about the need for adequate treatment services since the individuals being diverted from the criminal justice system generally require immediate attention for their mental health conditions.

610 SW 10th Avenue ▪ Suite 203 ▪ PO Box 675 ▪ Topeka, K
785-233-0755 ▪ 785-233-4804 (FAX) ▪ 800-539-266
namikansas@nami.org ▪ www.namikansas.org

3. More than half of admissions to the state hospitals are patients who have had no previous connection to the public mental health system. This is a major component of the increased demand for both community-based and hospital-based care. It also appears that a substantial percentage of new admissions is coming from the uninsured population. It remains to be seen how national health care reform will impact this trend, but at least for the next several years we have to manage the demand from the uninsured without the benefit of these reforms.
4. We have to remember that national data indicates that two-thirds of adults with serious mental illnesses and more than fifty percent of children with serious emotional disorders are not engaged in treatment. As we become more successful with outreach to these individuals and as the stigma associated with mental illness gradually recedes, we can expect to see even more demand on our public mental health system.
5. A continuum of care begins with having adequate resources for community-based care through the community mental health centers as primary care providers. Absent sufficient community-based resources, patients who need a more robust array of mental health services to support their recovery are at risk of encounters with the criminal justice system and potential admission to the state hospitals.
6. A secondary level (or intermediate level) of care is represented by inpatient treatment resources in a local community setting. State hospitals should be viewed as a tertiary or specialty level of care. This analysis is consistent with the recommendations from SRS' Hospital and Home initiative. We should be moving our public mental health system to resemble this model.
7. An intermediate level of care with additional in-patient capacity creates at least four principal benefits:

    a. Focusing the role of the state hospitals on those patients most difficult to treat and in need of specialty care
    b. Creating alternatives for those persons with serious mental illness who need temporary hospitalization or crisis stabilization as a complement to their ongoing community-based care
    c. Establishing resources to aid law enforcement agencies who are seeking to divert persons in crisis to suitable treatment facilities for stabilization and acute care
    d. Creating opportunities for in-patient treatment closer to home and lessening the burden on families being far removed from their loved ones

    Recovery from mental illness is a delicate process at best and includes a number of factors, including the love and support of family members and friends in home communities. By placing patients in hospitals far removed from home communities, we negatively impact the ability of family members to remain connected to their loved ones given that the time and expense of traveling longer distances is prohibitive for many families.

8. Parity in treatment for mental illness is now the law of the land. In this light we need to ask for what other medical issues would we consider treatment options that remove the patient at great distance from their home community?

9-2

9. In the wake of the suspension of voluntary admissions in May, and on other occasions sin May, SRS has developed contractual arrangements with Via Christi and Prairie View to deal with the increased demand. Purchasing beds for the public system from private providers is certainly one path to expanding secondary care treatment services and establishing this intermediate level of care.
10. At least part of the crisis leading to the suspension of voluntary admissions stems from the state hospitals being starved for resources. When the need for additional staffing and operating funds is not addressed, the hospitals are forced to operate on skeleton budgets while simultaneously experiencing census numbers which consistently exceed their licensed capacity. This has a direct impact on the level and quality of care that the hospitals can provide as well as the ability to consistently meet health and safety standards.
11. When hospital resources are scarce, there is increased pressure on the hospitals to return patients to the community who may not be quite ready to continue their treatment in a community-based setting. This sets in motion the dynamic between the community mental health centers and our state mental health hospitals since we also lack the resources to provide for more robust services at the community level for patients who have a need for a higher level of care and treatment and we also lack more localized inpatient resources.
12. ***What is needed are adequate resources to provide the right treatment, at the right time, in the right place, and in the right amount for as long as necessary to achieve a timely and lasting recovery. The right treatment is the one that works for a person in his or her particular unique circumstances. The time is right when the need is apparent and it is never right because it is convenient for the system. The right place is where the person's needs can be most effectively and expeditiously met. The right amount is determined by the person's readiness to move to another level of treatment or to function independently with or without continuing support.***
13. The demands on our public mental health system require a longer view than is afforded by our budget deliberations on an annual basis. We need a multi-year plan with the ability to make investments in the system over a number of years in order to create an adequate continuum of care that will advance public health and safety.
14. Failing to address the long-terms needs of our public mental health system will ensure that we will continue to move from crisis to crisis. If we have to periodically invoke the suspension of voluntary admissions, we are placing Kansans at risk of having their symptoms worsen, bringing harm to themselves or others and losing more lives to suicide. Early intervention and treatment is often the first step toward recovery. An increased delay in accessing treatment is a recipe for increased costs across the board for the state of Kansas.

Thank you for the opportunity to address these critical issues. The members of NAMI Kansas look forward to working with you to craft long-term solutions to strengthen our public mental health system.

9-3

DISABILITY RIGHTS CENTER of KANSAS
EQUALITY • LAW • JUSTICE

Disability Rights Center of Kansas
635 SW Harrison, Ste 100 • Topeka, KS 66603
785.273.9661 • 877.776.1541 (Voice)
877.335.3725 (TDD) • 785.273.9414 FAX
www.drckansas.org • *info@drckansas.org*

LEGISLATIVE BUDGET COMMITTEE

August 26, 2010

Thank you for the opportunity to speak before you today. My name is Nick Wood and I am the Systems Change Coordinator at the Disability Rights Center of Kansas (DRC). The DRC is a public interest legal advocacy agency, part of a national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. As such, DRC is the officially designated protection and advocacy organization for Kansans with disabilities. DRC is a private, 501(c)(3) nonprofit corporation, organizationally independent of state government and whose sole interest is the protection of the civil and legal rights of Kansans with disabilities.

First, we have attached a copy of the memo written by the Mental Health Coalition on this subject, signed by numerous mental health organizations. We encourage you to review this memo, as we believe it will prove extremely helpful to the committee in understanding the concerns of consumers with mental illness and the mental health community

We won't quote the whole memo to you, but we do want to highlight some of the information in the Kansas Mental Health Coalition memo to Secretary Don Jordon of the Department of Social and Rehabilitation Services on May 26, 2010, closing off voluntary admissions, or any admission, to a state psychiatric facility without the proper alternatives is devastating to Kansas. The Mental Health Coalition wrote:

> "There are essentially two front doors to state psychiatric hospitals for Kansans with mental illness – voluntary or involuntary admissions. The SRS action locks one of the two front doors. If Kansans cannot voluntarily admit themselves to a state psychiatric hospital, then their only choice is to endure a worsening of their psychotic episode, decompensate further, and to put themselves or others in risk of harm or even death ... Alternatively, they may have ended up in a jail or prison, at a much higher cost to both taxpayers and the person in need of treatment."

Legislative Budget Committee
Date 8-26/27-2010
Attachment 10

Additionally, the Mental Health Coalition memo raises legitimate concerns about the timing of the decision to temporarily close off voluntary admissions, basically one week after the close of the Legislative session:

> "The Kansas Legislature adjourned only seven days prior to the agency's abrupt announcement of this decision. Why was SRS not beating down the door of the Governor's Office and Kansas Legislature while the Mega/Omnibus budget bill was being finalized? Why was SRS not loudly sounding alarms to ensure that funding was appropriated to prevent this terrible outcome? In the agency's sudden May 19 announcement, it states that this issue had worsened "especially over the past several weeks." If SRS knew that this was a problem for the past several weeks, why didn't the agency take advantage of this unprecedented opportunity when the budget was written for all intents and purposes by only one chamber? Why didn't the agency seek these funds at the end of the session to avert this crisis?"

Perhaps the most discomforting concern about the issue of temporarily closing voluntary admissions to State Mental Health hospitals is it should have been prevented. The Department of Social and Rehabilitation Services has developed policies to proactively address and cure the problem before the census grew too high (2005 *Protocol for Managing State Mental Heath Hospitals Census*). As policymakers you should ask tough questions about why the protocol that was supposed to prevent this from happening failed? Also, why was protocol only implemented via policy at Osawatomie State Hospital? Why wasn't this protocol implemented or enforced at Larned State Hospital? Because the protocol was supposed to prevent this exact thing from happening, and didn't, what is the state doing to rewrite this protocol and develop new meaningful policies that will be more effective in the future?

DRC Kansas was surprised and concerned to receive a memo on May 19th regarding the moratorium on voluntary admissions to state psychiatric hospitals, only seven days after the Kansas Legislature had adjourned for the year. At our office, we naturally referred to the 2005 *Protocol for Managing State Mental Heath Hospitals Census* stated which states the intent of Social and Rehabilitation Services (SRS) to "work together on a continuous basis" to prevent the suspension of admissions.

Our understanding of the Protocol is that SRS would take proactive steps to avoid delays. These include, among other things, the utilization of referrals, transfers, and

discharges to lighten the burden on the State's mental health care system and render suspension of admissions unnecessary.

As per the Protocol, partners such as the Kansas Mental Health Coalition, NAMI Kansas, DRC, and others, should have been notified that the psychiatric hospitals were "approaching capacity" at *predetermined* "trigger points." This Protocol runs contrary to the memo from SRS dated May 19th which informed the mental health community that the voluntary admissions moratorium was to start on that same day, May 19th. Notice of these measures on their effective date is essentially notice after that fact.

It is important to remember that the availability of hospitalization, voluntary or involuntary, is a safety net. The most efficient use of state hospital beds is to provide a safe environment that serves as crisis stabilization and helps to connect people to natural and professional supports in the community. Discharge planning should begin at admission and is more effective when community supports can be easily identified.

KVC Hospitals, Inc.
4300 Brenner Drive
Kansas City, KS 66104
913/334-0294
913/312-0320 (Fax)

Legislative Budget Committee
Testimony on State Mental Health Facilities
August 26, 2010

Chairman Emler and honorable members of the Committee, I am Jason Hooper, President for KVC Hospitals, Inc. We appreciate the opportunity to provide testimony on state mental health hospitals.

KVC has a long history of helping children and families. Currently, KVC Hospitals provide psychiatric care to children and adolescents out of facilities in Kansas City and Hays. With nearly twenty years of experience, KVC has expertise in children's psychiatric care, residential treatment and community-based services. At KVC, children can receive a wide range of integrated medical and behavioral health services in the least restrictive setting available.

KVC is proud to have been awarded the contracts by SRS to provide services for children in need of psychiatric hospital care. In Kansas City, the STAR Program has served the population of children and adolescents previously served at Rainbow Mental Health Facility since 2007. Children and adolescents formerly treated at Larned State Hospital were welcomed to the Wheatland Program in Hays starting in May of this year. The personnel at these facilities are well trained and pride themselves on providing the most compassionate and effective treatment available.

Families from across the Midwest have sought care at KVC's Prairie Ridge Psychiatric Hospital, and we hold the same hope for Wheatland Psychiatric Hospital. With multiple lines of business including private pay and private insurance, along with the contracts with the State of Kansas, KVC has positioned itself to be a regional leader in the provision of services to children and families. With full accreditation from The Joint Commission (TJC), which is the nation's oldest and most prestigious healthcare accrediting body, KVC prides itself on the implementation and application of the most innovative evidence-based practices.

KVC looks forward to serving children and families far into the future as we try to give this vulnerable population the greatest chance to succeed.

This concludes my testimony. I would be happy to stand for questions.

Legislative Budget Committee
Date 8-26/27-2010
Attachment 11

Via Christi
HEALTH

Testimony Presented to the Legislative Budget Committee
By Lois Clendening, Service Line Director, Behavioral Health
Via Christi Hospitals Wichita, Inc.
August 26, 2010

Good afternoon, my name is Lois Clendening, Service Line Director, Behavioral Health with Via Christi Hospitals Wichita, Inc. I am providing testimony on the issue of our ministry's capacity to accept overflow patients from the state mental health hospitals.

Via Christi Health is the largest provider of health care services in Kansas and has a rich history of serving the people of Kansas and the surrounding region for more than 100 years. We serve Kansas and northeast Oklahoma through our hospitals, outpatient centers, senior villages and at home services.

Via Christi services in Wichita include the:

- 400 bed Via Christi Hospital, offering tertiary care on N St Francis
- 300 bed Via Christi Hospital on E Harry
- 68 bed Hospital on St Theresa Way
- Via Christi Behavioral Health Center (VCBHC), an 80 bed behavioral health campus offering inpatient and outpatient services
- Via Christi Rehabilitation Center, a 60-bed facility that serves as the hub for 12 outpatient rehabilitation clinics, an occupational and environmental medicine program and a sports medicine program
- Via Christi Research; Via Christi Home Health
- 17 Via Christi Medical Associates Family and Specialty Medicine clinics.

For the fourth year in a row, Wichita's Via Christi Hospital has received HealthGrades' Distinguished Hospital for Clinical Excellence Award. Via Christi medical centers are supported by foundations which benefit facility and community needs. In FY 2009, Via Christi Health provided $78.1 million in benefit to the communities we serve. This includes $39.7 million in charity care and $18.9 million in unpaid costs of Medicaid services provided. Via Christi Health employs more than 9,000 and in FY 2009 generated $989 million in revenue. Via Christi Health is affiliated with the Marian Health System and Ascension Health.

Via Christi's Behavioral Health Services include the 80 bed Behavioral Health Center in east Wichita and a 28 bed gero-psychiatric inpatient unit and a psychiatric assessment center (ASC) at the Via Christi Hospital on E Harry. The Behavioral Health Center also offers Partial Day Hospital and Intensive Outpatient Services and a traditional outpatient psychiatric clinic. 60 of the 80 VCBHC beds are reserved for adults and 20 for adolescents. In 2009 the ASC saw over 600 patients per month and 4195 patients were admitted to our behavioral health center and senior psychiatric unit. Via Christi accepts both voluntary and involuntary patients.

In May of 2010 we began to accept overflow patients (meeting our admission criteria) who historically would have gone to the state hospital. As of August 25, 2010, we have accepted more than 27 patients resulting in more than 100 patient days.

In most cases, when beds are requested by the State, Via Christi has the capacity to admit these patients. As a matter of fact, our experience has been overwhelmingly positive. In speaking with our Via Christi social workers and providers from the local mental health centers, they believe discharge planning in these situations is more complete. Appointments for follow-up care are in place when the patient leaves the hospital, as well as more effective connections needed for ancillary services. The patient's family can also be more involved when appropriate. Our sources all report that they believe follow-up with the discharge plan after hospitalization is better after these patients have been admitted in their own communities. The Sedgwick County Probate Court and the District Attorney's Office have been very supportive of this process. They feel the impact of court hearings and treatment taking place in the patients' own community, with their family/support consistently available, has been positive and actually results in more effective treatment. An unexpected benefit has been the provision of a different type of treatment process adding to the richness of educational experiences for medical students and psychiatric residents.

Communication with SRS, the state hospitals and our local mental health centers has been excellent throughout this process. Via Christi Health believes the current approach to addressing the overflow issue of the state mental health hospitals is working and we look forward to collaborating with all of these providers in the future.

Legislative Budget Committee
Date 8-26/27-2010
Attachment 1/3

Community Hospital Licensed Inpatient Psychiatric Beds

Facility Names	Facility Locations	2002 Bed Count	2003 Bed Count	2004 Bed Count	2005 Bed Count	2006 Bed Count	2007 Bed Count	2008 Bed Count	2009 Bed Count
Memorial Hospital	Abilene	10	10	10	10	10	10	10	10
Atchison Hospital	Atchison	10	10						
Mitchell County Hospital	Beloit	10	10	10	10	10	10	10	10
Coffeyville Regional Medical Center	Coffeyville	15	15	15	17	17	19	19	
Susan B. Allen Memorial Hospital	El Dorado	11	11	11	11	11	10	10	10
Morton County Hospital	Elkhart	10	10	10	11	11	11	11	11
Fredonia Regional Hospital	Fredonia	9	9	9	9	9	9	9	9
St. Catherine Hospital	Garden City	14	14	14	14	14	14	14	14
Girard Medical Center	Girard							10	10
Kiowa County Memorial Hospital	Greensburg			10	10	10	10		
Hertzler Regional Medical Center	Halstead	28							
Hillsboro Community Medical Center	Hillsboro	12							
Hutchinson Hospital Corporation (*Their name changed to Promise Regional Medical Center in 2009.)	Hutchinson	13	13	13	16	16	13	13	13
Geary Community Hospital	Junction City	11	11	11	11	11	9	9	9
Providence Medical Center	Kansas City	22							
University of Kansas Hospital	Kansas City	48	48	48	48	48	48	48	48
Edwards County Hospital	Kinsley						10	10	10
Lawrence Memorial Hospital	Lawrence	15	15						
Cushing Memorial Hospital	Leavenworth	14	14	14	14	20	20		
St. John Hospital	Leavenworth	16	16	16	16	16	16	16	18
Southwest Medical Center	Liberal	12	12	12	12	12	12	12	12
Mercy Regional Health Center	Manhattan	21	11	11	11	11	11		
Minneola District Hospital	Minneola	10	10						
Wilson County Hospital	Neodesha	12	12	12	10				
Newton Medical Center	Newton					12	12	12	12
Overland Park Regional Medical Center	Overland Park	21	21	21					
Mt. Carmel Medical Center	Pittsburg	14	14	14	14	14	14		
Salina Regional Health Center	Salina	16	16	16	16	16	16	16	16
Shawnee Mission Medical Center	Shawnee Mission	42	42	32	32	32	32	32	32
Stormont-Vail Regional Health Center	Topeka	16	16	16	16	16	16	16	16
Sumner Regional Medical Center	Wellington	10	10	10	10	10	10	10	10
Via Christi Regional Medical Center	Wichita	28	48	48	48	48	48	48	28
Wesley Medical Center	Wichita	18	18	18	18	18			
Total		488	436	401	384	392	380	335	298

LEGISLATIVE BUDGET COMMITTEE

Social and Rehabilitation Services Spending
on
FY2010 Contracting for MH Beds to Private Hospitals for Adults

SRS has two agreements to pay for the uninsured costs of adults served in community inpatient psychiatric service programs; one with COMCARE to pay Via Christi and one with Prairie View. The COMCARE agreement provides for payment to Via Christi for two different groups of people. One group are those who are involuntarily admitted to the program, but are expected to experience only a very short term stay (one to four days). This agreement was made to avoid the long trip from Sedgwick county to OSH for only very short stays, increase continuity of services, and keep people closer to their home. The second group are those persons who were screened for voluntary state mental health hospital admissions, but whose admission was delayed because of extremely high state mental health hospital census.

Prairie View's agreement provides for payment of inpatient treatment of persons diverted from admission to a state mental health hospital due to extremely high census from the catchment areas of Prairie View, The Center for Counseling and Consultation, Central Kansas Mental Health Center, Horizons Mental Health Center, and, when Via Christi is full, Sedgwick County.

Via Christi Short Term Involuntary Admissions and ER for Persons who Are Uninsured					
Month	No. Persons Served in the ER	ER Days	No. of Persons Served in the Inpatient Program	Inpatient Days	Grand Total
July	11	11	8	18	$17,950
August	16	16	4	10	$13,730
September	16	15	9	28	$27,120
October	7	7	8	20	$17,960
November	14	14	6	14	$16,030
December	10	10	8	15	$15,275
January	14	14	2	4	$8,380
February	16	16	5	12	$15,260
March	10	10	10	30	$26,750
April	13	13	4	8	$11,060
May	6	6	6	13	$12,225
June	7	7	5	8	$8,780
Totals	140	139	86	283	$190,520

Individual Persons Diverted to Via Christi					
Admit	Discharge	Inpatient Billable Days	Inpatient Days Billable to SRS	Amount SRS Paid	
5/25/2010	6/4/2010	10	9	$	6,885
5/18/2010	6/3/2010	16	7	$	5,355
5/18/2010	6/8/2010	21	21	$	16,065
5/20/2010	5/25/2010	5	5	$	3,825
6/17/2010	6/21/2010	4	4	$	3,060
6/16/2010	6/21/2010	5	5	$	3,825
6/16/2010	7/19/2010	33	32	$	24,480
6/29/2010	7/1/2010	2	1	$	765
6/23/2010	7/6/2010	13	7	$	5,355
6/30/2010	7/6/2010	6	5	$	3,825
6/21/2010	7/2/2010	11	7	$	5,355
Totals		**126**	**103**	**$**	**78,795**

Prairie View FY10 Diversions					
Admit	Discharge	IP Billable Days	IP Days Billable to SRS	Amount	
6/12/2010	6/17/2010	5	5	$	3,825
6/13/2010	6/21/2010	8	8	$	6,120
6/17/2010	6/22/2010	5	5	$	3,825
6/15/2010	6/16/2010	1	1	$	765
6/18/2010	6/28/2010	10	10	$	7,650
6/25/2010	6/25/2010	1	1	$	765
Totals		**30**	**30**	**$**	**22,950**

Association of Community Mental Health Centers of Kansas, Inc
534 S. Kansas, Suite 330, Topeka, Kansas 66603
Telephone: 785-234-4773 / Fax: 785-234-3189
Web Site: www.acmhck.org

Legislative Budget Committee

Testimony on
Temporary Suspension of Voluntary Admissions to State Psychiatric Hospitals

August 26, 2010

Presented by:

Michael J. Hammond, Executive Director
Association of CMHCs

Mr. Chairman and members of the Committee, my name is Mike Hammond, I am the Executive Director of the Association Community Mental Health Centers of Kansas, Inc. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,500 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs, collectively serving over 131,000 Kansans with mental illness.

Joining me in my testimony today are Walt Hill, Executive Director of High Plains Mental Health Center in Hays; and David Wiebe, Executive Director of Johnson County Mental Health Center in Mission. We will address our issues and concerns with psychiatric inpatient services capacity for the public mental health system here in our State as well as the decision by SRS to temporarily suspend voluntary admissions to our State psychiatric hospitals.

As has been previously testified by SRS, the State Psychiatric Hospitals – Osawatomie State Hospital (OSH), Larned State Hospital (LSH) and Rainbow Mental Health Facility (RMHF) serve persons experiencing serious symptoms of severe mental illness who require inpatient care. The individuals referred to these hospitals are typically those that CMHCs cannot safely and effectively treat in the community.

The State Psychiatric Hospital budgets were reduced by $698,916 in FY 2010 and by $1,643,875 in FY 2011. We know that the hospitals are operating at the bare minimum staffing to ensure active treatment and the safety of staff and patients. Current staff vacancy rates at the SMHHs are running from 7 percent to 14 percent. The actual cost to operate each of these facilities is the amount which SRS has budgeted. What SRS has told us as well as policy makers is that the only choice for reductions would be to serve less people in our hospitals. **Our concern is that reductions of the hospital budgets coupled with increased demand for inpatient care has resulted in the agency temporarily suspending voluntary admissions – once on May 20, 2010 (lasting until May 26, 2010), and again on July 16, 2010 (lasting until July 20, 2010). Without reducing patient census at critical times, the agency indicates it could put the hospitals at risk of losing their license and certification. This is further complicated by the fact that Mental Health Reform funding – funding dedicated to keeping individuals out of our State Psychiatric Hospitals has been reduced by 65 percent over the last three years. This collectively is a recipe for disaster in our public mental health system.**

If Kansans cannot voluntarily admit themselves to a State Psychiatric Hospital, then their only choice is to ensure a worsening of their psychotic episode, decompensate further, and to put themselves or others at risk of harm or even death. In that event, it may be necessary for a court to order them to be admitted involuntarily to the hospital. However, by that time they may have spiraled out of control and would be significantly harder to treat successfully. Alternatively, they may have ended p in a jail or prison, at a much higher cost to both taxpayers and the person in need of treatment.

I can stand here today and report that there was no tragedy in any of our communities as a result of these two occasions where voluntary admissions were temporarily suspended. Both occasions were very short in duration. However, what happens in the future if the frequency increases as does the duration? To be honest, I think we as a system are pressing our luck and it remains very concerning to us and those we

serve that in a critically important situation where a person with mental illness is in crisis and require psychiatric inpatient care, they may not have access to inpatient care when they need it and there will be dire consequences.

Examples of what occurred at the community-level during these periods of suspension of voluntary admissions when the need arose:

- Extra staff were placed on call to provide support and services in the community if at all possible.
- Continued utilization of crisis services as best possible to attempt to support the client until inpatient resources were available.
- High risk clients were sent to community inpatient facilities who then in turn were asked to hold them until a State Psychiatric Hospital bed became available, increasing the burden of uncompensated care on local hospitals and in some cases, asking them to take on more challenging and difficult clients than they would normally accept.
- SRS did open up 11 beds at LSH that were not budgeted for.
- SRS turned to two community hospital partners – Via Christi in Wichita and Prairie View in Newton, who agreed to help overflow at OSH and LSH. SRS agreed to pay for all uncompensated care they incurred. SRS did not have these funds budgeted. These two agreements were key to the short duration of the temporary suspension of voluntary admissions.

It is important to note that approximately 40 percent of all admissions to CMHC crisis services and consequently then to our State Psychiatric Hospitals are new to the Kansas mental health system. It is also noteworthy that over 50 percent of those admitted to State Psychiatric Hospitals do not have Medicaid as a payor source.

For a number of years, our State Psychiatric Hospitals have reached their maximum capacity and are often significantly over census on a continual basis – sometimes at very alarming rates. This situation has forced the philosophy of the use of SMHHs in Kansas to change. The utilization of these hospitals has evolved from serving as long-term residential treatment facilities to the role of short-term acute care treatment facilities.

To help alleviate such overcrowding, in 2007, the Kansas Legislature funded SRS's budget for facility improvements at OSH to prepare for expansion with a new 30-bed adult psychiatric unit. The 2008 Legislature appropriated $1.4 million to staff the expanded unit beginning in FY 2009, however, the Governor's Revised FY 2009 Budget recommended delaying the opening of this unit for the remainder of FY 2009 and for FY 2010. The Legislature accepted that recommendation. For FY 2011, it was yet again not recommended for opening and the Legislature accepted that recommendation. We need this unit to come online.

In FY 2010, SRS contracted out the adolescent unit at LSH. The unit freed up by this action had 30 beds available to the system, but the SRS budget only called for 19 of those 30 beds to be opened back up to serve adults. During the 2010 Legislature, we also asked for funding to bring those 11 beds online. That request was not funded.

It is important to note that the agency did submit to the Governor as part of their enhancement request for FY 2010, a proposal for establishing local private mental health inpatient beds across Kansas, with a request of $7.8 million, including $5 million in SGF. This would reimburse private hospitals for additional days of psychiatric treatment for people who would otherwise be transferred to State Psychiatric Hospitals. This would occur in two different ways: the first part would allow adjustments to the Medicaid reimbursement methodology to fund

extended lengths of stay for people who need more time to complete their treatment in the local hospital. The second part would provide a state only payment for inpatient psychiatric hospital treatment for persons who have no private or public insurance and no other method to pay for their treatment. While the situation has not changed at all, the agency, due to the State's continued financial crisis, did not submit this budget enhancement for FY 2011.

The Importance of Inpatient Resources

The vast majority of persons treated in the CMHC system are either indigent or low income with few resources to pay for private care. Because CMHCs function as an out-patient safety net resource for large numbers of persons with the most severe forms of mental illness, it is vitally important that we, in turn, have access to a safety net resource for those consumers whose illness simply cannot be managed in a community setting, and who have no resource to pay for private care. For us, and those consumers, the State Psychiatric Hospital is the safety net.

There is a longstanding partnership between the State Psychiatric Hospitals and CMHCs. Each CMHC designates a liaison to their respective State Psychiatric Hospital. Liaisons work with hospital staff to coordinate services upon discharge. This coordination helps to reduce the length of stays by ensuring that community based services are available. In addition, CMHCs are required to plan for and implement mechanisms to deal with emergency service needs. Throughout Kansas, CMHCs work to quickly respond to mental health emergencies by stabilizing crisis situations and providing follow-up services.

As outlined in the charts on the following page, which is also included in the SRS testimony, inpatient capacity of our State Psychiatric Hospital system can be at critical stages of maximum utilization several times throughout the year. The mental health system did not anticipate the explosion of need for State Psychiatric Hospital beds in the past few years. That explosion is in part due to the continued decline of private psychiatric hospital beds – resources the CMHCs relied upon at the community level.

OSH Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2005	73	20%
FY 2006	81	22%
FY 2007	100	28%
FY 2008	64	17%
FY 2009	82	23%
FY 2010	123	34%

Source: SRS

RMHF Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2007	19	5%
FY 2008	36	10%
FY 2009	27	7%
FY 2010	131	36%

Source: SRS

14-4

LSH Psychiatric Services Days Over Budgeted Census

Fiscal Year	Number Days Over Census	Percent of Time Over Census
FY 2006	31	8%
FY 2007	34	9%
FY 2008	259	71%
FY 2009	141	39%
FY 2010	302	83%

Source: SRS

As you know, State Psychiatric Hospitals are funded by state appropriations. This means they must operate at the budgeted level, even though that may not be the capacity level of the facility.

The following chart shows the number of psychiatric admissions to SMHHs in recent years, excluding the State Security Program and SPTP.

Civil Psychiatric Services Admissions								
State Hospital	**FY02**	**FY03**	**FY04**	**FY05**	**FY06**	**FY07**	**FY08**	**FY09**
LSH	819	836	929	990	1,064	1,097	1,176	1,071
OSH	1,137	1,371	1,570	1,943	2,016	1,969	2,181	2,042
RMHF	513	588	715	671	664	671	810	875
Total	**2,469**	**2,795**	**3,214**	**3,604**	**3,744**	**3,737**	**4,167**	**3,988**
Percent Change		13%	15%	12%	4%	0%	12%	-4%

Note: In FY08 RMHF began serving only adults

Source: SRS

Factors Impacting Increased Admissions at State Psychiatric Hospitals

Community providers are serving more individuals and those individuals are challenging patients with more intense needs.

- Since FY99, there has been a 47 percent increase in the total number of individuals served. This growth is consistent with national data that is outlined later in this testimony.

Funding for community-based mental health services for those who are uninsured or underinsured has been cut drastically.

- A loss of $20 million in SGF Mental Health Reform funding since FY 2008 – a 65 percent reduction.
- A loss of $3.1 million SGF in MediKan funding in FY 2010 – a 45 percent reduction.
- A loss of $560,000 SGF in Community Support Medication Program funding in FY 2010 – a 53 percent reduction.

There has been a significant decline in private psychiatric hospitals.

- Local inpatient psychiatric bed capacity statewide has been declining since 2002, from 488 beds to 324 today – a 34 percent decline. The Veterans Administration Hospitals in Kansas have only 58 psychiatric

beds for adults, in two locations in Kansas. Northwest Kansas has lost the only inpatient psychiatric unit (21 beds) between Salina and Denver, Kearney, Nebraska and Wichita/ Hutchinson during this time period also. Last year, Coffeyville Regional Medical Center closed its 17 bed psychiatric unit. Just last week, Southwest Medical Center in Liberal announced they will close the hospital's 12 bed psychiatric unit, citing lose of money and difficulty recruiting psychiatrists as the reasons for the decision.

- In the May 2006 issue of *Communicator*, a newsletter of the University of Kansas School of Medicine – Wichita, Department of Psychiatry, Dr. Sheldon Preskorn, Chair of the Psychiatry Department, wrote in his article, "Mental Health Care Crisis Brewing for Kansas," that there were seven inpatient services in Sedgwick County in 1990, with more than 350 beds and today there is one, the Via Christie inpatient psychiatric facility, with approximately 100 beds. He cites the loss of this capacity is due to the eroding of financial support for that level of care over the last 15 years and the inability for many to continue supporting this level of care. He goes on to say the State needs to support inpatient beds in urban centers for its citizens suffering from acute exacerbations of psychiatric illnesses who have no means to pay for that care.

- According to national data provided by the U.S. Dept. of Health and Human Services, Center for Mental Health Services, the number of mental health organizations providing 24-hour hospital or residential treatment care private psychiatric hospitals nationwide declined by 53 percent between 1992 and 2002. The data shows that for Kansas, the decline was 89 percent.

- Based on a 2006 State Psychiatric Hospital survey conducted by the National Association of State Mental Health Program Directors (NASMHPD), 80 percent of the States report experiencing shortages in psychiatric beds as a result of hospital downsizing and the closure of general hospital psychiatric units and private psychiatric hospital beds.

The number of inpatient psychiatric beds per capita has declined substantially.

- According to the President's New Freedom Commission, the total number of inpatient psychiatric beds per capita has declined substantially between 1990 and 2000 – a 27 percent reduction. Over this same period of time, State and county psychiatric hospital beds per capita have decreased even more sharply (44 percent). Private psychiatric hospital beds per capita decreased by 43 percent, while per capita beds in psychiatric units of general hospitals showed a 32 percent decline.

The State Psychiatric Hospital capacity has remained static for a decade (with the exception of the additional 20 beds for adults that were added to the system in FY 2008, referenced earlier), though many factors in our society are driving up utilization of inpatient psychiatric capacity.

- A majority of admissions also need substance abuse treatment. Anywhere from 50 to 70 percent of people served by both OSH and LSH also need substance abuse treatment.

- In 1997, 20 inpatient beds on the Chemical Dependence Recovery Program (CDRP) unit at LSH were closed with the commitment to move funding to community based programs to treat patients with serious substance abuse disorders. That funding was never realized, and in addition to closing approximately 90 beds at LSH with mental health reform, the system capacity was reduced by another 20 beds.

- Approximately 40 percent of all admissions to our crisis services, and to our State Psychiatric Hospitals are new to the Kansas mental health system, thus constantly producing a new and different group of clients to serve.

14-6

- Evidence is being identified that the occurrence of severe psychiatric disorders may be increasing. The number of individuals on SSI/SSDI between 2000 and 2008 increased by 33 percent, while persons who have a mental disorder who are on SSI and SSDI, increased by 57 percent during the same time frame. The U.S. population increased by only 8 percent in this same time period.

- In comparing national surveys on comorbidity that were completed in 1992 and again in 2003, data shows that Americans have been increasing their use of mental health services. The proportion of the population receiving treatment in the previous year rose more than 50 percent during the decade between the two studies. Treatment has become more widespread since the early 1990s because of greater public awareness, more effective diagnosis, less stigma, more screening and outreach, and greater availability of medications (Harvard Mental Health Letter, 2005).

What is happening in Kansas is not unique to Kansas.

- State hospitals in most states are seeing increased admissions. Increasing admissions can co-exist with a shrinking bed supply because of the continued drop in the length of stay and an increase in average occupancy rates, according to the Commission. Temporarily shutting off voluntary admissions is a tool other States have used to address this same trend.

- A growing number of employers have dropped health insurance for their employees and in some cases their dependents – many of whom show up on the doorsteps of community providers seeking services that we must provide, regardless of their ability to pay. These are men, women and children who will turn to community providers for help, when untreated problems build and result in a behavioral healthcare emergency. And we know from experience that, in crisis, care is more expensive to deliver. When they walk through our doors, for whatever reason, our challenge and commitment is to serve them.

- In 34 states, the result is a shortage of acute care beds; in 16 states a shortage of long-term care beds. In response to this trend, States are reporting undertaking a variety of activities to address these problems, including: expanded contracts with private hospitals to provide acute psychiatric care; expansion of emergency and community treatment facilities; adding additional state hospital bed capacity; as well as other initiatives.

- In 2006, NASMHPD issued a report on the crisis in acute psychiatric care. The report cited that SMHAs are identifying the crisis in acute psychiatric care as one of the most troubling challenges they face.

<u>Importance of Sustaining and Expanding Local Inpatient Resources</u>

The Association believes it is very important to recognize that Mental Health Reform, the closure of Topeka State Hospital and other measures have left the state with approximately 340 state-operated psychiatric beds statewide for adults and children. With the diminished capacity of local inpatient resources in our communities, added to a 65 percent reduction in Mental Health Reform funding since FY 2008, the most critical concern we are facing is having an adequate supply of state hospital beds to provide for an inpatient safety net for the public mental health system.

We believe a major reason for the diminished capacity of local inpatient resources is in part tied to how they are funded. General hospital psychiatric specialty units may be shifting the designation of beds from psychiatric to other, more financially lucrative uses. While reimbursement for psychiatric clients has eroded, reimbursement for cardiac and other medical/surgical patients has climbed, providing a clear financial incentive to reduce availability

of general hospital psychiatric unit specialty beds. The advent of the Diagnosis Related Grouping (DRG) in the 1980s led to an increase in general hospital specialty unit psychiatric beds, due to the waiver of financial constraints that subsequently permitted full reimbursement for the cost of care. The later rescinding of this exemption appears to have contributed to a drop in general hospital specialty unit psychiatric beds.

Without access to inpatient psychiatric resources, consumers and families will end up accessing emergency rooms. Because the emergency room can only provide a limited crisis response to the individual's symptoms, treatment is not very effective. The repeated use of emergency rooms in lieu of hospitalization is an expensive and ineffective means of treating individuals with mental illness.

State Hospitals as Critical and Necessary Public Safety Net

The Association and its members believe that State Psychiatric Hospitals function as a critically important safety net resource for consumers of the public mental health system who require inpatient care. The CMHCs look to local community hospitals as the first option for persons needing inpatient treatment. When private community hospitals are either not appropriate or unavailable, State Psychiatric Hospitals are frequently the only option remaining. Generally speaking, persons utilizing State Psychiatric Hospitals fall into one or more of the following four categories:

1. Indigent patients with no third-party or other resources to pay for care;
2. Involuntary admissions;
3. Forensic patients; and
4. Those patients whose symptoms or behavior management issues are such as to make community hospital admission and treatment difficult or even impossible. They may need a longer period for medication management, excess violence, behavior management that requires structured, long term attention.

The importance of the safety net role of State Psychiatric Hospitals is further underscored by the extensive range of alternative services developed by CMHCs to avert hospitalization and maintain consumers in the community. Because CMHCs are prone to push the envelope in their efforts to avert hospitalizations, ready access to inpatient resources for persons whose personal safety is often at risk due to symptoms of mental illness is essential. For the person with serious mental illness who takes longer to respond to treatment, the state hospital plays a key role in stabilization and preparation for transition to community based services.

We were unable to locate defining research that tells us with any level of confidence what the appropriate number of inpatient beds is to meet the needs of our population. However, one study of 16 metropolitan areas concluded that methods that relied on expert opinion, historical use, epidemiologic data, and social indicators predicted the need more accurately than those that relied exclusively on historical use. It is our hope that in the future the State would commission a scientific and actuarial study to make recommendations for future inpatient needs.

Conclusion and Recommendations for Psychiatric Inpatient Services

One of our most pressing immediate needs is adequate inpatient capacity to so that inpatient care is available timely. This need is further highlighted by the cuts in funding that have and continue to occur in grants to CMHCs that serve the uninsured and underinsured. Without that funding being restored, we believe it is likely the State will continue to see even greater increases in reliance on inpatient services as we face challenges in meeting all the needs of the uninsured who are mentally ill.

14-8

There is and will continue to be a renewed focus by the CMHCs in the gatekeeping function they perform for our State Psychiatric Hospitals both in controlling the "front door" and the "back door." This crisis in both funding and inpatient resources forces our CMHCs to become more innovative, to think outside the box, and to ensure strong partnerships with community organizations to ensure all resources are utilized. In visiting with the Superintendent of OSH this week, he assured me they are not seeing inappropriate admissions. It is our duty to ensure that continues. This week, my Board meets in Dodge City. We will have a focused discussion on what we can do to share resources in various communities across the State that will allow us to continue to support persons in a psychiatric emergency in our communities as best we can. However, please know there will always be a need for some level of psychiatric inpatient resources and most importantly, access to such in a timely manner.

We are pleased that the Administration and the Secretary of SRS found resources to purchase local acute care psychiatric inpatient services from two hospitals to reduce pressure on the State Psychiatric Hospitals. We are also pleased that the Administration and the Secretary of SRS have found resources to open up the remaining 11 beds at LSH that went off line. We also have urged the Administration to fund transitional housing and crisis stabilization beds.

What is Needed?

1. Additional capacity for crisis stabilization beds. We are exploring an opportunity within the OSH catchment area where a CMHC is attempting to secure a vacant building owned by the State of Kansas, and to add 26 crisis stabilization beds. This could help us tremendously in reducing the stress on OSH and RMHF. The Association is assisting the CMHC to navigate the State bureaucracy around purchasing the building. If all goes well, we could relieve the State of the debt service on this building and there would be not cost to the State of Kansas for these 26 crisis beds to come online. It's a win-win situation.

2. The 30 bed unit at OSH needs to come online. That comes with a price tag of $3.1 million SGF.

3. An appropriation of $500,000 to pay for staffing and other operating expenditures for LSH to permanently open up the 11 beds that have not been budgeted for within SRS.

4. We also support funding to establish local private mental health inpatient hospital beds across Kansas, to alleviate demand for State Psychiatric Hospital beds. Given the continued increase in the number of individuals who present for admission to State Psychiatric Hospitals, it is important to plan for the future needs in strategic areas of the State. In Kansas, the urban counties of Wyandotte, Johnson, Sedgwick and Shawnee see the majority of consumers that are impacted by the lack of psychiatric inpatient resources. By contracting with local hospitals or other providers for inpatient care, youth and adults who need acute care inpatient treatment will be able to remain closer to their families and support systems.

Mr. Chairman, I thank you and the Committee for allowing us to tell our story and for your consideration of our ideas and concerns.

14-9

JOHNSON COUNTY MENTAL HEALTH CENTER

6000 Lamar Ave
Suite 130
Mission, KS 66202
(913) 831-2550
Fax (913) 826-1608

OTHER SERVICE LOCATIONS

1125 W. Spruce St.
Olathe, KS 66061
(913) 782-2100
Fax (913) 782-1186

15118 Glenwood
Overland Park, KS 66223
(913) 715-7950
Fax: (913) 715-7960

Community Support Services
6440 Nieman Rd.
Shawnee, KS 66203
(913) 962-9955
Fax (913) 962-7843

Regional Prevention Center
1125 W. Spruce St.
Olathe, KS 66061
(913) 715-7880
Fax (913) 715-7881

Adolescent Center for Treatment
301 N. Monroe St.
Olathe, KS 66061
(913) 782-0283
Fax (913) 782-0609

Adult Detoxification Unit
11120 West 65th Street
Shawnee, KS 66203
(913) 826-4100
Fax (913) 826-4104

After Hours Emergency Service
(913) 384-3535
Fax (913) 588-6568

Testimony to

LEGISLATIVE BUDGET COMMITTEE

August 26, 2010

David Wiebe
Executive Director
Johnson County Mental Health Center

Legislative Budget Committee
Date 8-26/27-2010
Attachment 15

I appreciate the opportunity to provide comments regarding the suspension of voluntary admissions to the state psychiatric hospitals. To adequately address this issue, however, it is important to understand it in the context of our local experience as a Community Mental Health Center.

JOHNSON COUNTY MENTAL HEALTH CENTER

Johnson County Mental Health Center is the Community Mental Health Center serving residents of Johnson County. We provide a range of outpatient treatment, community-based services, 24-hour emergency response, and residential services to over 10,000 county residents each year. The individuals we serve are primarily low income (80% have annual family incomes under $25,000) and uninsured or under-insured. Just over 4,000 of those we serve fit into the state's definition of adults with a severe and persistent mental illness (SPMI) or children with severe emotional disturbance (SED).

Issues and Trends:

Mike Hammond noted in his testimony the $20 million statewide reduction in mental health reform grants over the last 2-½ years, plus other reductions in state funding. Johnson County Mental Health Center's share of these revenue reductions has been over $1.7 million. In order to live within our budget we are currently holding 32 staff positions vacant, in addition to other expenditure reductions such as reducing or eliminating staff salary increases; deferring property maintenance; reducing travel expenditures; etc.

Increased Demand for Services:

At the same time we are dealing with the above noted cuts, the Center is seeing an unprecedented increase in demand for services. Below is a snapshot of this increase over the past ten years.

Total clients served		Average new intakes per month	
2000	6,594	2000	308
2004	8,384	2004	506
2008	9,954	2008	564
2009	10,922	2009	600

Thus far, in 2010 we are averaging 657 new intakes per month. Although it is difficult to pinpoint any single reason for this dramatic increase in demand, we must assume a relationship between the current economic downturn and the increase in the number of people in severe emotional distress. Our intake staff report receiving on average 50 – 60 calls a week from individuals whose call to us was precipitated by some form of economic stress (job loss, home foreclosure, loss of insurance, etc).

15-2

STATE HOSPITALS AND SUSPENSION OF VOLUNTARY ADMISSIONS

The increasing demand experienced in Johnson County and across all Community Mental Health Centers is paralleled by a similar growth in admissions to the state hospitals. Below is the ten year trend of the combined admissions to Osawatomie State Hospital and the Rainbow Mental Health Facility from Johnson County.

Johnson County admissions to
OSH/Rainbow Mental Health Facility

2000	122
2004	254
2008	328
2009	348

For the entire OSH/Rainbow catchment area, these two facilities combined have seen their admissions increase from 944 admissions in fiscal year 2000 to over 3,000 admissions in the recently concluded fiscal year 2010. During this same period there has been one 20 bed increase when the Rainbow Facility outsourced its children's unit.

As Mr. Hammond noted, in addition to dealing with a 3-fold increase in admissions, the hospitals are also currently operating with staffing levels that have been reduced by 7-14%.

Two primary points can be made with respect to our state hospital system:

- State hospitals are a critically important part of the state's public mental health system. They function as the often final safety net for Community Mental Health Centers and those individuals who simply cannot be safely or successfully treated in the community. Typical characteristics of persons served by state hospitals include:
    - Those without financial or insurance resources
    - Those refused by, or not appropriate for admission to, local hospitals
    - Considered to be dangerous to themselves or others
- Our state hospitals are a point of crisis with respect to their ability to both meet the growing needs of the public mental health system and maintain quality treatment programs. Simply put, the number of available beds has not kept pace with the number of people served by the overall public mental health system. This crisis has been exacerbated by the dramatic closure of private psychiatric hospital beds throughout the state. Since the early 1990s the Kansas City metropolitan area alone has lost nearly 1,000 of these beds.

Impact of Suspension of Voluntary Admissions to State Hospitals.

The suspension of voluntary admissions to the state hospitals is simply symptomatic of the larger issue of an underfunded public mental health system and the inadequate number of state hospital beds. While the recent instances of suspension of voluntary admissions were relatively brief, with no bad results, the eventual outcome will be less and less access to state hospitals. When individuals meet the criteria for admission to a state hospital, but cannot be admitted, two immediate consequences can and do occur:

- **Cost shifting to private community hospitals and a growing incentive for hospitals to close psychiatric beds.** Over the last several years, our local community hospitals have felt increased pressure to accept difficult to manage, uncompensated patients they would otherwise not admit. This occurred on at least three occasions with the two recent, although brief, admission suspensions. As this trend continues it places hospitals in an increasingly untenable position, leading to even more closures of their psychiatric units.

- **Increased involvement by law enforcement with the mentally ill.** Without ready and appropriate access to state hospital treatment, the likelihood of law enforcement becoming involved with the mentally ill increases.

    - Johnson county Mental health Center now averages three contacts a day with local law enforcement officers regarding mental illness situations, more than double the number of contacts just three years ago.

    - Eighteen percent of all inmates at the Johnson County Adult Detention Center have a diagnosed mental illness (144 inmates). When officers know that finding appropriate treatment for a mentally ill person will be a long, time consuming process, they become increasingly likely to simply identify a charge and book the individual in jail.

SOLUTIONS

Mr. Hammond identified four recommendations to address the current crisis of inadequate state hospital beds. We endorse and support those recommendations. For the Osawatomie/Rainbow catchment area, I would especially highlight three of those recommendations:

- Funding of the long planned additional 30 bed unit at Osawatomie State Hospital

- Funding for development of community crisis stabilization beds

- Funding to purchase psychiatric inpatient services from private community hospitals. At the very least this would address the uncompensated care issue these hospitals face.

I would also underscore the importance of maintaining adequate staffing levels at our state hospitals. The current 7 – 14% staff vacancy rate at the hospitals in an environment of extraordinarily high admission rates, creates issues of safety for both patients and staff, and seriously impacts the ability of the hospitals to provide effective, high quality treatment.

Thank you for the opportunity to provide these comments.

15-4

Legislative Budget Committee

Testimony on

Impact of Budget Cuts and Suspension of Voluntary Admissions to State Psychiatric Hospitals

August 26, 2010

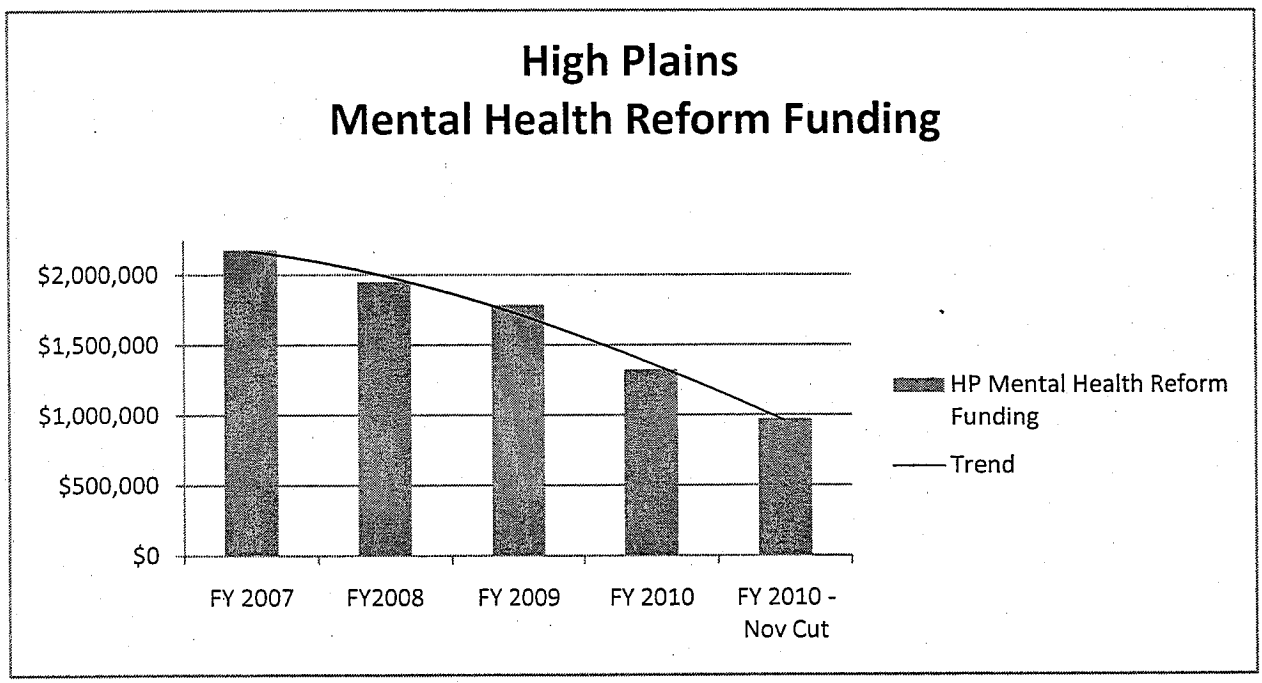
Presented by:

Walter Hill, Executive Director
High Plains Mental Health Center

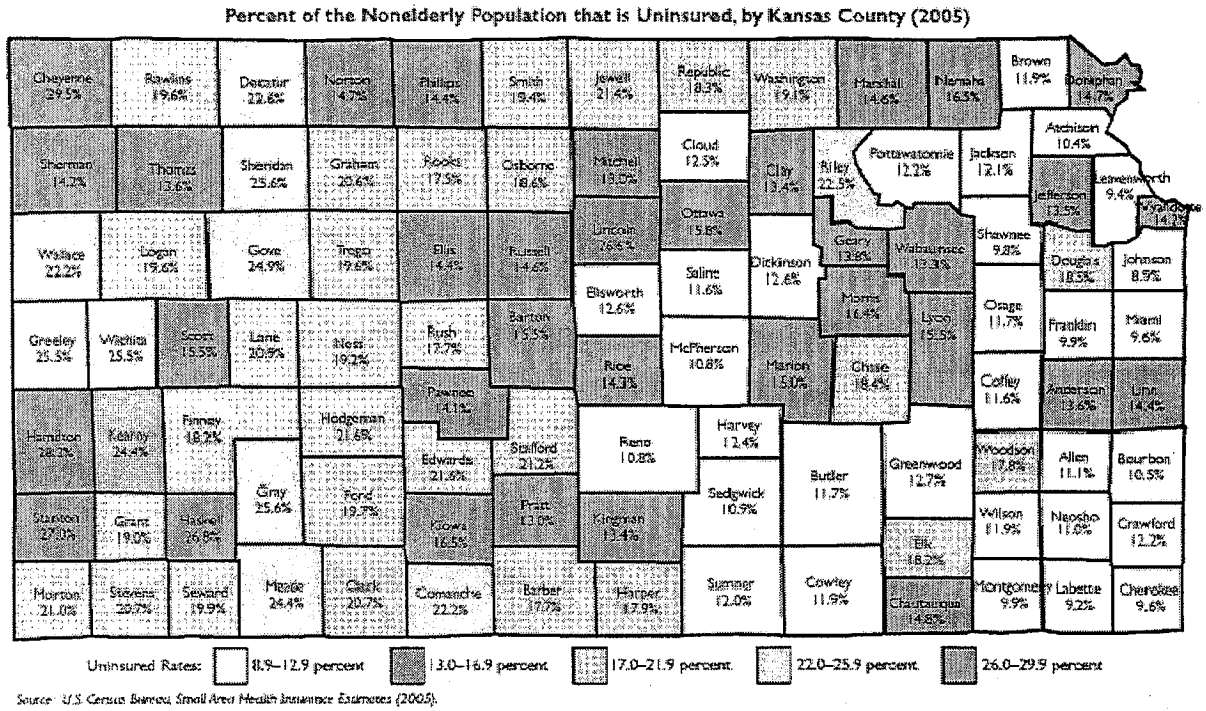
Legislative Budget Committee
Date 8-26/27-2010
Attachment 16

Mr. Chair and members of the committee, thank you for the opportunity to speak with you about the impacts of cuts to Mental Health Reform funding to community programs and impacts on state hospitals. My name is Walter Hill and I am the Executive Director of the High Plains Mental Health Center, the licensed Community Mental Health Center providing services in the 20 counties in Northwest Kansas.

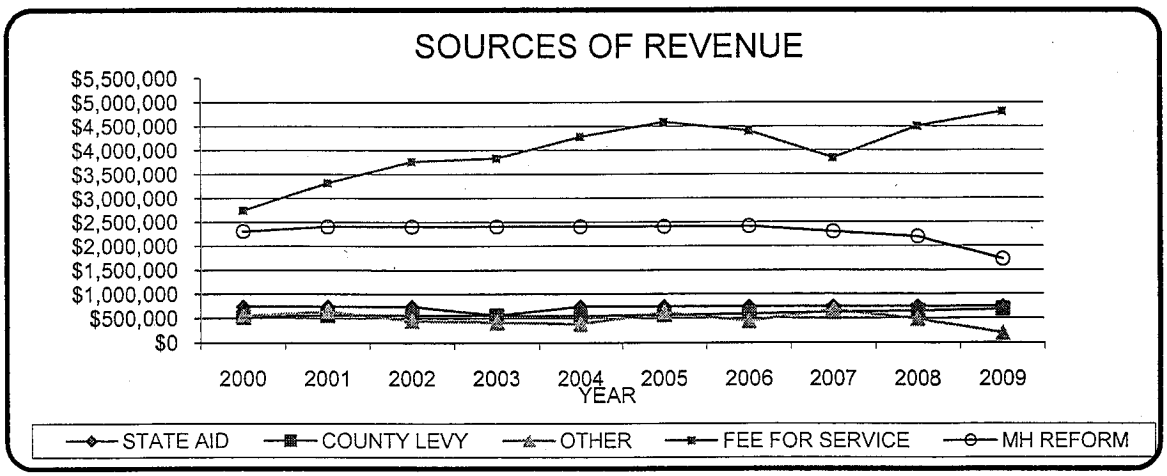
Mental Health Reform was founded on a promise of moving state dollars to communities as state hospital beds were closed and community providers cared for Kansas citizens in communities rather than in hospitals. Since 1989 our CMHC has continued our promise of Mental Health Reform, serving folks in the community and keeping thirty Larned State Hospital beds closed with no increases in that funding. Over the past several years, we have seen our Mental Health Reform Contract funding cut by nearly one half, $1.2 Million.



As you may recall, the funding cuts in the contracts for Mental Health Reform, were used to fund the repair of the Kansas Medicaid program that was in distress and under the microscope with the federal government. The theory was that Community Programs would make up the lost Mental Health Reform Contract funds with Medicaid revenues. That has not been the case in our twenty counties. The presence of Medicaid populations and uninsured is very low in Western Kansas compared to the rest of the state.



High Plains has only been able to generate the following Medicaid revenues - **$1,324,921 in CY 2007, $1,186,462 in CY 2008, $1,217,576 in CY 2009, and we project in CY 2010 $1,086,096. Though we have cut costs and attempted to raise other revenues, we continue to operate under a budget that is in the red nearly $40,000 each month.**



The impact of these cuts is that, though we do not have waiting lists, it is taking twice as long for a patient to be seen for medication evaluation, generally a two month wait for an appointment. Of our 5,000 plus patients each year, approximatly half are treated with a combination of services that involves medications for various mental health disorders.

We have seen increases in our need to utilize the state mental health hospitals, with our utilization increasing by nearly 50% over the past several years as it takes longer for patients to get into services, especially medication services; and overall service intensity has declined, especially for the uninsured.

Service access and intensity have been negatively impacted because of reductions in the number of staff, longer waits, less services, and expecting patients to pay more of the cost of care. We have reduced operating hours and reduced our travel to reach out to patients in their homes and home communities.

Over the past months that we have been discussing and dealing with cuts to our state funding, both we and others, including our auditors, board and counties, have indicated that such cuts will need to be dealt with, in addition to streamlining, by passing more of the cost of services on to service recipients.

With the removal of over $1 million in state funding the Center is challenged to operate in historical ways with respect to the degree to which we can subsidize the cost of services. As part of considering the impact of these declines in subsidy funding, we have conducted several studies of how subsidy funding has been operating at the Center.

From April 1, 2009 through March 31, 2010 the Center provided $2,355,309 in subsidized services to patients through fee adjustments. Of those adjustments $987,718 was for self pay services.

Faced with continued cuts of over a million dollars annually in state funding, High Plains has reduced staffing levels by 20% over the past year and a half, cut office hours, reduced employee benefits, eliminated non-mandated services such as psychological evaluations, domestic violence interventions, community education and intervention and made other internal cuts to adjust to cuts in funding imposed by SRS and the legislature. Recently, without restoration of these revenues by the state and continued increases in operating costs, the High Plains Board was faced with no other options than face unsustainable levels of budget short falls, or change expectations about the share of costs that service recipients are expected to pay. In the past 30% of patients received a 96% fee discount, paying $4 or less for an hour of service that costs over $100. The base fees at High Plains have only been increased once before in the past 10 years.

On October 1, the base fees for services at High Plains will be increased approximately 25%. For the most common type of treatment appointment, the fee will increase from $100 to $125. Many patients at High Plains receive a discount in this fee, and the Board changed the maximum discount from 96% to 90%. For an hour of therapy, the minimum fee will be $12.50. Additionally, in the past, further fee discounts were offered on a special fee consideration basis. Beginning October 1, the minimum fee will be the lowest fee and will not be discounted further unless patients are being funded by limited state funds. High Plains will work with patients to develop reasonable payment plan agreements, to carry their payment balances, without interest for up to one year.

High Plains will also begin expecting patients, who are not Severely and Persistently Mentally Ill or Seriously Emotionally Disturbed youth, to pay their fees for services in order to continue to receive regular treatment services. High Plains will provide only emergency services to individuals who are unwilling to pay their fair share of treatment cost.

Since making these announcements at the beginning of the year, we have seen self pay patients reduce the amount of services they seek by nearly 5,000 hours of treatment in six months.

We believe there is a direct correlation between the cuts in Mental Health Reform Contract funding and state hospital census, especially among non-Medicaid patients who have nowhere else to receive services when the community safety net can no longer serve them. The closure of state hospital beds puts patients at risk as there are no safe alternatives when the state hospital shuts its doors. The Mental Health Reform statute requires that SRS declare a moratorium when they shut the doors of the state hospitals and gain approval of the Supreme Court.

During the recent moratorium by SRS on voluntary admissions to the state mental health hospitals, we found no reduction in the number of admissions. Rather those who came to us for screening, in the absence of voluntary beds, had to be sent to the state hospital under civil commitment, due to the dangerousness.

We have, even with the state hospital taking voluntary patients, seen situations where there have not been other voluntary beds available to citizens in Western Kansas. Patients have declined voluntary admission to Larned, and we have seen negative patient outcomes and tragedies as a result.

We have reached a point that our system without sufficient inpatient resources is jeopardizing patients and communities. I have stood before committees in this building over the past three years and warned of the looming crisis in our system because of an unaddressed shortage of state hospital beds. In 2006, the legislative proviso directed SRS to conduct a study of the number of state hospital beds we need.

"SRS and mental health stakeholders shall work together to define what the future role of the State Mental Health Hospitals (SMHH) is going to be; to determine what the appropriate number of inpatient beds that is necessary to meet the needs of the citizens of Kansas based on the State's current population and respective population growth projections (either SMHH beds or a combination of SMHH beds and local acute care inpatient resources); and to propose a plan as part of the agency's budget hearings in 2007 to the Ways and Means and Appropriations Committees that would support the needs identified in the plan."

To date, no number of beds has been projected and we stand here today in the midst of the crisis we anticipated having it continuing to loom before us without enough capacity to protect the citizens of Kansas.

August 26, 2010

Legislative Budget Committee

Presented by: Spence McCurry (Consumer)

Members of the committee, the following six comments give my sense of the hospitalization situation in the state of Kansas.

First, hospitalization (in a larger state facility or in a community psychiatric unit) must be two of the treatment options available for consumers as part of the array of mental health treatment services. Our goal must be the right treatment at the right time (as early as possible) in the right setting for the right amount of time to achieve a lasting recovery.

Second, hospitalization options should be as near the natural living setting as possible: as close to ones community as possible – and not hours away, which hinders or discourages maintaining contact with natural supports. My nephew who is 12 years old had to be hospitalized earlier this year and the closest available hospital bed was in Kansas City, Missouri, a 3 hour drive from Wichita. It was very difficult to maintain contact with him, the hospital, and the doctors. It is both lonely and scary for a child to leave his family and be hospitalized. It was also a financial burden that had not been planned as we had to make 3 round trips to Kansas City including the initial transport of him to the hospital that happened overnight.

Third, in Mental Health Reform days in the 1990's with focus on enhancing community services, we assumed that almost all needed mental health services could be delivered in the local setting. It's not just that the money did not follow clients from state hospitals to the community so that services there could be expanded to cover the need. We assumed state hospitals would not play a significant role in treatment and also did not maintain nearly enough beds to meet the serious needs faced by some consumers that could not be addressed in the community. Hospitalization is a critical part of effective treatment to assure critically ill persons achieve stability, that proper medications have time to work, and that community-based services are in place with proper supports to help that person maintain wellness in the community.

Fourth, our state psychiatric hospitals (and the few other private ones in the state) are and have been either full or at capacity speaks to the need for addressing the critical shortage of space. Clients are generally staying very short periods of time – not nearly long enough to achieve significant stability – before returning to their communities. Their need for intense services continues and places significant stress on the community MH services systems.

Fifth, support additional psychiatric units in a number of hospitals (or self-standing facilities) based on the length of time a client is estimated to need that level of care (shorter term to longer term) may be appropriate to consider. Use of the existing state hospital beds for those persons requiring longer term

care and maintaining or establishing other units in respective communities for shorter term could be workable.

Sixth, I want to pose the following question: Is there a possibility that the national Health Insurance Parity Act for Mental Health Services may make a difference in funds available that could help with both longer and shorter term care?

Furthermore, I know no one wants to spend any time in any kind of hospital for whatever medical condition, but it's really important to have the appropriate services available when they're required. We wouldn't think of limiting the numbers of persons admitted with cancer, heart disease, diabetes, etc., etc., if they needed either a few days, a month, or even longer treatment. But we do it all the time for persons with brain diseases.

ordinating health & health care
for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

Legislative Budget Committee
August 26, 2010

Update on Medicaid/SCHIP Eligibility Processing Delays and Funding
Barb Langner, Medicaid Director

- Clearinghouse Backlog

Eligibility determinations for low income families and pregnant women occur primarily at the HealthWave Clearinghouse. The Clearinghouse is operated by a contractor Policy Studies, Inc. using contract employees and state staff to review applications for Medicaid and the Children's Health Insurance Program (CHIP). Several factors have contributed to an increase in the length of time it takes and the amount of work needed to process and application including:

- Citizenship verification
- Transition to a new Clearinghouse contractor
- Allotment reductions of $826,326 AF/$413,163 SGF in available contract resources in FY 2010
- Expansion on CHIP eligibility to 250% of the 2008 federal poverty level

Combined, these factors have resulted, for the past several months, in a consistently high inventory of unprocessed applications and reviews. At this point in time, the inventory of received but unprocessed applications and reviews is 32,481 (24,124 applications and 8,357 reviews). Included in that number are 16,954 applications and 3,676 reviews that are over 45 days old and in non compliance with federal processing requirements.

The current budget for the Clearinghouse does not provide enough capacity to process all of the applications received and waiting to be processed. The Clearinghouse is currently processing over 9,700 applications and reviews monthly and that is close to the number of applications and renewals received each month. Thus there is only adequate capacity to handle incoming applications and reviews and no unused resources to process backlog applications except for the limited amount allocated through use of overtime and temporary staff financed by private donations.

KHPA has received a warning letter from CMS requiring a corrective action plan to address the processing time. The exponential backlog growth will likely result in a violation of federal processing time requirements, which could lead to the loss of Federal matching funds and

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

future CHIPRA bonus payments for successfully enrolling eligible children.

- CMS Corrective Action Plan

CMS Recommendation: To ensure timely determination of eligibility in CHIP and maintain compliance with Federal regulations, please provide an action plan within 90 days from the date of this report regarding how Kansas plans to resolve this issue.

KHPA's response: KHPA plans to use a three-pronged approach to resolve the application backlog. In addition to continuation of the current efforts using donation funds for overtime and temporary staff, KHPA will :

1. Implement system modifications to hasten the application processing. Many of the system enhancements have already been implemented. For example:

   - The system's functionality has been improved by adding keyboard shortcuts, hot keys, and better search capabilities within the system
   - The system was enhanced to enable workers to make multiple month determinations at one time
   - Implementation of a single screen to create cases
   - Elimination of duplicate entry by allowing entry of a case into a single system and transferring it to the eligibility system overnight

2. Adopt CMS approved eligibility policy options to simplify the eligibility determination process:

   - KHPA will be accepting self-declaration of income in additional situations
   - State staff will do minimum verification of the contractor's work prior to authorizing Medicaid eligibility
   - Parents will be allowed to apply for children 18 years of age
   - KHPA and its contractor will perform eligibility determination only for those individuals who request coverage on the application
   - KHPA will initiate in phases the Express Lane eligibility option-targeting food stamp recipients first
   - KHPA will pursue the establishment of access to the SSA electronic verification system to confirm the declaration of citizenship with SSA records in lieu of the current presentation of citizenship documentation
   - KHPA will also utilize a newly developed pre-populated review form for adult beneficiaries seeking to renew their HealthWave eligibility and implement passive review determinations for child beneficiaries renewing their HealthWave eligibility.

   KHPA plans to fully implement these eligibility simplification policies over the next 6 months. These simplifications will help prevent the re-emergence of a backlog in future years.

3. KHPA will continue to seek financial resources from multiple sources to increase application processing capacity. Strategies include seeking private funding from philanthropic foundations, submitting budget enhancement requests to the governor and legislature and seeking a favorable CHIPRA bonus payment decision.

- Children's Health Insurance Reauthorization Act (CHIPRA) Bonus
  The 2009 Children's Health Insurance Program Reauthorization law authorized the payment of a Performance Bonus to states adopting program features that were aimed at simplifying the Medicaid application and enrollment process for children. $72.6 million was appropriated for the performance bonuses. Qualification for a CHIPRA Bonus required states to adopt at least five of eight specified program features and demonstration of an increase in enrollment of children in Medicaid above a baseline. Kansas qualified because we had previously implemented the following eligibility features:
  - Continuous eligibility for 12 months for Title XIX and XXI (January, 1999)
  - Liberalization of Asset for Title XIX and XXI (1988 Medicaid/January, 1999 XXI)
  - Elimination of In-Person Interview for Title XIX and XXI (January, 1999)
  - Use of Same Application/Renewal for Medicaid and CHIP (January, 1999)
  - Presumptive Eligibility for Title XIX and XXI (July, 2006)

  On August 13, 2010 KHPA received an award notice that Kansas had been approved for a CHIP Performance Bonus Payment of $1,220,479. On August 14, 2010 this award was announced at the KHPA Board meeting and that body endorsed the application of those funds to eliminate the backlog at the Clearinghouse. Funding for the Clearinghouse in FY 2012 is not expected to be sufficient to keep up with the high volume of applications. The decision to implement simplification in the eligibility process will improve productivity and lower ongoing costs. KHPA will also include a request in it's FY 2012 budget for any remaining resources necessary to prevent recurrence of an enrollment backlog.

Interim Legislative Budget Committee
August 27, 2010
Major General Tod M. Bunting

Life of a Disaster

- Disaster occurs at the local level
- Local Response
  - Fire
  - EMS
  - Public Safety
  - Public Works
  - County Emergency Operations Center activated
- State agencies respond on own authority*
- City/county resources become over tasked
- County declaration*
- County requests mutual aid resources and pre-disaster contracts
- Mutual aid resources are exhausted
- County requests assistance from the State through Kansas Division of Emergency Management (KDEM)
- KDEM validates need for resource/issues mission assignment
- Governor declaration*
  - Implements the Kansas Response Plan
  - State agencies/private contracts/mutual aid implemented
  - State Emergency Operations Center (SEOC) is activated
- Response to stabilize situation
- Recovery
  - Disaster assessment
  - Implement recovery programs and provide assistance

*can occur anywhere in the process as deemed appropriate

Types of Declarations

1. Federal only
    a. SBA or USDA
2. Emergency
    a. Emergency protective measures/life saving measures
3. Major (usually referred to as a Presidential declaration)
    a. Individual Assistance
    b. Public Assistance
    c. Hazard Mitigation

Federal only

- A specific federal agency
    - USDA or Small Business Administration (SBA)
- Process
    - SBA
        - County identifies 25 homes and/or businesses with more than a 40% uninsured loss
        - County provides list of addresses and validates the address
        - KDEM requests a SBA joint (county/state/SBA) preliminary damage assessment
        - Joint PDA is conducted
        - Governor requests SBA program
        - SBA Administrator approves/denies request
        - If approved, SBA sets up loan workshops and provides assistance to all eligible applicants
    - USDA
        - County Emergency Board (CEB) members advise USDA – Farm Service Agency in Manhattan
        - State Emergency Board Members review "County Flash Reports" submitted by CEB
            - Requires a 40% loss in yield from the previous 3 year period on one crop or one million dollar physical loss (equipment, facilities, livestock); or an economic loss (implement dealer, elevator, etc.)
        - State Emergency Board makes recommendation to the Governor to request USDA for declaration
        - Governor requests USDA declaration
        - USDA collects damage assessments from counties-eligibility is
- Cost share
    - 100% federal loan program

Emergency

- Granted by the President through FEMA
  - Provides supplementary federal emergency assistance to save lives, protect property, public health or safety or to avert the threat of a disaster
    - Usually limited to direct federal assistance and/or emergency debris removal and emergency protective measures
- Cost share
  - 75% federal/25% state

Major – also known as a Presidential declaration

- Individual Assistance
  - Assistance available to individuals, families, and businesses
  - Process
    - State and county conduct a disaster assessment
    - Governor requests a joint preliminary damage assessment to FEMA
    - Joint teams comprised of FEMA, SBA, KDEM, and the county/city assess damage
    - KDEM provides disaster assessment analysis and recommendation to Governor
    - Governor requests a major declaration for Individual Assistance to President through FEMA
      - Specifies impact to state and county/city
      - Identifies areas
      - FEMA Region VII makes recommendation to FEMA HQ
      - FEMA HQ and others review and then submits to President
      - President makes final decision
  - Criteria
    - Number of Disaster Housing Applications – 2,747
    - Number of homes with major/destroyed – 582
    - Dollar amount of uninsured housing loss - $4.6 million
    - Severity, magnitude and impact of the disaster
      - Trauma (death/injuries) and impact on special populations
  - Cost share of Individual & Family Households Assistance – Other Needs Assistance (grants)
    - 75% federal/25% state

- Public Assistance
  - Funding assistance and technical expertise to aid state and local governments and eligible non-profit organizations
  - Assistance available to individuals, families, and businesses
  - Process
    - State and county conduct a disaster assessment
    - Governor requests a joint preliminary damage assessment to FEMA
    - Joint teams comprised of FEMA, Kansas Division of Emergency Management (KDEM), and the county/city assess damage
    - KDEM provides disaster assessment analysis and recommendation to Governor
    - Governor requests a major declaration for Public Assistance to President through FEMA
      - Specifies impact to state and county/city
      - Identifies areas
      - FEMA Region VII makes recommendation to FEMA HQ
      - FEMA HQ and others review and then submits to President
      - President makes final decision
  - Criteria
      - $3.23 per capita per county
      - $1.29 per capita per state
      - Minimum threshold of $1 million in public assistance per disaster
      - Localized impacts
  - Cost share of Public Assistance Program
    - 75% federal/25% non-federal share
      - Historically the non-federal share has been 10% state/15% local

- Hazard Mitigation
  - Efforts to reduce loss of life and property by lessening the impact of disasters
    - Examples
      - Safe rooms in schools
      - Flood buy-outs
      - Upgrading utility systems
  - Criteria
    - Requested in the major declaration for either Public Assistance or Individual Assistance
    - The entire state of Kansas is eligible
  - Eligibility
    - Must have a FEMA approved County Hazard Mitigation Plan
    - Must have a FEMA approved State Hazard Mitigation Plan
  - Cost Share of Hazard Mitigation Program
    - 75% federal/25% non-federal share

Recommendations for distribution if funding falls short:

1. Based on estimated projections, KDEM will need additional funds from the Finance Council in late September-early October 2010.
    a. Work on large projects for permanent work are coming to completion (specifically utility rebuilds).
    b. By law, work should be completed within 18 months of date of disaster. Exceptions may be granted by FEMA for permanent work up to 30 months.
2. KDEM must keep enough funds available to pay the 25% state portion of the augmentee payroll
3. KDEM must reconcile all non-federal payments at the end of disaster closeout which is usually four years from the date of disaster declaration
    a. The following declarations will be approaching the 4 year mark in 2011:
        i. DR1675 – snow storm/ice storm
        ii. DR1699 – Greensburg tornado and Southeast Flooding
        iii. DR1741 – snow storm/ice storm
4. Pay the federal portion to applicants and remit state's share when funding becomes available
5. First priority will be given to:
    a. Greensburg/Kiowa County applicants
    b. Chapman schools
    c. Remainder of disaster applicants less rural electric companies (RECs)
    d. RECs

Declaration Number	Declaration Date	Disaster Type	Declared Counties
1932	08/10/2010	Severe Storms/ Flooding	Atchison, Brown, Butler, Chase, Cheyenne, Clay, Cloud, Comanche, Decatur, Doniphan, Elk, Ellis, Franklin, Greenwood, Harvey, Jackson, Jewell, Kiowa, Lyon, Marion, Marshall, McPherson, Miami, Mitchell, Morris, Norton, Osage, Osborne, Pawnee, Phillips, Pottawatomie, Republic, Riley, Rooks, Rush, Sheridan, Smith, Wabaunsee, Washington, Wilson, Woodson
1885	02/16/2010	Severe Winter Storm and Snow storm	Allen, Anderson, Atchison, Bourbon, Brown, Butler, Cherokee, Cheyenne, Clay, Cowley, Crawford, Decatur, Doniphan, Elk, Franklin, Gove, Graham, Greenwood, Jackson, Jefferson, Jewell, Labette, Linn, Logan, Lyon, Marshall, Miami, Morris, Nemaha, Neosho, Norton, Osage, Phillips, Pottawatomie, Rawlins, Republic, Riley, Shawnee, Sheridan, Wabaunsee, Wallace, Washington, Wilson, Woodson, and Wyandotte
1868	12/23/2009	Severe Winter Storm	Republic, Marshall, Washington
1860	09/30/2009	Severe Storms/Flooding	Anderson, Bourbon, Franklin, Linn, Sedgwick
1849	06/25/2009	Severe Storms/Flooding	Anderson, Barber, Bourbon, Butler, Chase, Cherokee, Coffey, Cowley, Crawford, Elk, Finney, Greenwood, Harper, Harvey, Kingman, Labette, Linn, Lyon, Marion, Marshall, Montgomery, Morris, Neosho, Reno, Rice, Sumner, Wabaunsee, Wilson.
1848	06/24/2009	Winter Storm	Butler, Chase, Chautauqua, Coffey, Cowley, Dickinson, Elk, Grant, Greenwood, Harvey, Lyon, Marion, Morris, Sumner, Woodson Snow Removal: Barber, Barton, Clark, Comanche, Edwards, Grant, Haskell, Kearny, Kingman, Kiowa, McPherson,

Declaration Number	Declaration Date	Disaster Type	Declared Counties
			Meade, Pratt, Reno, Rice, Seward, Stafford, Stanton, Stevens
1808	10/31/2009	Severe Storms/Flooding	Anderson, Butler, Chase, Cowley, Greenwood, Harper, Harvey, Russell, Sumner
1776	07/09/2008	Severe Storms/flooding	Barber, Barton, Bourbon, Brown, Butler, Chautauqua, Cherokee, Clark, Clay, Comanche, Cowley, Crawford, Decatur, Dickinson, Edwards, Elk, Ellis, Ellsworth, Franklin, Gove, Graham, Harper, Haskell, Hodgeman, Jackson, Jewell, Kingman, Kiowa, Lane, Linn, Logan, Mitchell, Montgomery, Ness, Norton, Osborne, Pawnee, Phillips, Pratt, Reno, Republic, Riley, Rooks, Rush, Saline, Seward, Sheridan, Smith, Stafford, Sumner, Thomas, Trego, Wallace, Wilson
1741	01/01/2008	Winter Storm	Atchison, Barber, Barton, Brown, Butler, Chase, Cherokee, Clark, Clay, Cloud, Comanche, Crawford, Dickinson, Doniphan, Edwards, Ellis, Ellsworth, Ford, Geary, Graham, Gove, Harvey, Hodgeman, Jackson, Jefferson, Jewell, Kingman, Kiowa, Labette, Leavenworth, Lincoln, Logan, Lyon, Marion, Marshall, McPherson, Miami, Mitchell, Morris, Nemaha, Osage, Osborne, Ottawa, Pawnee, Phillips, Pottawatomie, Pratt, Reno, Republic, Rice, Riley, Rooks, Rush, Russell, Saline, Sedgwick, Shawnee, Sheridan, Smith, Stafford, Thomas, Wabaunsee, Wallace, Washington, Woodson
1711	07/02/2007	Severe storms/Flooding	Allen, Anderson, Bourbon, Butler, Chautauqua, Cherokee, Coffey, Cowley, Edwards, Elk, Franklin, Greenwood, Harper, Linn, Miami, Montgomery, Neosho, Osage,

Declaration Number	Declaration Date	Disaster Type	Declared Counties
			Pawnee, Wilson, Woodson
1699	06/06/2007	Severe storms/Flooding	Barton, Brown, Chase, Cherokee, Clay Cloud, Comanche, Cowley, Dickinson Doniphan, Douglas, Edwards, Ellsworth, Harper, Harvey, Jackson, Kingman, Kiowa, Leavenworth, Lincoln, Lyon Marshall, McPherson, Morris, Nemaha, Osage, Osborne, Ottawa, Phillips, Pottawatomie, Shawnee, Smith, Stafford, Sumner, Pawnee, Riley, Rice, Reno, Saline, Wabaunsee, Washington
1675	01/07/2007	Winter Storm	Cheyenne, Clark, Comanche, Decatur, Edwards, Ellis, Finney, Ford, Gove, Graham, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Jewell, Kearny, Kiowa, Lane, Logan, Meade, Morton, Ness, Norton, Osborne, Pawnee, Phillips, Rawlins, Rooks, Rush, Russell, Scott, Seward, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Thomas, Trego, Wallace, Wichita Snow removal: Cheyenne, Decatur, Greeley, Logan, Morton, Rawlins, Sherman, Stanton, Thomas, Wallace Wichita.

FY 2011 & FY 2012 Budget - Disaster Funds Required for Federally Declared Disasters - Paid & Pending - SUMMARY

As of: 8/18/2010

Estimated Total State Disaster Match Required:	Total State Match Required	State Amounts Paid To-Date	Estimated State Share Payments Due		Estimated Federal Share Payments Due	Estimated Local Share Payments Due
DISASTERS DECLARED 2007 AND BEYOND						
Disaster 1675 - 2006 SW Kansas Ice Strom - Federally Declared 12-2006						
Estimated Total State Disaster Match Required	$ 32,404,991	$ 29,511,994	$ 2,892,998		$ 21,697,482	$ 4,339,496
Disaster 1699 - 2007 Tornado Greensburg / NE KS Flooding - Federally Declared 5-2007						
Estimated Total State Disaster Match Required	$ 14,563,266	$ 12,671,527	$ 1,891,739		$ 14,188,041	$ 2,837,608
Disaster 1711 - 2007 SE Kansas Flooding - Federally Declared 7-2007						
Estimated Total State Disaster Match Required	$ 4,217,721	$ 3,028,605	$ 1,189,116		$ 8,918,373	$ 1,783,675
Disaster 1741 - December 2007 Ice Storm - Federal Declared 2/2008						
Estimated Total State Disaster Match Required	$ 34,437,347	$ 18,823,350	$ 15,613,997		$ 117,104,974	$ 23,420,995
Disaster 1776 - June 2008 Storms - Federal Declared 7/2008						
Estimated Total State Disaster Match Required	$ 7,514,579	$ 3,546,129	$ 3,968,450		$ 29,763,377	$ 5,952,675
Disaster 1808 - September 2008 Flooding - Federal Declared 10/2008						
Estimated Total State Disaster Match Required	$ 404,539	$ 332,663	$ 71,876		$ 539,071	$ 107,814
Disaster 1848 - March 2009 Winter Storm - Federal Declared 6/2009						
Estimated Total State Disaster Match Required	$ 1,301,766	$ 454,523	$ 847,243		$ 6,354,320	$ 1,270,864
Disaster 1849 - Spring 2009 Flooding - Federal Declared 6/2009						
Estimated Total State Disaster Match Required	$ 1,616,492	$ 1,227,491	$ 389,001		$ 2,917,509	$ 583,502
Disaster 1860 - Severe Storms and Flooding 2009 - Federal Declared 10/2009						
Estimated Total State Disaster Match Required	$ 525,653	$ 198,956	$ 326,697		$ 2,450,225	$ 490,045
Disaster 1868 - Winter Storm 2009 - Federal Declared 12/2009						
Estimated Total State Disaster Match Required	$ 14,183,528	$ 8,537	$ 14,174,991		$ 106,312,431	$ 21,262,486
Disaster 1885 - Holiday Storm 2009 - Federal Declared 3/2010						
Estimated Total State Disaster Match Required	$ 2,746,002	$ 67,317	$ 2,678,685		$ 20,090,139	$ 4,018,028
Disaster 1932 - Spring/Summer 2010 Floods - Federal Declared 8/2010						
Estimated Total State Disaster Match Required	$ 1,222,054	$ -	$ 1,222,054		$ 9,165,407	$ 1,833,081

City of Greensburg Operating Funds - ALSO FEMA #1699						
Estimated Total State Disaster Match Required	$ 2,067,880	$ 2,067,880	$ -		$ -	$ -
...ency Operations Center Taskings						
Estimated Total State Disaster Match Required	$ 2,500	$ 2,500	$ -		$ -	$ -
Direct Federal Assistance Payments Due FEMA #1699 #1711 &#1741						
Estimated Total State Disaster Match Required	$ 98,151	$ 84,103	$ 14,048		$ 42,144	$ -
PA Management Costs - Estimated State Disaster Match						
Estimated Total State Disaster Match Required	$ 1,299,703	$ 52,652	$ 1,247,051		$ -	$ -
Totals	**$ 118,606,172**	**$ 72,078,226**	**$ 46,527,945**		**$ 339,543,492**	**$ 67,900,270**

11-91

CASH ON HAND				State Funds Shortfall	Federal Funds Shortfall	Local Share Remaining
Disaster Match Fund Balances						
ıd 1000-0200	$ 6,177,011					
Fund 2357	$ -					
Total State Disaster Match Funds Balance	$ 6,177,011			$ 40,350,935	$ 296,306,076	$ 58,885,888
Anticipated Timeline of State Disaster Match Payments:						
FY 2011 - Estimated total amount state anticipated to be paid out						
Disaster 1675			$ 2,699,500		$ 20,246,249	$ 4,049,250
Disaster 1699			$ 1,578,172		$ 11,836,290	$ 2,367,258
Disaster 1711			$ 940,946		$ 7,057,095	$ 1,411,419
Disaster 1741			$ 9,033,100		$ 67,748,251	$ 13,549,650
Disaster 1776			$ 2,259,716		$ 16,947,869	$ 3,389,574
Disaster 1808			$ 1,654		$ 12,405	$ 2,481
Disaster 1848			$ 382,992		$ 2,872,441	$ 574,488
Disaster 1849			$ 174,645		$ 1,309,838	$ 261,968
Disaster 1860			$ 156,717		$ 1,175,377	$ 235,075
Disaster 1868			$ 12,819,284		$ 96,144,632	$ 19,228,926
Disaster 1885			$ 2,165,602		$ 16,242,011	$ 3,248,402
Disaster 1932			$ 719,286		$ 5,394,646	$ 1,078,929
City of Greensburg Operations Cost			$ -		$ -	$ -
Emergency Operations Center Taskings			$ -		$ -	$ -
Direct Federal Assistance			$ 14,048		$ 42,144	$ -
PA Management Costs			$ 594,765		$ 1,784,295	$ -
Total			$ 33,540,427		$ 248,813,541	$ 49,397,420
Funds Required for Remainder of SFY 2011				**$ (27,363,416)**	**$ (202,990,514)**	**$ (40,300,089)**
FY 2012 - Estimated total amount state anticipated to be paid out						
Disaster 1675			$ -		$ -	$ -
Disaster 1699			$ -		$ -	$ -
Disaster 1711			$ -		$ -	$ -
Disaster 1741			$ 4,338,412		$ 32,538,088	$ 6,507,618
Disaster 1776			$ 1,354,181		$ 10,156,358	$ 2,031,272
Disaster 1808			$ -		$ -	$ -
Disaster 1848			$ 444,762		$ 3,335,715	$ 667,143
Disaster 1849			$ 113,988		$ 854,910	$ 170,982
Disaster 1860			$ 127,403		$ 955,523	$ 191,105
Disaster 1868			$ 1,290,168		$ 9,676,257	$ 1,935,251
Disaster 1885			$ 169,636		$ 1,272,271	$ 254,454
Disaster 1932			$ -		$ -	$ -
Direct Federal Assistance			$ -		$ -	$ -
PA Management Costs			$ 652,286		$ 1,956,858	$ -
Total			$ 8,490,836		$ 60,745,980	$ 11,757,824
Subtotal of Funds Required for SFY 2012				**$ (8,490,836)**	$ (60,745,980)	$ (11,757,824)
Less: Funds Recommended by the Governor				$ -		
Funds Required for SFY 2012				**$ (8,490,836)**	**$ (60,745,980)**	**$ (11,757,824)**

19-12

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

68-West–Statehouse, 300 SW 10th Ave.
Topeka, Kansas 66612-1504
(785) 296-3181 ♦ FAX (785) 296-3824
kslegres@klrd.ks.gov http://www.kslegislature.org/klrd

August 27, 2010

To: Legislative Budget Committee

From: Amy Deckard, Senior Fiscal Analyst and Reagan Cussimanio, Senior Fiscal Analyst

Re: Medicaid Reimbursement of Attendant Care Services

Effective July 1, 2010, the Kansas Health Policy Authority (KHPA) discontinued reimbursement for attendant care services in schools under the Medicaid School Based Services Program. This change was the result of an interpretation made by the Centers for Medicaid and Medicare Services (CMS) at the federal level. According to CMS, attendant care service payments can no longer be covered in the school setting unless the Kansas Medicaid program also covered those services in non-school settings. According to KHPA, an expansion of attendant care services to non-school settings would cost an additional $25.0 to $30.0 million per year. Attendant care services are still allowed for individuals receiving home and community based waiver services (HCBS). However, CMS does not allow the HCBS waivers to claim for services included in a child's individual education plan (IEP). In addition, waiver attendant care services cannot be provided in an educational setting, used for education, used as a substitute for educationally-related services or used for transition services as outlined in the child's IEP.

KHPA submitted a Medicaid State Plan Amendment in June 2009 to CMS requesting changes to the reimbursement methodology for Local Education Area (LEA) Medicaid expenditures. The federal government and KHPA engaged in a series of communications regarding the submitted amendment. A modified State Plan Amendment was approved in early summer 2010. The modification no longer allows to the reimbursement of attendant care services in schools. Services covered by the Kansas Medicaid Program prior to the amendment include the following:

- Specialized transportation;
- Nursing services;
- Occupational therapy;
- Physical therapy; and
- Speech, language and hearing services.

The State Plan Amendment now allows for reimbursement for services provided by psychologists and social workers, which were not previously covered. Additionally, prior to the change, schools were reimbursed on a set fee-for-services schedule that paid less than the actual cost of services. The amended plan will allow schools at the end of each school year to submit cost reports and be reimbursed for the difference between what they have already received on the fee-for-service schedule and the actual cost of providing services. A potential drawback to the cost report method is the time and additional paperwork that may be required. The reimbursement system with these changes was approved retroactive to July 1, 2009 which will allow school districts to submit claims and be reimbursed for the actual costs they incurred during the 2009-2010 school year.

KHPA estimates a net increase to school districts of approximately $5.0 million, based on FY 2009 information when the increase in potential funding is combined with the loss of funding for attendant care services.

Legislative Budget Committee
Date 8-26/27-2010
Attachment 20

How are services provided?

Services may be provided by a school district or may be contracted out to an association, agency or organization through either a special cooperative an interlocal agreement. Medicaid enrollment is completed by each individual school district even though the cooperative or interlocal manages the program. Payments are made to each school district which then works with the cooperatives and interlocals to distribute funding. If a cooperative or interlocal is listed as a provider, they may receive payments directly.

What are Attendant Care Services?

Attendant Care Services consist of medically necessary services which are provided by a paraprofessional and must be documented in a physician's treatment plan, an individual education plan (IEP) or an individualized family services plan (IFSP). Paraprofessionals provide services such as direct instruction, redirection, guidance and personal care to students. These students commonly have severe mental or physical disabilities and require this service in order to function in an educational setting.

The following charts provide a breakdown of attendant care services in Kansas as a part of Medicaid expenditures for special education in schools for FY 2009 and FY 2010. The data is based on information provided by KHPA.

FY 2009 Medicaid Expenditures for Special Education and Attendant Care Services			
Total Medicaid Expenditures in Schools	Attendant Care Services Expenditures	Attendant Care Percentage Increase/Decrease from FY 2008	Attendant Care as a Percent of Medicaid Expenditures in Schools
$26,201,777	$8,535,402	284.2%	32.6%

FY 2010 Medicaid Expenditures for Special Education and Attendant Care Services			
Total Medicaid Expenditures in Schools	Attendant Care Services Expenditures	Attendant Care Percentage Increase/Decrease from FY 2009	Attendant Care as a Percent of Medicaid Expenditures in Schools
$24,589,976	$9,986,575	17.0%	40.6%

Home and Community Based Services Waiting List

	July 2010	Omnibus 2010	October 2009	Omnibus 2009	Omnibus 2008
Department on Aging					
HCBS/FE	-	-	-	-	-
Senior Care Act	121	152	269	215	146
Deparment of Social and Rehabilitation Services					
HCBS/DD					
Unserved	2,414	2,246	1,863	1,650	1,345
Underserved	1,024	915	985	1,036	730
Total HCBS/ DD	*3,438*	*3,161*	*2,848*	*2,686*	*2,075*
HCBS/PD	2,108	1,975	1,382	552	-
HI/TBI	-	-	-	-	-
TA	-	-	-	-	-
Autism	247	243	275	224	141

Actions by 2010 Legislature regarding Home and Community Based Services Waivers

Department on Aging

Added $1.3 million, including $311,835 from the State General Fund, to fund telehealth services for 500 individuals on the Home and Community Based Services-Frail Elderly waiver program for FY 2011.

Added language specifying that any expansion of the Home and Community Based Services-Frail Elderly waiver program for telehealth services in FY 2011 be distributed geographically statewide. In addition, no funds generated from Senate Substitute for Senate Substitute for Substitute for House Bill 2320, which authorizes an annual, uniform assessment on all skilled nursing facility licensed beds, are allowed to be expended for any telehealth program.

Department of Social and Rehabilitation Services

Added $2.4 million in State General Fund moneys to restore the 10.0 percent Medicaid provider reduction for Home and Community Based Services for individuals with developmental disabilities and deleted the same amount from grants and state aid payments to Community Developmental Disability Organizations in FY 2010. This resulted in the addition of $5.5 million, all from federal funds, in FY 2010 to reflect the amount received in federal matching funds associated with the increased state Medicaid expenditures for the waiver. The 10.0 percent Medicaid provider reduction was included in the Governor's November 2009 allotment and reduced reimbursement rates for most Medicaid providers by 10.0 percent for dates of service from January 1, 2010 to June 30, 2010. The allotment affected the Department of Social and Rehabilitation Services, the Kansas Health Policy Authority, the Department on Aging, and the Juvenile Justice Authority.

Added $10.9 million, including $3.3 million from the State General Fund, for FY 2011 to increase funding for the Home and Community Based Services Waiver for individuals with Developmental Disabilities to ensure all individuals in crisis are able to access waiver services and allow approximately 145 individuals currently not receiving services (on the waiting list) to begin receiving services.

Added $11.9 million, including $3.6 million from the State General Fund, for FY 2011 to increase funding for the Home and Community Based Services Waiver for Individuals with Physical Disabilities, to implement a rolling waiting list policy to provide services for one new individual for every individual who stops receiving services.

Home and Community Based Service Waivers (HCBS) Expenditures from the State General Fund FY 2007 to FY 2011 Approved

	FY 2007	FY 2008	FY 2009	FY 2010 Approved	FY 2011 Approved
Department on Aging					
HCBS/FE	$ 25,123,026	$ 26,246,366	$ 25,151,011	$ 21,214,819	$ 21,554,366
Senior Care Act	2,431,200	3,385,000	3,210,157	2,101,612	1,785,928
Deparment of Social and Rehabilitation Services					
HCBS/DD	98,535,965	109,519,509	97,967,491	$ 88,782,473	87,039,926
HCBS/PD	37,494,203	44,229,044	48,121,139	39,763,397	37,625,608
HI/TBI	3,286,755	3,542,533	3,795,393	2,615,644	2,159,810
TA	71,363	48,919	6,056,066	6,528,145	6,156,119
Autism		6,526	176,132	370,929	366,151
TOTAL	$ 166,942,512	$ 186,977,897	$ 184,477,389	$ 161,377,019	$ 156,687,908

Staff Note: The FMAP rate for Kansas Medicaid programs was increased beginnning October 2008 due to the federal American Recovery and Reinvestment Act of 2008 (ARRA). This increased the federal share and decreased the state portion for Medicaid expenditures.

Home and Community Based Service Waivers (HCBS) Expenditures from all funding sources FY 2000 to FY 2011 Approved

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010 Approved	FY 2011 Approved
Department on Aging												
HCBS/FE	$ 44,748,114	$ 49,527,953	$ 58,223,782	$ 53,529,370	$ 45,069,948	$ 54,125,403	$ 55,706,959	$ 63,264,442	$ 68,765,887	$ 72,096,548	$ 69,772,881	$ 71,735,084
Senior Care Act	2,079,265	2,074,134	7,865,402	6,774,547	6,523,513	6,258,229	6,624,094	6,783,690	7,560,059	7,584,588	6,601,412	6,285,928
Deparment of Social and Rehabilitation Services												
HCBS/DD	170,350,998	175,759,758	189,467,567	194,605,709	204,954,171	217,398,123	221,149,613	248,145,859	279,254,523	293,283,426	$ 306,478,431	315,226,304
HCBS/PD	52,369,330	57,604,827	60,528,414	60,457,651	59,736,010	70,857,648	80,980,683	94,423,948	102,144,039	139,059,707	130,864,410	124,111,645
HI/TBI	4,847,074	3,607,662	3,883,033	4,593,058	5,455,886	5,703,934	3,400,107	8,277,479	6,844,597	10,882,090	11,432,012	11,524,845
TA	125,885	153,178	121,642	166,401	181,244	182,470	112,115	179,712	240,806	18,189,216 *	24,182,778	24,194,773
Autism									744,417	531,301	1,220,762	1,207,786
TOTAL	$ 274,520,666	$ 288,727,512	$ 320,089,840	$ 320,126,736	$ 321,920,772	$ 354,525,807	$ 367,973,571	$ 421,075,130	$ 465,554,328	$ 541,626,876	$ 550,552,686	$ 554,286,365

* In FY 2009, all expenditures for the Attendant Care for Independent Living Program were shifted to the Technology Assistance Waiver.
Staff Note: Prior to FY 2009 numbers also included Targeted Case Management Services.

Kansas Legislative Research Department

August 26, 2010

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attenda Care a Percent Medica
WICHITA PUBLIC SCHOOL 259	$ 1,683,404	$ -	0%	$ 1,659,031	$ -	0%	0%	$ 1,370,297	$ 157,877	0%	11.5%
KANSAS CITY KS PUBLIC SCHOOLS USD #500	1,390,082	-	-	1,458,895	-	-	-	272,449	-	-	-
LAWRENCE USD 497	567,307	380,645	67.1	1,076,708	969,232	154.6	90.0	889,026	704,490	(27.3)	79.2
BLUE VALLEY USD 229	363,894	241,610	66.4	1,245,266	770,092	218.7	61.8	887,778	595,801	(22.6)	67.1
SOUTHEAST KS INTERLOCAL 637	398,337	264,848	66.5	1,582,067	1,143,696	331.8	72.3	55,266	41,319	(96.4)	74.8
CENTRAL KS COOPERATIVE	499,269	131,354	26.3	1,177,467	448,776	241.7	38.1	109,411	42,209	(90.6)	38.6
OLATHE USD #233	150,864	-	-	740,958	3,225	-	0.4	861,115	158,880	4,826.4	18.5
LAKEMARY CENTER INC	39,146	-	-	842,232	770,652	-	91.5	520,467	498,580	(35.3)	95.8
SEDGWICK CO AREA ED SERV 618	516,033	-	-	711,388	-	-	0.0	82,502	-	-	0.0
TOPEKA PUBLIC USD 501	111,765	-	-	522,629	-	-	0.0	665,567	284,136	-	42.7
THREE LAKES EDUCATIONAL COOP	181,424	93,135	51.3	972,122	669,649	619.0	68.9	95,984	74,394	(88.9)	77.5
TRI COUNTY SPEC EDUC #607	262,967	163,390	62.1	748,466	478,172	192.7	63.9	123,112	93,247	(80.5)	75.7
HUTCHINSON PUBLIC SCHOOLS #308	109,478	-	-	477,668	154,278	-	32.3	513,592	214,039	38.7	41.7
USD 500	-	-	-	-	-	-	-	1,051,910	-	-	-
EL DORADO USD #490	367,757	-	-	597,253	1,381	-	-	78,623	36,204	2,521.8	46.0
HAYSVILLE USD # 261	179,339	77,377	43.1	429,430	162,836	110.4	37.9	403,023	161,181	(1.0)	40.0
SO CENTRAL KS SPEC ED COOP	270,254	52,833	19.5	635,886	252,831	378.5	39.8	85,573	25,623	(89.9)	29.9
ANW SPECIAL EDUCATION COOP	327,007	44,541	13.6	501,630	128,172	187.8	25.6	52,876	14,785	(88.5)	28.0
MANHATTAN U S D #383	118,277	55,041	46.5	399,142	134,750	144.8	33.8	319,657	150,695	11.8	47.1
AUBURN WASHBURN USD 437	184,988	38,508	20.8	335,709	143,838	273.5	42.8	282,243	110,106	(23.5)	39.0
EAST CENTRAL KS SPEC EDUC COOP	127,746	-	-	569,360	189,819	-	33.3	64,790	13,417	(92.9)	20.7
GARDEN CITY USD #457	61,507	17,388	28.3	283,297	145,187	735.0	51.2	411,166	267,228	84.1	65.0
USD 305 SALINA	-	-	-	-	-	-	-	741,516	341,912	-	46.1
JUNCTION CITY USD 475	79,938	12,838	16.1	289,531	201,739	1,471.4	69.7	290,109	216,752	7.4	74.7
COWLEY CO SPEC SERV # 465	296,722	-	-	345,918	-	-	-	7,727	-	-	0.0
LEAVENWORTH USD # 453	230,521	-	-	250,493	-	-	-	150,530	-	-	0.0
HIGH PLAINS EDUC COOPERATIVE	76,038	-	-	362,062	158,904	-	43.9	173,932	77,408	(51.3)	44.5
UNIFIED SCHOOL DISTRICT #333	279,026	29,977	10.7	185,405	19,773	(34.0)	10.7	131,542	18,065	(8.6)	13.7
WAMEGO USD 320	170,446	120,030	70.4	367,781	189,545	57.9	51.5	42,164	26,883	(85.8)	63.8
RAINBOWS UNITED INC	159,125	-	-	217,700	-	-	-	202,917	-	-	-
SHAWNEE HEIGHTS USD 450	84,731	30,708	36.2	300,599	89,176	190.4	29.7	186,124	72,348	(18.9)	38.9
DERBY USD 260	74,850	-	-	200,532	-	-	-	284,355	105,064	-	36.9
NORTHWEST KANSAS EDU SERV	296,597	-	-	231,165	-	-	-	15,334	-	-	-
DESOTO USD 232	81,593	40,418	49.5	214,363	130,617	223.2	60.9	216,308	113,232	(13.3)	52.3
KA' SCHOOL FOR THE DEAF	124,656	11,582	9.3	222,563	2,647	(77.1)	1.2	161,371	-	(100.0)	-
SI : MISSION PUBLIC	9,034	-	-	192,705	-	-	-	290,985	-	-	-
HA JO SPECIAL ED COOP	137,086	80,546	58.8	325,497	180,809	124.5	55.5	26,978	19,671	(89.1)	72.9
BROWN CO KS SPECIAL EDUC COOP	140,150	65,366	46.6	249,448	127,849	95.6	51.3	98,715	37,444	(70.7)	37.9
FLINT HILLS SPECIAL ED	83,034	2,155	2.6	369,795	5,178	140.3	1.4	33,331	-	(100.0)	-

Legislative Budget Committee
Date 8-26/27-2010
Attachment 21

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
MAIZE USD #266	-	-	-	-	-	-	-	466,701	304,619	-	65.3
RENO CNTY EDCOOP	60,817	-	-	373,740	95,642	-	25.6	25,132	10,456	(89.1)	41.6
HOLTON USD 336 HOLTON SPECIAL	148,743	-	-	254,673	-	-	-	18,242	-	-	-
BELOIT USD #273	59,983	1,524	2.5	344,396	84,452	5,441.8	24.5	1,193	178	(99.8)	14.9
SOUTHWEST KANSAS AREA COOP 613	228,478	8,814	3.9	155,264	21,885	148.3	14.1	7,542	2,133	(90.3)	28.3
ATCHISON PUBLIC SCHOOL	48,938	34,061	69.6	186,874	118,186	247.0	63.2	155,126	97,135	(17.8)	62.6
TURNER PUBLIC #202	180,175	-	-	143,156	-	-	-	66,858	-	-	-
NORTHEAST KS EDUC SERVICE CTR	92,081	13,046	14.2	252,524	21,347	63.6	8.5	31,567	3,919	(81.6)	12.4
EAST CENTRALKS COOPER ED	134,047	60,415	45.1	198,069	75,162	24.4	37.9	42,226	16,729	(77.7)	39.6
USD 489 HAYS PUBLIC SCHOOLS	167,134	-	-	175,293	-	-	-	21,828	-	-	-
MCPHERSON USD #418	83,809	-	-	273,350	33,790	-	12.4	5,364	2,687	(92.0)	50.1
SEAMAN USD #345	71,661	-	-	152,083	-	-	-	128,884	-	-	-
NORTH CENTRAL KS SPECIAL ED	135,109	-	-	193,433	-	-	-	4,858	-	-	-
FORT LARNED USD #495	90,636	44,373	49.0	188,801	74,142	67.1	39.3	51,210	31,066	(58.1)	60.7
UNIFIED SCHOOL DISTRICT NO 265	-	-	-	-	-	-	-	308,592	213,468	-	69.2
ANDOVER USD 385	-	-	-	-	-	-	-	287,696	138,333	-	48.1
MISSION VALLEY USD #330	62,573	47,717	76.3	59,054	47,913	-	81.1	156,832	128,563	168.3	82.0
COFFEY CO USD 244	86,282	-	-	132,919	-	-	-	40,850	13,616	-	33.3
USD #418 MCPHERSON	-	-	-	-	-	-	-	259,707	134,053	-	51.6
EL DORADO PUBLIC SCHOOLS USD 490	-	-	-	-	-	-	-	255,924	147,578	-	57.7
USD 234 FORTSCOTT	17,637	-	-	119,145	45,823	-	38.5	117,501	65,539	43.0	55.8
USD 434 SANTA FE TRAIL	-	-	-	-	-	-	-	238,809	162,814	-	68.2
GREAT BEND USD 428 BARTON CO	90,029	-	-	129,388	-	-	-	18,620	-	-	-
CLAY CENTER USD 379	36,736	-	-	163,429	-	-	-	29,256	1,633	-	5.6
PITTSBURG USD 250	-	-	-	-	-	-	-	222,627	146,370	-	65.7
SPRING HILL USD #230	15,498	-	-	111,904	17,348	-	15.5	94,725	18,441	6.3	19.5
VALLEY CENTER SCHOOLS USD #262	-	-	-	-	-	-	-	220,824	145,812	-	66.0
KAW VALLEY USD 321	46,824	17,727	37.9	108,212	30,304	70.9	28.0	62,942	21,421	(29.3)	34.0
MULVANE USD 263	16,703	3,754	22.5	96,178	40,900	989.6	42.5	103,850	71,694	75.3	69.0
USD #373 NEWTON	-	-	-	-	-	-	-	215,231	112,158	-	52.1
UNIFIED SCHOOL DISTRICT 405	106,022	-	-	101,796	-	-	-	1,907	-	-	-
GARDNER EDGERTON ANTIOCH 231	12,215	-	-	87,586	-	-	-	83,535	-	-	-
USD 248 GIRARD	-	-	-	-	-	-	-	179,495	153,838	-	85.7
KANSAS SCHOOL FOR THE BLIND	32,665	-	-	81,142	-	-	-	62,437	-	-	-
HOWARD USD 282	30,662	21,611	70.5	125,881	83,631	287.0	66.4	15,278	9,769	(88.3)	63.9
NEMAHA VALLEY USD 442	44,395	6,270	14.1	125,885	12,145	93.7	9.6	-	-	(100.0)	-
UNIFIED SCHOOL DISTRICT 413	-	-	-	-	-	-	-	160,876	52,884	-	32.9
MARION CO SPEC EDUCATION COOP	44,528	-	-	91,601	10,864	-	11.9	20,644	13,569	24.9	65.7
CLEARWATER USD #264	-	-	-	-	-	-	-	154,697	97,427	-	63.0
SUMNER CNTY EDUC SERV USD 619	52,658	-	-	79,614	-	-	-	21,954	20,000	-	91.1

Kansas Legislative Research Department

August 26, 2010

2-3

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
USD # 493 COLUMBUS	-	-	-	-	-	-	-	148,292	135,005	-	91.0
USD 465 WINFIELD	-	-	-	-	-	-	-	137,902	-	-	-
HAYS USD 489	-	-	-	-	-	-	-	134,177	-	-	-
USD #402	-	-	-	-	-	-	-	131,218	47,514	-	36.2
USD # 273 BELOIT	-	-	-	-	-	-	-	129,038	73,677	-	57.1
NICKERSON USD 309	-	-	-	-	-	-	-	121,087	58,865	-	48.6
USD 506 LABETTE COUNTY	-	-	-	6,518	4,639	-	71.2	113,499	76,057	1,539.5	67.0
USD 470 ARKANSAS CITY	-	-	-	-	-	-	-	119,907	-	-	-
PRATT USD 382	-	-	-	-	-	-	-	119,690	70,046	-	58.5
USD 287 WEST FRANKLIN	-	-	-	-	-	-	-	119,591	76,176	-	63.7
EMPORIA USD #253	-	-	-	-	-	-	-	117,984	-	-	-
WELLINGTON PUBLIC SCHOOLS	9,406	-		40,355	-	-	-	67,273	13,614	-	20.2
USD 420 OSAGE CITY	-	-	-	-	-	-	-	114,200	79,839	-	69.9
USD #379 CLAY CENTER	-	-	-	-	-	-	-	113,987	21,604	-	19.0
RUSSELL COUNTY USD 407	9,305	-	-	51,998	11,068	-	21.3	50,142	-	(100.0)	-
HAVEN PUBLIC SCHOOLS USD 312	-	-	-	-	-	-	-	104,810	58,153	-	55.5
SILVER LAKE USD 372	6,333	-	-	59,873	15,864	-	26.5	37,101	12,143	(23.5)	32.7
LIBERAL PUBLIC SCHOOLS USD 480	12,179	-	-	41,897	-	-	-	48,171	-	-	-
KINGMAN NORWICH USD 331	-	-	-	-	-	-	-	100,617	50,772	-	50.5
USD #244 BURLINGTON	-	-	-	-	-	-	-	99,554	57,964	-	58.2
USD 247 CHEROKEE	-	-	-	-	-	-	-	92,827	62,638	-	67.5
IOLA USD 257	-	-	-	-	-	-	-	92,484	19,604	-	21.2
USD 503 PARSONS	-	-	-	-	-	-	-	91,922	55,493	-	60.4
ANTHONY HARPER USD 361	-	-	-	-	-	-	-	90,579	49,141	-	54.3
OTTAWA PUBLIC SCHOOL	25,926	-	-	45,826	-	-	-	17,561	-	-	-
USD # 495 FT LARNED	-	-	-	-	-	-	-	88,821	55,093	-	62.0
BELLE PLAINE SCHOOL DISTRICT USD 357	-	-	-	-	-	-	-	85,422	29,817	-	34.9
USD 435 ABILENE	-	-	-	-	-	-	-	85,402	38,483	-	45.1
EUREKA USD 389	21,616	7,794	36.1	35,813	17,472	124.2	48.8	27,809	10,225	(41.5)	36.8
USD 446 INDEPENDENCE	-	-	-	-	-	-	-	83,507	24,784	-	29.7
DODGE CITY PUBLIC SCHOOLS USD 443	-	-	-	-	-	-	-	83,241	28,589	-	34.3
USD 415 HIAWATHA	-	-	-	-	-	-	-	82,518	46,688	-	56.6
UNIFIED SCHOOL DISTRICT NO 356	-	-	-	-	-	-	-	82,459	62,989	-	76.4
USD 320 WAMEGO	-	-	-	-	-	-	-	79,617	50,478	-	63.4
GF REND PUBLIC SCHOOLS USD 428	-	-	-	-	-	-	-	78,624	-	-	-
U COFFEYVILLE	-	-	-	-	-	-	-	78,555	28,400	-	36.2
FL S UNLIMITED, INC	20,952	-	-	25,972	-	-	-	31,615	2,153	-	6.8
USD 367 OSAWATOMIE	-	-	-	-	-	-	-	78,232	22,072	-	28.2
USD # 456 MARAIS DES CYGNES VALLEY	-	-	-	-	-	-	-	74,463	58,050	-	78.0
USD #329 MILL CREEK VALLEY	-	-	-	-	-	-	-	73,353	42,214	-	57.5

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
USD 508 BAXTER SPRINGS	-	-	-	-	-	-	-	72,437	52,397	-	72.3
GARNETT USD 365	-	-	-	-	-	-	-	71,393	44,740	-	62.7
ROYAL VALLEY USD 337	11,662	112	1.0	32,613	-	(100.0)	-	24,131	-	-	-
CHENEY USD 268	-	-	-	-	-	-	-	68,100	47,598	-	69.9
DONIPHAN COUNTY ED	38,672	-	-	25,541	-	-	-	2,955	-	-	-
USD #404 RIVERTON	-	-	-	-	-	-	-	66,564	54,842	-	82.4
USD 108 WASHINGTON COUNTY SCHOOLS	-	-	-	-	-	-	-	62,710	46,225	-	73.7
CHETOPA ST PAUL USD 505	-	-	-	-	-	-	-	62,549	30,610	-	48.9
MARSHALL CNTY SPEC ED #364	24,459	-	-	37,819	-	-	-	-	-	-	-
USD #107 ROCK HILLS	-	-	-	-	-	-	-	61,293	37,111	-	60.5
USD #336 HOLTON	-	-	-	-	-	-	-	59,997	-	-	-
USD 327 ELLSWORTH	-	-	-	-	-	-	-	59,412	30,530	-	51.4
USD 214 ULYSSES SCHOOLS	-	-	-	-	-	-	-	59,043	31,934	-	54.1
USD 286 CHAUTAUQUA CO COMMUNITY	-	-	-	-	-	-	-	58,986	43,479	-	73.7
GOODLAND USD 352	-	-	-	-	-	-	-	57,785	-	-	-
ROCK CREEK USD 323	-	-	-	-	-	-	-	57,778	23,866	-	41.3
ROSE HILL UNIFIED SCHOOL DISTRICT 394	-	-	-	-	-	-	-	57,281	5,811	-	10.1
COUNTY OF BUTLER UNIFIED SCHOOL DISTRICT	-	-	-	-	-	-	-	56,157	37,890	-	67.5
LYONS USD 405	-	-	-	-	-	-	-	55,393	-	-	-
BONNER SPRINGS SCHOOL DISTRICT USD #204	-	-	-	-	-	-	-	54,860	-	-	-
USD #368 PAOLA	-	-	-	-	-	-	-	53,896	21,484	-	39.9
GALENA USD 499	-	-	-	-	-	-	-	53,336	37,740	-	70.8
DURHAM HILLSBORO LEHIGH USD 410	-	-	-	-	-	-	-	52,247	25,772	-	49.3
USD 337 ROYAL VALLEY	-	-	-	-	-	-	-	50,271	-	-	0.0
USD 240 TWIN VALLEY	-	-	-	-	-	-	-	49,451	30,517	-	61.7
RENWICK USD 267	-	-	-	-	-	-	-	48,778	28,019	-	57.4
OXFORD UNIFIED SCHOOL DISTRICT USD 358	-	-	-	-	-	-	-	48,117	27,067	-	56.3
EUDORA USD 491	-	-	-	-	-	-	-	48,071	25,404	-	52.8
WOODSON SCHOOL DISTRICT 366	-	-	-	-	-	-	-	47,887	9,849	-	20.6
USD 363 HOLCOMB SCHOOLS	-	-	-	-	-	-	-	47,782	25,621	-	53.6
USD 454 BURLINGAME PUBLIC SCHOOLS	-	-	-	-	-	-	-	47,768	31,913	-	66.8
USD362 PRAIRIE VIEW	-	-	-	-	-	-	-	47,174	16,331	-	34.6
USD #272 WACONDA	-	-	-	-	-	-	-	45,917	18,545	-	40.4
BUHLER USD 313	-	-	-	-	-	-	-	43,359	4,531	-	10.4
USD # 340 JEFFERSON WEST	-	-	-	-	-	-	-	43,210	11,216	-	26.0
USD 430 SOUTH BROWN COUNTY	-	-	-	-	-	-	-	41,330	10,140	-	24.5
USD 348 BALDWIN CITY	-	-	-	-	-	-	-	41,152	12,167	-	29.6
MARION UNIFIED SCHOOL DISTRICT 408	-	-	-	-	-	-	-	39,725	25,335	-	63.8
USD 393 SOLOMON	-	-	-	-	-	-	-	39,598	10,108	-	25.5
USD #298 LINCOLN	-	-	-	-	-	-	-	37,441	21,783	-	58.2

Kansas Legislative Research Department

August 26, 2010

25-1-28

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
COLBY USD 315	-	-	-	-	-	-	-	36,947	-	-	-
USD 283 ELK VALLEY	-	-	-	-	-	-	-	36,604	28,197	-	77.0
USD 239 NORTH OTTAWA CO	-	-	-	-	-	-	-	35,486	12,230	-	34.5
ERIE GALESBURG USD 101	-	-	-	-	-	-	-	35,387	8,638	-	24.4
REPUBLIC COUNTY UNIFIED SCHOOL	-	-	-	-	-	-	-	35,263	-	-	-
USD 375 CIRCLE	-	-	-	-	-	-	-	34,437	1,151	-	3.3
BLUESTEM USD 205	-	-	-	-	-	-	-	34,410	14,507	-	42.2
BARBER CO NORTH USD 254	-	-	-	-	-	-	-	34,407	10,789	-	31.4
SEDGWICK PUBLIC SCHOOLS USD 439	-	-	-	-	-	-	-	34,279	12,991	-	37.9
USD 328 LORRAINE	-	-	-	-	-	-	-	34,211	24,522	-	71.7
USD 218 ELKHART SCHOOLS	-	-	-	-	-	-	-	33,327	9,642	-	28.9
OSWEGO USD 504	-	-	-	-	-	-	-	32,669	15,325	-	46.9
USD 466 SCOTT COUNTY SCHOOLS	-	-	-	-	-	-	-	32,253	10,203	-	31.6
FAIRFIELD USD 310	-	-	-	-	-	-	-	32,156	18,304	-	56.9
USD 271 STOCKTON	-	-	-	-	-	-	-	32,123	-	-	-
USD 210 HUGOTON SCHOOLS	-	-	-	-	-	-	-	31,994	12,516	-	39.1
USD 441 SABETHA	-	-	-	-	-	-	-	31,437	-	-	-
USD 461 NEODESHA	-	-	-	-	-	-	-	31,318	19,684	-	62.9
USD 473 CHAPMAN	-	-	-	-	-	-	-	30,803	9,953	-	32.3
USD 270 PLAINVILLE	-	-	-	-	-	-	-	30,613	-	-	-
USD 289 WELLSVILLE	-	-	-	-	-	-	-	30,379	15,969	-	52.6
CENTRE UNIFIED SCHOOL DISTRICT #397	-	-	-	-	-	-	-	30,167	18,216	-	60.4
COMANCHE COUNTY USD 300	-	-	-	-	-	-	-	29,991	14,198	-	47.3
TONGANOXIE USD #464	-	-	-	-	-	-	-	29,205	-	-	-
USD 447 CHERRYVALE	-	-	-	-	-	-	-	28,678	22,774	-	79.4
USD 421 LYNDON	-	-	-	-	-	-	-	28,432	17,430	-	61.3
USD 400 SMOKY VALLEY	-	-	-	-	-	-	-	28,174	4,839	-	17.2
GRAHAM COUNTY USD 281	-	-	-	-	-	-	-	27,899	-	-	-
USD249 FRONTENAC PUBLIC SCHOOLS	-	-	-	-	-	-	-	27,053	16,172	-	59.8
OAKLEY USD 274	-	-	-	-	-	-	-	26,410	-	-	-
LANSING USD # 469	-	-	-	-	-	-	-	26,391	-	-	-
USD 440 HALSTEAD	-	-	-	-	-	-	-	26,115	12,154	-	46.5
USD 255	-	-	-	-	-	-	-	25,880	18,052	-	69.8
USD 398 PEABODY BURNS	-	-	-	-	-	-	-	25,186	4,494	-	17.8
H[illegible]DT USD 258	-	-	-	-	-	-	-	24,945	140	-	0.6
C[illegible]SD 479	-	-	-	-	-	-	-	24,524	13,724	-	56.0
US[illegible]34 MARYSVILLE	-	-	-	-	-	-	-	24,275	-	-	-
USD # 343 PERRY PUBLIC SCHOOLS	-	-	-	-	-	-	-	24,086	-	-	-
USD 347 KINSLEY OFFERLE	-	-	-	-	-	-	-	23,924	10,651	-	44.5
USD 288 CENTRAL HEIGHTS	-	-	-	-	-	-	-	23,446	7,917	-	33.8

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
BURRTON SCHOOL DISTRICT USD 369	-	-	-	-	-	-	-	22,887	13,577	-	59.3
USD 378 RILEY COUNTY	-	-	-	-	-	-	-	22,201	6,281	-	28.3
USD 282 WEST ELK	-	-	-	-	-	-	-	22,072	16,381	-	74.2
STERLING USD 376	-	-	-	-	-	-	-	21,793	-	-	-
USD 484 FREDONIA	-	-	-	-	-	-	-	21,627	9,353	-	43.2
USD 392 OSBORNE COUNTY SCHOOLS	-	-	-	-	-	-	-	21,572	-	-	-
USD 487 HERINGTON	-	-	-	-	-	-	-	21,379	10,741	-	50.2
USD # 342 MCLOUTH	-	-	-	-	-	-	-	20,828	-	-	-
ALTOONA MIDWAY USD 387	-	-	-	-	-	-	-	20,767	11,465	-	55.2
USD 246 NORTHEAST	-	-	-	-	-	-	-	20,454	1,837	-	9.0
USD 243 LEBO WAVERLY	-	-	-	-	-	-	-	19,770	7,367	-	37.3
FORT LEAVENWORTH USD 207	-	-	-	-	-	-	-	19,527	-	-	-
USD 335 NORTH JACKSON	-	-	-	-	-	-	-	18,990	-	-	-
USD 481 RURAL VISTA	-	-	-	-	-	-	-	18,359	8,756	-	47.7
USD # 341 OSKALOOSA PUBLIC SCHOOLS	-	-	-	-	-	-	-	17,995	-	-	-
USD 110 THUNDER RIDGE SCHOOLS	-	-	-	-	-	-	-	17,983	-	-	-
ST JOHN HUDSON USD 350	-	-	-	-	-	-	-	17,764	9,237	-	52.0
USD 322 ONAGA HAVENSVILLE WHEATON	-	-	-	-	-	-	-	17,031	-	-	-
USD 215 LAKIN SCHOOLS	-	-	-	-	-	-	-	16,835	4,426	-	26.3
USD 346 JAYHAWK	-	-	-	-	-	-	-	16,356	722	-	4.4
USD # 339 JEFFERSON COUNTY NORTH	-	-	-	-	-	-	-	16,218	-	-	-
USD 237 SMITH CENTER	-	-	-	-	-	-	-	15,486	-	-	-
USD #438 SKYLINE PUBLIC SCHOOL	-	-	-	-	-	-	-	15,280	10,665	-	69.8
MARMATON VALLEY USD #256	-	-	-	-	-	-	-	15,066	-	-	-
USD 452 STANTON COUNTY SCHOOLS	-	-	-	-	-	-	-	15,003	11,465	-	76.4
USD 344 PLEASANTON	-	-	-	-	-	-	-	14,641	4,710	-	32.2
USD #349 STAFFORD SCHOOL DISTRICT	-	-	-	-	-	-	-	14,496	-	-	-
USD 217 ROLLA PUBLIC SCHOOLS	-	-	-	-	-	-	-	14,496	10,789	-	74.4
CHASE COUNTY USD 284	-	-	-	-	-	-	-	14,370	-	-	-
USD 211 NORTON COMMUNITY SCHOOLS	-	-	-	-	-	-	-	14,280	-	-	-
BASEHOR LINWOOD USD #458	-	-	-	-	-	-	-	13,548	-	-	-
OBERLIN USD 294	-	-	-	-	-	-	-	13,340	-	-	-
USD 419 CANTON GALVA	-	-	-	-	-	-	-	13,148	5,489	-	41.7
USD #498 VALLEY HEIGHTS	-	-	-	-	-	-	-	13,113	-	-	-
USD 306 SOUTHEAST OF SALINA	-	-	-	-	-	-	-	13,078	1,950	-	14.9
USD #252 SOUTHERN LYON COUNTY	-	-	-	-	-	-	-	12,021	-	-	-
ARGONIA SCHOOL DISTRICT USD 359	-	-	-	-	-	-	-	11,726	3,105	-	26.5
MORRIS COUNTY USD 417	-	-	-	-	-	-	-	11,677	-	-	-
USD 228 HANSTON	-	-	-	-	-	-	-	11,667	9,619	-	82.4
USD 326 LOGAN	-	-	-	-	-	-	-	11,575	-	-	-

Kansas Legislative Research Department

August 26, 2010

7-1-8

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
USD 431 HOISINGTON PUBLIC SCHOOLS	-	-	-	-	-	-	-	11,464	-	-	-
GOESSEL USD 411	-	-	-	-	-	-	-	11,162	7,897	-	70.8
TREGO USD 208	-	-	-	-	-	-	-	11,088	-	-	-
NEMAHA VALLEY SCHOOLS USD 442	-	-	-	-	-	-	-	11,069	2,298	-	20.8
USD 467 WICHITA COUNTY SCHOOLS	-	-	-	-	-	-	-	10,905	4,012	-	36.8
USD 325 PHILLIPSBURG	-	-	-	-	-	-	-	10,881	-	-	-
DOUGLASS PUBLIC SCHOOLS USD 396	-	-	-	-	-	-	-	10,479	-	-	-
ELLIS USD 388	-	-	-	-	-	-	-	10,403	-	-	-
LITTLE RIVER USD 444	-	-	-	-	-	-	-	10,255	-	-	-
USD 494 SYRACUSE SCHOOLS	-	-	-	-	-	-	-	10,141	7,014	-	69.2
USD 463 UDALL	-	-	-	-	-	-	-	9,835	-	-	-
USD #111 DONIPHAN WEST	-	-	-	-	-	-	-	9,605	-	-	-
USD 285 CEDAR VALE	-	-	-	-	-	-	-	9,488	-	-	-
USD 462 CENTRAL	-	-	-	-	-	-	-	8,783	-	-	-
USD 416 LOUISBURG	-	-	-	-	-	-	-	8,634	-	-	-
FLINTHILLS USD 492	-	-	-	-	-	-	-	8,466	-	-	-
UNIONTOWN USD 235	-	-	-	-	-	-	-	8,212	-	-	-
USD 448 INMAN	-	-	-	-	-	-	-	8,159	761	-	9.3
CALDWELL SCHOOL DISTRICT USD 360	-	-	-	-	-	-	-	8,097	1,827	-	22.6
USD #251 NORTH LYON CO. SCHOOL DISTRICT	-	-	-	-	-	-	-	8,075	-	-	-
USD # 338 VALLEY FALLS	-	-	-	-	-	-	-	8,050	-	-	-
GOLDEN PLAINS USD 316	-	-	-	-	-	-	-	8,002	-	-	-
USD 307 ELL SALINE	-	-	-	-	-	-	-	7,753	948	-	12.2
USD 216 DEERFIELD SCHOOLS	-	-	-	-	-	-	-	7,680	559	-	7.3
USD 245 LEROY GRIDLEY	-	-	-	-	-	-	-	7,659	4,280	-	55.9
USD 436 CANEY VALLEY	-	-	-	-	-	-	-	7,299	-	-	-
ELLINWOOD PUBLIC SCHOOLS USD 355	-	-	-	-	-	-	-	7,269	-	-	-
UNIFIED SCHOOL DISTRICT 459	-	-	-	-	-	-	-	7,208	-	-	-
USD 384 BLUE VALLEY	-	-	-	-	-	-	-	7,141	-	-	-
MADISON VIRGIL UNIFIED SCHOOL DISTRICT 386	-	-	-	-	-	-	-	7,114	-	-	-
USD # 377 ATCHISON CO. COMMUNITY SCHOOLS	-	-	-	-	-	-	-	6,997	-	-	-
NORTHERN VALLEY USD # 212	-	-	-	-	-	-	-	6,650	-	-	-
QUINTER USD 293	-	-	-	-	-	-	-	6,502	-	-	-
PARADISE UNIFIED SCHOOL DISTRICT #399	-	-	-	-	-	-	-	6,008	-	-	-
E USD #449	-	-	-	-	-	-	-	5,922	-	-	-
F D# 203	-	-	-	-	-	-	-	5,796	-	-	-
US. , DEXTER	-	-	-	-	-	-	-	5,779	-	-	-
USD #429 TROY	-	-	-	-	-	-	-	5,757	-	-	-
RAWLINS COUNTY USD 105	-	-	-	-	-	-	-	5,718	-	-	-
UNIFIED DISTRICT NO 390	-	-	-	-	-	-	-	5,581	-	-	-

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
ATTICA PUBLIC SCHOOLS USD #511	-	-	-	-	-	-	-	5,532	722	-	13.0
USD 269 PALCO	-	-	-	-	-	-	-	5,423	-	-	-
USD 507 SATANTA SCHOOLS	-	-	-	-	-	-	-	5,419	-	-	-
HAVILAND USD 474	-	-	-	-	-	-	-	5,373	-	-	-
USD 380 VERMILLION	-	-	-	-	-	-	-	5,252	-	-	-
DIGHTON USD #482	-	-	-	-	-	-	-	5,212	-	-	-
USD 334 SOUTHERN CLOUD	-	-	-	-	-	-	-	5,040	-	-	-
HOXIE COMMUNITY SCHOOLS USD 412	-	-	-	-	-	-	-	5,024	-	-	-
LA CROSSE USD 395	-	-	-	-	-	-	-	4,769	-	-	-
USD 303 NESS CITY	-	-	-	-	-	-	-	4,650	-	-	-
USD 224 CLIFTON CLYDE	-	-	-	-	-	-	-	4,610	-	-	-
HEALY USD 468	-	-	-	-	-	-	-	4,311	-	-	-
USD 332 CUNNINGHAM	-	-	-	-	-	-	-	4,082	905	-	22.2
USD #299 SYLVAN GROVE	-	-	-	-	-	-	-	3,994	-	-	-
WHEATLAND USD 292	-	-	-	-	-	-	-	3,927	-	-	-
USD 351 MACKSVILLE	-	-	-	-	-	-	-	3,704	-	-	-
PIKE VALLEY USD 426	-	-	-	-	-	-	-	3,688	-	-	-
USD 227 JETMORE	-	-	-	-	-	-	-	3,324	-	-	-
SOUTH HAVEN SCHOOL DISTRICT USD 509	-	-	-	-	-	-	-	3,274	-	-	-
MINNEOLA SCHOOLS USD# 219	-	-	-	-	-	-	-	3,230	-	-	-
MEADE USD 226	-	-	-	-	-	-	-	3,154	-	-	-
USD #381	-	-	-	-	-	-	-	3,152	-	-	-
USD 422 GREENSBURG	-	-	-	-	-	-	-	3,117	-	-	-
USD 423 MOUNDRIDGE	-	-	-	-	-	-	-	3,055	-	-	-
PRETTY PRAIRIE USD 311	-	-	-	-	-	-	-	3,042	-	-	-
USD 401 CHASE RAYMOND	-	-	-	-	-	-	-	3,002	-	-	-
USD #354 CLAFLIN	-	-	-	-	-	-	-	2,774	-	-	-
USD # 486	-	-	-	-	-	-	-	2,630	-	-	-
USD 223 BARNES	-	-	-	-	-	-	-	2,630	-	-	-
USD 403 ODTIS BISON PUBLIC SCHOOLS	-	-	-	-	-	-	-	2,585	-	-	-
BREWSTER USD 314	-	-	-	-	-	-	-	2,574	-	-	-
USD 200 GREELEY COUNTY SCHOOLS	-	-	-	-	-	-	-	2,420	760	-	31.4
TRIPLAINS USD 275	-	-	-	-	-	-	-	2,406	-	-	-
USD 476 COPELAND SCHOOLS	-	-	-	-	-	-	-	2,336	-	-	-
USD # 106 WESTERN PLAINS	-	-	-	-	-	-	-	2,161	-	-	-
WALLACE COUNTY SCHOOLS USD 241	-	-	-	-	-	-	-	1,812	-	-	-
ST FRANCIS COMMUNITY SCHOOLS USD 297	-	-	-	-	-	-	-	1,746	-	-	-
USD 460 HESSTON	-	-	-	-	-	-	-	1,519	1,471	-	96.9
USD 209 MOSCOW SCHOOLS	-	-	-	-	-	-	-	1,409	-	-	-
CHEYLIN USD 103	-	-	-	-	-	-	-	1,396	-	-	-

Kansas Legislative Research Department

August 26, 2010

9-1-2

Total Medicaid Expenditures for Special Education and Attendant Care by School District

FY 2008, 2009, and 2010

Provider	Total Medicaid FY 2008	Attendant Care Expenditure FY 2008	Attendant Care as Percent of Medicaid	Total Medicaid FY 2009	Attendant Care Expenditure FY 2009	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid	Total Medicaid FY 2010	Attendant Care Expenditure FY 2010	Attendant Care Percentage Increase/ Decrease	Attendant Care as Percent of Medicaid
USD 371 MONTEZUMA SCHOOLS	-	-	-	-	-	-	-	1,326	-	-	-
USD 102 CIMARRON ENSIGN	-	-	-	-	-	-	-	1,301	-	-	-
USD 496 PAWNEE HEIGHTS	-	-	-	-	-	-	-	1,239	-	-	-
USD # 432 VICTORIA	-	-	-	-	-	-	-	1,209	-	-	-
GRINNELL USD 291	-	-	-	-	-	-	-	1,201	-	-	-
UNIFIED SCHOOL DISTRICT NO 483 SW HT	-	-	-	-	-	-	-	972	-	-	-
USD 374 SUBLETTE SCHOOLS	-	-	-	-	-	-	-	959	-	-	-
WESKAN USD 242	-	-	-	-	-	-	-	907	-	-	-
USD #406 WATHENA	-	-	-	-	-	-	-	613	-	-	-
INGALLS USD #477	-	-	-	-	-	-	-	212	-	-	-
Grand Total	**$12,611,936**	**$ 2,221,507**	**1761.4%**	**$ 26,201,777**	**$ 8,535,402**	**284%**	**32.6%**	**$ 24,589,976**	**$ 9,986,575**	**17.0%**	**40.6%**

Lawrence Public Schools
110 McDonald Drive
Lawrence, Kansas 66044-1063
Telephone: (785) 832-5000

LAWRENCE
PUBLIC SCHOOLS

August 27, 2010

Legislative Budget Committee
Re: Changes to Medicaid Reimbursement Guidelines
Frank Harwood, Chief Operations Officer – Lawrence Public Schools
Shelia Smith, Assistant Director of Special Education – Lawrence Public Schools

On June 17th the Kansas Health Policy Authority (KHPA) announced that school districts would no longer be eligible for Medicaid reimbursement for attendant care services they provide. This announcement was in response to an interpretation made by the Centers for Medicaid and Medicare Services (CMS) at the federal level. This interpretation from CMS indicated that schools could not be allowed to be reimbursed for attendant care if other agencies were not eligible for similar reimbursement. Although this has been the practice in Kansas for many years, this announcement was made without warning in June to become effective July 1, 2010. This means that with less than a month to plan, schools were faced with changes to revenues available to provide services that are mandated by state and federal regulations.

The passage of Public Law 94-142 in the 1970's was the beginning of special education in public schools. With this change and the continued reduction in services from other agencies, the make-up of our student body has changed. As it should be, participation in public education is a right afforded by the Constitution of the State of Kansas. In order to help these, our most fragile, students be as successful as possible, attendant care services are required. All public schools will continue to provide the attendant care that is needed. These services are part of IEP's that cannot and should not be changed just because schools will no longer be reimbursed through Medicaid. Our parents and students should understand that we will continue to provide a Free and Appropriate Education. That means that funding to provide these services will have to be redirected from other programs.

Last year Lawrence Public Schools billed Medicaid for 502 students who received eligible services. Of these students, 149 received attendant care services averaging 294 hours per day or just less than two hours per day per eligible student. Attendant Care services refer to the assistance received by students with disabilities for undertaking the full range of everyday tasks that non-disabled students do for themselves. In a school setting, attendant care services may encompass assistance with toileting; dressing and hygiene; feeding assistance and tube feeding; and assistance with mobility, which might include transferring a student from a wheelchair to

another seat or assisting a student who uses a walker. Attendant care services may vary from a few minutes a day to hours a day, depending upon the needs of a student. Often times, children with severe physical or mental disabilities require attendant care services just to be able to attend school.

Take as an example a second grade student who moved into one of our schools last year from out of state. "Sarah" is a happy student who likes to attend school and be with peers. She is well liked by peers and has many friends. Sarah also has severe multiple disabilities, including visual and physical impairments, mental retardation, and medical needs. She is nonverbal and nonambulatory. Sarah has attendant care services throughout her entire school day. The moment she arrives at school, an adult assists her off of the bus and helps her take her coat off. Sarah has a g-tube and receives all of her feedings (water, juice, formula and liquid medications) through this g-tube. Due to a movement disorder, in which Sarah is likely to pull her g-tube out, two adults are required to assist with every tube feeding. These feedings are required five times each day. An adult is also required to safely manipulate her wheelchair throughout the day. Sarah requires a two-person lift when transferred in and out of her wheelchair for activities, required daily exercises, sitting, bathrooming, etc. Sarah has five to seven restroom breaks each day, in which two adults must lift her out of her wheelchair to a changing table. Due to one of her medical diagnoses, Sarah requires assisted daily exercise to work on range of motion and prone sitting.

The cost of attendant care services to Lawrence Public schools was approximately $730,000 in fiscal year 2010. During the same time frame we received $450,000 in Medicaid reimbursement for these services. Based on discussions between the Kansas Association of Special Education Administrators (KASEA) liaison committee and KHPA, it appears that some of the lost Medicaid funding could be made available to schools in fiscal year 2011as part of new funding guidelines. KHPA has provided a template to calculate hypothetical Medicaid funding, the actual formula that will be used is to our knowledge still under consideration and will be made available at a later date. The template provided will mean that less of our reimbursement will be based on actual services but adds money to the Medicaid Settlement. Because 70% of Lawrence's Medicaid reimbursement is from attendant care, it would appear that the new formula will result in a net reduction in our Medicaid funding. Using the template from KHPA and our best guesses on interpreting its use, we think we will see a reduction of $350,000 in our Medicaid funding. This will mean that where as in the past we could expect to be reimbursed for 60% of the cost of providing these vital services, it is possible that the new formula would result in funding of 6% of these services going forward. Until all of the regulations are finalized and the mechanism for billing is defined, there is no way for districts to budget for fiscal year 2011 revenues even though we are now almost two full months into the fiscal year. It is also nearly assured that most districts will not receive the same amount of Medicaid reimbursement under the new formula that they may have expected under last year's rules. It is imperative, as we

move forward, that all agencies work together to find stable equitable funding to provide services that our students need to receive the most benefit from public education.

Since we will continue to provide the attendant care services that are needed by our students, we will have to allocate other funds to cover the expenditure. For the first year we will be able to use unencumbered cash reserves. It is for circumstances like these that it is so important for districts to maintain healthy reserves. However for subsequent years we will have to shift funds within the budget. During the 2010 fiscal year, Lawrence Public Schools transferred $6.75 million from the general and supplemental general fund to the special education fund, this is in addition to any state or federal funds including Medicaid. Since most special education services are mandated or provided as part of a student's IEP, the reduction in Medicaid reimbursement will mean that this transfer will need to be increased. Subsequently fewer general fund resources will be available for other educational programs. All of this comes on the heels of two fiscal years that have seen our general fund budget cut $7.1 million. With the loss of AARA dollars for the state's general fund, the state will have to make up $180 million in fiscal year 2012 in order to avoid additional cuts to K-12 funding. This assumes that the state's revenues keep up with projections, which looks unlikely at this point. Unless the economy rebounds significantly or the state finds a way to fill the hole left by the end of AARA funding, Lawrence Public Schools will have to brace for another very painful round of budget cutting which would be exacerbated by reductions in Medicaid reimbursement.

At this point it is still a guessing game as to the effect of no longer getting reimbursement for attendant care services. What we do know is that students who need these services to benefit from public education will continue to come to our schools and we will continue to do what we can to help them make the most of their time in Lawrence Public Schools.

Thank you for this opportunity to address the Legislative Budget Committee.

For educators, this is the greatest time of year! Students and teachers are back in school with much excitement and great expectations. Those feelings have not changed significantly over the years; however, what has changed since the early 1990s are some of the students served in our public schools. In the 90s, the Legislature made the correct decision to shut down institutions and to begin serving children with significant physical, cognitive and emotional disabilities in their home schools and communities. These children, the kids who would have previously been served at KNI or state hospitals, are now in our schools. These most fragile learners require constant and direct care to be able to attend school. These are the services that Medicaid calls attendant care.

Since 1994, schools have been allowed to access Medicaid funds to provide these necessary services. With little warning, these funds disappeared on July 1, 2010.

This change was a result of KHPA submitting the State plan amendment to the Center for Medicaid Services (CMS), so the state could access cost-based reimbursement. Unfortunately, everyone was shocked when CMS made their surprise ruling that eliminated attendant care reimbursement to schools unless it was made available to all service providers.

KHPA had two choices—eliminate attendant care reimbursement to schools which caused an unexpected loss of approximately $10 million or to petition the Legislature in difficult budget times and ask for additional funds. The school districts wish it would have been the latter, but it was not. The impact upon districts in the State varies from a range of 30-70% loss in Medicaid funds.

As Director of Special Education for the Topeka Public School District for just the last eight weeks, I am doing my best to learn about our Medicaid history. Under the bundled rate formula, Topeka Public Schools at one time generated over $2 million in Medicaid revenue. After the state changed to fee for service, it took our district some time to ramp up. However, I discovered that Topeka is improving each year. Year one, we put the structural processes in place, adopted computerized IEPs, and changed billing agents. Year two, we focused on fee for service billing for our related services. During the 2009-2010 school year, Topeka Public Schools added billing for attendant care services on 65 Medicaid eligible students. Because of the loss of attendant care billing, Topeka Public Schools is now estimated to lose 46% of our Medicaid revenue. Even though we may be able to access additional funds for some new services, it is not possible to calculate how much of the $287,000 loss can be regained.

It is important to know that 65 children with the highest medical and behavioral needs will NOT lose their attendant care services. These children still require such services as tube feedings, toileting, wheelchair assistance, and direct behavioral support. Such mandated IEP services are the only way these children can access and remain in public education. Unfortunately, with such short notice, this loss in revenue will further deplete our already shrinking general funds. In difficult financial times, it is important to understand that schools lost a major funding resource.

Testimony provided on August 27, 2010

Jennifer Barnhart, Ph.D.
Director of Special Education
Topeka Public Schools, USD #501

Legislative Budget Committee
Date 8-26/27-2010
Attachment 23

23-2

UNIFIED SCHOOL DISTRICT NO. 501
MEDICAID DIRECT SERVICE FEE REVENUE
26 AUGUST 2010

FISCAL YEAR	DOLLARS RECEIVED	CHANGE $	CHANGE %
2004	$1,421,031	N/A	N/A
2005	$2,088,392	$667,361	46.96%
2006	$1,446,158	($642,234)	-30.75%
2007	$1,572,419	$126,261	8.73%
2008	$149,118	($1,423,301)	-90.52%
2009	$501,295	$352,177	236.17%
2010	$592,850	$91,554	18.26%

Legislative Budget Committee
"Attendant Care Change"

Rm 548-S—State House

Dr. Rod Allen, Superintendent
Paola USD 368

FY10 & 11 USD 368 Budget Cuts

- Cut $2,000,000
- Cut 15 Classified Staff, 15 Teachers
- KCPL Energy Study Improvements
  - M-Power--cut 50% Electricity noon-8pm, ten events
  - Disabled boiler elements, lighting, etc.
- Retirement Incentive saved $185,000
- Cut Culinary Arts, other programs & services
- Raised fees and class sizes; cut budgets
- August--only bus 2.5 miles or further ($400,000)

Paola-Lakemary Collaboration

- Baldwin once sponsored Lakemary
  - District teachers, receive state special ed. funding and Lakemary reimbursed district for difference in payroll costs.
  - Paola assumed this role with fear of census funding by Baldwin.
  - FY09 switch to tuition model with USD 368 reduced tuition for resident students and USD 368 as host for Coop providing services to all day students

Disproportionate Impact on USD368

Coop Students at Lakemary

64	USD 368 Lakemary Resident Students
4	USD 368 Lakemary Day Students
15	Other 7 Coop Districts' Day Students
6	Other Districts
89	Total

76%	USD 368 Lakemary Students

% smaller if serving other districts

Disproportionate Impact for USD 368 Loss of Attendant Care

68 extraordinary needs students out of 2140 total students

Little extra funding for psych's/socialworkers only serving 2140 students

Disproportionate Impact on USD368

Revenue (20 FTE teachers; 17.6 FTE paras)

Number Students	BSAPP $4,012	At Risk Weighting (.456 or $1,829)	*LOB (30%) $1,908/FTE	*Medicaid to Lakemary	Special Ed Cat Aid $24,250 per teacher FTE		Total Revenue
					$911,800	76%	
68	$272,816	$124,404	$129,806.07	$528,683.00		$747,676	$1,803,385
Total Base, Weighting & LOB			$527,026				

Expense

# Lakemary Students	Tuition		Total Expense
64	$27,000	USD 368 Lakemary Resident Students	$1,728,000
4	$30,500	Day Students	$122,000
Total Tuition Costs			$1,850,000
Net Difference ***(taken now from regular education students' programming)***			**($46,615)**
Lakemary $6,100 tuition increase (more regular ed teacher/program cuts			**($414,800)**
from a FY11 budget already set and teachers under contract)			($461,415)

Disproportionate Impact on USD368

Funding Excess Costs	**Current**	**Tuition Inc**
Total Tuition Costs	$1,850,000	$2,264,800
Total Base, Weighting & LOB for 68 Lakemary students	-$527,026	-$527,026
Excess Cost	$1,322,974	$1,737,774
Special Education Categorical Aid	$747,676	$747,676
% of Excess Cost Funded (Law 92%, actual in state 86-87%)	57%	43%

One psychologist and one social worker at Lakemary--minimal additional funding.

We have a legal and moral obligation to serve these extraordinary students, but it will be at the expense of the 3rd Grade, 8th Grade Math, HS English.... regular education classrooms and students.

Why Not Cut Special Education? …like the rest of your budget?

- With the Federal Law and unfunded Mandates (19% funding of 40% promise on passing IDEA) and moral/educational obligations, the district can not afford to share the current budget pain w/Sp Ed.
- Reducing services generates due process rights and legal proceedings where the district pays a lawyer to challenge a federally funded advocacy lawyer. *…Lack of funds is not an acceptable justification under federal law.*

Suggestions

- This was an extremely late notice by government after budgets are set by publically elected boards through public hearings and teachers are hired under state-required contracts.
- Delay implementation to FY12—time to adjust for new psychologists/social worker data collections and time to non-renew regular education teachers at the end of the FY11 to fund the change.
- Request a waiver allowed under new guidelines to provide attendant care to K-12; to the government who is providing a mandated K-12 education.
- Provide some level of "hold harmless" to those severely affected by the new rule

Thank you for the time and consideration of all who can possibly help address this serious issue!

24.5

Paola USD #368 - Lakemary

Coop Students at Lakemary

64	USD 368 Lakemary Resident Students
4	USD 368 Lakemary Day Students
15	Other 7 Coop Districts' Day Students
6	Other Districts
89	Total

76% USD 368 Lakemary Students

% smaller if serving other districts

Disproportionate Impact for USD 368 Loss of Attendant Care

68 extraordinary needs students out of 2140 total students

Little extra funding for psych's/socialworkers only serving 2140 students

Revenue (20 FTE teachers; 17.6 FTE paras)

Number Students	BSAPP $4,012	At Risk Weighting (.456 or $1,829)	*LOB (30%) $1,908/FTE	*Medicaid to Lakemary	Special Ed Cat Aid $24,250 per teacher FTE		Total Revenue
					$911,800	76%	
68	$272,816	$124,404	$129,806.07	$528,683.00		$747,676	$1,803,385

Total Base,Weighting & LOB $527,026

Expense

# Lakemary Students	Tuition		Total Expense
64	$27,000	USD 368 Lakemary Resident Students	$1,728,000
4	$30,500	Day Students	$122,000
Total Tuition Costs			$1,850,000
Net Difference	***(taken now from regular education students' programming)***		**($46,615)**
Lakemary $6,100 tuition increase	(more regular ed teacher/program cuts		**($414,800)**
from a FY11 budget already set and teachers under contract)			($461,415)

Funding Excess Costs	**Current**	**Tuition Inc**
Total Tuition Costs	$1,850,000	$2,264,800
Total Base,Weighting & LOB for 68 Lakemary students	-$527,026	-$527,026
Excess Cost	$1,322,974	$1,737,774
Special Education Categorical Aid	$747,676	$747,676
% of Excess Cost Funded (Law 92%, actual in state 86-87%)	57%	43%

One psychologist and one social worker at Lakemary--minimal additional funding.

***LOB Calculation**

FY11 LOB	$3,871,275
FY11 FTE	2028
*LOB/FTE	$1,908.91

Lakemary receives Medicaid $ as part of $1,500 tuition reduction ($30,500>$27,000, includes -$1,500 collaboration)

Transportation funding/costs not included (residents not transported and with day student transportation reimbursed at 80%, it would only add to unfunded excess costs)

LAKEMARY CENTER

Corporate Headquarters
100 Lakemary Drive
Paola, Kansas 66071
Voice/TDD: (913) 557-4000
Fax: (913) 557-4910

Johnson County Offices
15145 South Keeler
Olathe, Kansas 66062
(913) 768-6831
Fax: (913) 768-6834

5940A Dearborn
Mission, Kansas 66202
(913) 671-1800
Fax: (913) 671-1809
www.lakemaryctr.org

Testimony for the Legislative Budget Committee
Senator Jay Emler, Chair

Provided by: Bill Craig, Ph.D., President/CEO, Lakemary Center

Lakemary Center School - Attendant Care Services

Lakemary Center provides a unique statewide resource with its residential school serving children with the challenging combination of developmental disability and significant psychiatric and behavioral disorders.

Because of this uniqueness children come from all over the state typically after they have exhausted the resources of their home families and local school programs. After 12 to18 months of intensive treatment and educational programming, most of these children are able to return to their home communities successfully.

A central component of this successful treatment milieu is the specialized aides in the school whose work is funded through the Medicaid service called Attendant Care.

In mid June of this year, Lakemary was notified that the funding for this service was being discontinued as of July 1. Last year we had billed over $500,000 of attendant care which accounted for 1/5 of our total school budget.

So, every school day since July 1, over 90 of the most challenging and disabled children in Kansas, who can be kept in school only because of the supports provided by Attendant Care, are depending on the borrowed time of Lakemary's severely limited cash reserves, and the hope that the government will meet its obligations.

The precipitous decision to remove Attendant Care from the Medicaid plan has created a crisis which must be addressed. The services specified in these children's Individualized Educational Plans are required by law, and a solution cannot await a protracted bureaucratic process. Please assure that action is taken now. Thank you.

Legislative Budget Committee
Date 8-26/27-2010
Attachment 25

Attendant Care (ACS)

Medicaid reimburses Local Education Agencies (LEA) for all medically necessary services for children to receive a free and appropriate public education. These services are identified on each child's Individualized Educational Program (IEP).

Attendant care services are an important part of these services for children who are served at the Lakemary School. Attendant care matches up the children who are most in need with trained paraprofessional staff who assist them with activities and living skills that are crucial for each child's ability to function and succeed in the school setting. Such services are medically necessary. These services include:

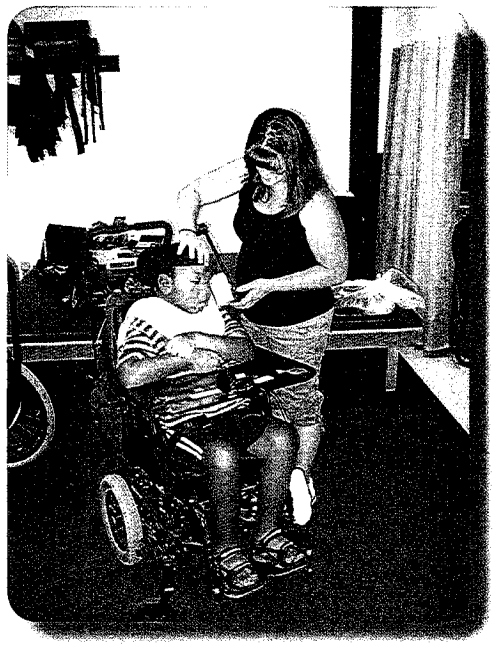
- **Dressing** – Assisting with underwear, disposable briefs, sweater, tie, jacket, gloves, socks, jewelry, shoes, etc. This would include dressing appropriately for weather and activities; cold, snow, rain, swimming, etc.
- **Grooming** – Face & hands – washing, rinsing, drying. Hair – brushing, combing, towel drying. Fingernails – cleaning & trimming
- **Feeding Assistance/Tube Feeding** – Preparing student meals, providing assistance in preparing, serving and/or feeding meals. This also includes hand-over-hand assistance in cutting food into bite-size pieces, supervision of meals, etc.
- **Mobility** – Assists student from a sitting position (wheelchair/chair). Supervises or assists student in walking. Assist students with pushing wheelchairs.
- **Hygiene** – Bathroom – cleaning a bathroom after a student's use. Clothing care – hanging up a student's clothes or sorting laundry. Oral hygiene – assists brushing and flossing. Assist student with application of deodorant, shaving, showering, bathing, etc.
- **Supervisory** – Student lacks the ability to be self-sufficient due to physical abilities. Student lacks the ability to be self-sufficient due to behavior. This includes supervision in the school, as well as during community based instruction and/or community outings.
- **Exercise** – Assists student with prescribed exercise/stretching program. Assists student with walking activities using crutches, braces, and/or walker. This includes seating and positioning for non-ambulatory students.
- **Skin care** – Attends to skin care needs/wounds, sore, eruptions. Applies medication and prescribed dressings. Applies creams, lotions, etc. Checks body for skin care needs.
- **Toileting** – Assist student with toileting functions; including personal care hygiene, proper disposal of toileting products, changing underwear, clothes, or disposable underwear. This also includes feminine care needs.
- **Implementing behavior plan** - Providing support, reinforcement, and assistance that consistent with the strategies and services to address the behavior of a child with a disability and to help the child learn socially appropriate and responsible behavior in the school and other community-based educational settings.

Service providers maintain logs documenting the attendant care services they have performed. The logs track services in 15 minute increments. Providers then bill Medicaid for the documented units at $3.11 per unit using billing code S5125.

LAKEMARY

A Day In The Life of David

David is a 9 year old boy with severe multiple disabilities as a result of Shaken Baby Syndrome



David's only means of communication is through his augmentative communication device which Alice sets up for him every morning.

When David arrives at school, Alice, his attendant care provider greets him, gets him off the bus, and wheels him into his classroom. Once inside, she hooks up his feeding pump into his g-tube site and turns on the machine that administers David's liquid breakfast. After breakfast is over and the feeding pump is removed and cleaned, Alice sets up his augmentative communication device, which is his only means of communication, as David is completely non-verbal. The device is operated by a head switch because David's only independent controlled muscle movement is in his ability to move his head.

David reviews, with Alice's help, his daily picture schedule, greets his peers, and takes the classroom attendance all by using his augmentative communication device. He is asked questions, and he responds by activating his head switch to answer. After morning group with his peers, David is transferred from his wheelchair to a therapy table and, once on the therapy table, Alice does a diaper change for David, as he is dependent on 100% total care.

After a diaper change, Alice performs range of motion, movement and weight bearing exercises. These must be done at least twice daily. If not, David will develop contractures (when the muscle over-tightens from non-use and pulls bones out of sockets – particularly common at hips, elbows, and wrists), increased edema, and decreased flexibility.

Alice transfers David to a therapy table where he does range of motion, movement, and weight bearing exercises with Alice's help.

After these important exercises, David is transferred back to his wheelchair and attends art and music therapy, and adaptive physical education, with Alice providing 1:1 support during each of these activities. David is also able to participate in community based instruction and computer lab/technology because his attendant care provider is by his side 100% of the time, providing 1:1 support so that he may experience life and participate in functional daily activities.

As a result of David's severe multiple disabilities Alice must also monitor and support him for his extreme startle reflex, which requires sensory input activities. Additionally, Alice is trained in vision stimulation and monitoring for tracking, fixation, and eye gaze shift.

David requires 100% attendant care service in all aspects of his daily life in order for him to participate and thrive. Without these services and supports, David would not be able to care for himself, communicate, or participate in any activities required under his Education IEP.

100 Lakemary Drive
Paola, KS 66071

www.lakemaryctr.org

(913) 557-4000
(913) 557-4910

25-3

Actions by 2010 Legislature regarding Home and Community Based Services Waivers

Department on Aging

Added $1.3 million, including $311,835 from the State General Fund, to fund telehealth services for 500 individuals on the Home and Community Based Services-Frail Elderly waiver program for FY 2011.

Added language specifying that any expansion of the Home and Community Based Services-Frail Elderly waiver program for telehealth services in FY 2011 be distributed geographically statewide. In addition, no funds generated from Senate Substitute for Senate Substitute for Substitute for House Bill 2320, which authorizes an annual, uniform assessment on all skilled nursing facility licensed beds, are allowed to be expended for any telehealth program.

Department of Social and Rehabilitation Services

Added $2.4 million in State General Fund moneys to restore the 10.0 percent Medicaid provider reduction for Home and Community Based Services for individuals with developmental disabilities and deleted the same amount from grants and state aid payments to Community Developmental Disability Organizations in FY 2010. This resulted in the addition of $5.5 million, all from federal funds, in FY 2010 to reflect the amount received in federal matching funds associated with the increased state Medicaid expenditures for the waiver. The 10.0 percent Medicaid provider reduction was included in the Governor's November 2009 allotment and reduced reimbursement rates for most Medicaid providers by 10.0 percent for dates of service from January 1, 2010 to June 30, 2010. The allotment affected the Department of Social and Rehabilitation Services, the Kansas Health Policy Authority, the Department on Aging, and the Juvenile Justice Authority.

Added $10.9 million, including $3.3 million from the State General Fund, for FY 2011 to increase funding for the Home and Community Based Services Waiver for individuals with Developmental Disabilities to ensure all individuals in crisis are able to access waiver services and allow approximately 145 individuals currently not receiving services (on the waiting list) to begin receiving services.

Added $11.9 million, including $3.6 million from the State General Fund, for FY 2011 to increase funding for the Home and Community Based Services Waiver for Individuals with Physical Disabilities, to implement a rolling waiting list policy to provide services for one new individual for every individual who stops receiving services.

Home and Community Based Services Waiting List

	July 2010	Omnibus 2010	October 2009	Omnibus 2009	Omnibus 2008
Department on Aging					
HCBS/FE	-	-	-	-	-
Senior Care Act	121	152	269	215	146
Deparment of Social and Rehabilitation Services					
HCBS/DD					
Unserved	2,414	2,246	1,863	1,650	1,345
Underserved	1,024	915	985	1,036	730
Total HCBS/ DD	*3,438*	*3,161*	*2,848*	*2,686*	*2,075*
HCBS/PD	2,108	1,975	1,382	552	-
HI/TBI	-	-	-	-	-
TA	-	-	-	-	-
Autism	247	243	275	224	141

Home and Community Based Service Waivers (HCBS) Expenditures from the State General Fund FY 2007 to FY 2011 Approved

	FY 2007	FY 2008	FY 2009	FY 2010 Approved	FY 2011 Approved
Department on Aging					
HCBS/FE	$ 25,123,026	$ 26,246,366	$ 25,151,011	$ 21,214,819	$ 21,554,366
Senior Care Act	2,431,200	3,385,000	3,210,157	2,101,612	1,785,928
Deparment of Social and Rehabilitation Services					
HCBS/DD	98,535,965	109,519,509	97,967,491	$ 88,782,473	87,039,926
HCBS/PD	37,494,203	44,229,044	48,121,139	39,763,397	37,625,608
HI/TBI	3,286,755	3,542,533	3,795,393	2,615,644	2,159,810
TA	71,363	48,919	6,056,066	6,528,145	6,156,119
Autism		6,526	176,132	370,929	366,151
TOTAL	$ 166,942,512	$ 186,977,897	$ 184,477,389	$ 161,377,019	$ 156,687,908

Staff Note: The FMAP rate for Kansas Medicaid programs was increased beginnning October 2008 due to the federal American Recovery and Reinvestment Act of 2008 (ARRA). This increased the federal share and decreased the state portion for Medicaid expenditures.

4-92

Home and Community Based Service Waivers (HCBS) Expenditures from all funding sources FY 2000 to FY 2011 Approved

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010 Approved	FY 2011 Approved
Department on Aging												
HCBS/FE	$ 44,748,114	$ 49,527,953	$ 58,223,782	$ 53,529,370	$ 45,069,948	$ 54,125,403	$ 55,706,959	$ 63,264,442	$ 68,765,887	$ 72,096,548	$ 69,772,881	$ 71,735,084
Senior Care Act	2,079,265	2,074,134	7,865,402	6,774,547	6,523,513	6,258,229	6,624,094	6,783,690	7,560,059	7,584,588	6,601,412	6,285,928
Deparment of Social and Rehabilitation Services												
HCBS/DD	170,350,998	175,759,758	189,467,567	194,605,709	204,954,171	217,398,123	221,149,613	248,145,859	279,254,523	293,283,426	$ 306,478,431	315,226,304
HCBS/PD	52,369,330	57,604,827	60,528,414	60,457,651	59,736,010	70,857,648	80,980,683	94,423,948	102,144,039	139,059,707	130,864,410	124,111,645
HI/TBI	4,847,074	3,607,662	3,883,033	4,593,058	5,455,886	5,703,934	3,400,107	8,277,479	6,844,597	10,882,090	11,432,012	11,524,845
TA	125,885	153,178	121,642	166,401	181,244	182,470	112,115	179,712	240,806	18,189,216 *	24,182,778	24,194,773
Autism									744,417	531,301	1,220,762	1,207,786
TOTAL	$ 274,520,666	$ 288,727,512	$ 320,089,840	$ 320,126,736	$ 321,920,772	$ 354,525,807	$ 367,973,571	$ 421,075,130	$ 465,554,328	$ 541,626,876	$ 550,552,686	$ 554,286,365

* In FY 2009, all expenditures for the Attendant Care for Independent Living Program were shifted to the Technology Assistance Waiver.
Staff Note: Prior to FY 2009 numbers also included Targeted Case Management Services.

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Joint Committee on Legislative Budget

August 27, 2010

Home and Community Based Services Waivers

Ray Dalton, Deputy Secretary
Disability and Behavioral Health Services

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

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Home and Community Based Services Waivers

Joint Committee on Legislative Budget

August 27, 2010

Chairman Emler and members of the Committee, thank you for the opportunity to appear before you today to discuss the Home and Community Based Services (HCBS) waivers and the Money Follows the Person (MFP) grant. I will present information today regarding six Home and Community Based Service Waivers that provide services to persons with disabilities, including the number of individuals served and funding for each of the programs. I will also provide information regarding the MFP grant which impacts the HCBS waivers. I have included a chart with more detail on the waivers impacted by the MFP grant in Attachment A.

Background

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. Many of the community supports and services provided to persons with disabilities such as respite care, attendant care services, and assistive services, are not covered by the regular federal Medicaid program. HCBS waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. The Centers for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions.

Developmental Disability (DD) Waiver

The DD waiver serves individuals with significant developmental disabilities. At this time there are 2,444 people on the waiting list receiving no waiver services, and another 1,047 people receiving some services who are waiting for additional services. In FY 2010 there were 295 individuals who left waiver services. These positions were filled by individuals in crisis situations. SRS maintains one statewide waiting list for HCBS-DD services which includes both the unserved and the underserved. A person's position on the waiting list is determined by the request date for the service(s) for which the person is waiting. Each fiscal year, if funding is made available, people on the statewide waiting list are served, beginning with the oldest request dates at the top of the list. An additional $3.3 million SGF was allocated to the DD waiver for FY 2011. SRS is in the process of working with the Community Developmental Disability Organizations to offer services to individuals on the waiting list. At this time we know at least 145 individuals will be served with this funding. The exact number

taken off of the waiting list will be determined by the projected annualized cost to serve each person that is offered and accepts services.

On January 1, 2010 and on February 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- On January 1, 2010, Oral Health Services were eliminated.
- On February 1, 2010, Temporary Respite Care services were eliminated.

Physical Disability (PD) Waiver

During FY 2008 the rate of growth in the waiver increased significantly and on December 1, 2008, SRS implemented a waiting list for the PD waiver. The waiting list was implemented not to cut the budget, but to avoid further overspending. With the implementation of a waiting list approximately 7,300 individuals have been able to continue receiving services. In December 2008 when the waiting list was implemented only persons in a crisis situation were allowed to access new waiver services. On March 2, 2009, the "rolling" waiting list methodology was implemented whereby one consumer was offered services for every two terminations. On January 1, 2010, due to the budget situation, the rolling waiting list methodology was terminated and only persons meeting the crisis criteria were allowed to access PD waiver services (the only other opportunity to access these services was through the MFP grant). As of August 1, 2010, there were 2,286 individuals on the PD Waiver waiting list.

The PD waiver received an additional $3.6 million SGF, which will allow for the start of a rolling waiting list in October 2010. The rolling waiting list will be implemented in this way: for every two people leaving the waiver, one person from the waiting list will be added. It is anticipated that through implementing this rolling waiting list approximately 321 people can be put into service from the waiting list. 153 people would be removed from the waiting list, in the chronological order in which they were placed on the waiting list. Approximately 168 people would be removed from the waiting list and added to the PD waiver in other than waiting-list order, due to crisis situations. The actual number that could be added will be dependent on several variables, including the service needs and resulting average cost per person, and the number of people added to the PD waiver other than in waiting-list order, due to crisis situations.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Eliminating Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.
- Limiting assistive services to crisis situations only, with approval by the program manager.
- A change in the crisis criteria was made to eliminate the criteria that a person could enter services if the individual was at significant, imminent risk of serious harm because the primary caregiver(s) were no longer able to provide the level of support necessary to meet the consumer's basic needs due to the primary caregiver(s): own disabilities, return to full time employment, hospitalization or placement in an institution, moving out of the area in which the consumer lived, or death.

Traumatic Brain Injury (TBI) Waiver

The TBI waiver is designed to serve individuals who would otherwise require institutionalization in a Head Injury Rehabilitation Hospital. The TBI waiver services are provided at a significant cost savings over institutional care and provide an opportunity for each person to live and work in their home communities. Each of these individuals is provided an opportunity to rebuild their lives through the provision of a combination of supports, therapies and services designed to build independence.

A significant difference in this program is that it is not considered a long term care program. It is considered a rehabilitation program and consumers are expected to transition off the program or to another program upon completion of rehabilitation. Individuals currently receive up to four years of therapy and, if by that time progress in rehabilitation is not seen, the individual is transitioned to another program. In FY 2010 the average length of stay in this program was 1.9 years. This number is based on the consumers who transitioned from services during FY 2010. There is currently no waiting list for this program.

On January 1, 2010, there were waiver changes implemented by SRS to assist in avoiding further overspending. The waiver changes included:

- Elimination of Oral Health Services.
- Limiting personal services to 10 hours per day unless there is the determination of a crisis situation.
- Limiting assistive services to crisis situations only, with approval by the program manager.
- Moving third year continuation of service review to program manager as opposed to committee.

Technology Assisted (TA) Waiver

The TA waiver is designed to serve children ages 0 to 22 years who are medically fragile and technology dependent, requiring intense medical care comparable to the level of care provided in a hospital setting, for example, skilled nursing services. The services provided through this waiver are designed to ensure that the child's medical needs are addressed effectively in the child's family home, thereby eliminating the need for long term and or frequent hospitalization for acute care reasons. There is no waiting list for this program. The TA waiver served 483 (unduplicated) children in FY2010 at a total cost of $ 24,594,116 and an average monthly cost per person of $ 5,418.

Serious Emotional Disturbance (SED) Waiver

The HCBS waiver for youth with a Serious Emotional Disturbance allows federal Medicaid funding for community based mental health services for youth who have an SED and who are at risk of being placed in a state mental health hospital. The SED waiver determines the youth's Medicaid eligibility based on his/her own income separate from that of the family. Once the youth becomes a Medicaid beneficiary he/she may receive

the full range of all Medicaid covered services including the full range of community mental health services. In addition, the youth is eligible for specific services only available to youth on the SED Waiver. The services offered through the SED waiver and other community mental health services and supports are critical in assisting the youth to remain successfully in his/her family home and community. During FY 2010, $48,448,927 was paid through the SED waiver to serve a total of 6,021 children.

Autism Waiver

The autism waiver is the newest of our HCBS waivers with the first funding approved for FY 2008. The target population for the autism waiver is children with autism spectrum disorders (ASD), including autism, Aspergers' Syndrome, and other pervasive developmental disorders. The diagnosis must be made by a licensed medical doctor or PhD psychologist using an approved autism specific screening tool. Children are able to enter the program from the age of diagnosis through the age of five. Children receiving services through this waiver would be eligible for placement in a state mental health hospital if services were not provided through the waiver. A child will be eligible to receive waiver services for a time period of three years with an exception process in place to allow children who demonstrate continued improvement to continue services beyond the three year limit.

The autism waiver was implemented on January 1, 2008. At that time 25 children were selected through a random process to receive services. The other applicants were placed on the waiting list. The 2008 Legislature approved funding for an additional 20 children to be served by the autism waiver in FY 2009. The waiver is now serving 45 children. There are 247 children waiting for services through this waiver. Since this waiver was implemented, 166 children have aged off of the waiting list before services could begin. The total expenditure for the waiver in FY2010 was $743,673 with the average monthly cost per person being $1,546.

SRS Fee Fund

Over the past several years SRS fee fund balances have been used to fill the gap between available SGF and waiver spending and the funds allocated for the HCBS Waivers. The fee fund balance has now been depleted and SRS will be $11 million short for FY 2012. SRS will be requesting an enhancement to replace the $11 million shortfall with the next budget submission. SRS's options regarding changes that may be made to fill this gap are limited by federal regulations that have been implemented through the Recovery Act and the Affordable Care Act. These regulations do not allow states to change the waiver eligibility requirements without loss of federal funding. Under the Recovery Act the number of persons served by the waivers may not drop below the number of individuals that were being served on July 1, 2008. The only options that are available to SRS to control spending are through serious rate reductions and then to evaluate what additional service limitations could be implemented.

Money Follows the Person (MFP) Grant

The federally funded Money Follows the Person (MFP) demonstration grant is designed to enhance participating states' ability to increase the capacity of approved HCBS programs to serve individuals that are

currently residing in institutional settings. The benefit for Kansas is enhanced federal funding to create additional community capacity, facilitate private Intermediate Care Facilities for people with Mental Retardation (ICFs/MR) voluntary bed closure, train staff, and ensure individuals have the supports in their homes to be successful, reducing the risk of re-institutionalization.

Target populations for this grant include persons currently residing in nursing facilities and ICFs/MR. Individuals must have resided in the facility for a minimum of 90 days, which is a decrease from a minimum of six months. The federal Affordable Care Act reduced the length of stay in order to enhance the program and decrease the cost of institutional placement. Persons must also have been Medicaid eligible for a minimum of 30 days to be eligible to move into the community through this program.

SRS and Kansas Department on Aging (KDOA) are working together with the LTC Ombudsman office to identify individuals that are currently residing in qualified institutional settings and assist them to move into home settings of their choice.

SRS, as the lead agency for the demonstration grant, has partnered with the KDOA to develop benchmarks and implementation strategy. Additionally, Kansas Health Policy Authority is an integral partner as the Single State Medicaid Agency.

The individuals transitioning into the community are representing the mentally retarded/developmentally disabled, traumatic brain injury, physically disabled and elderly population groups. Kansans who have chosen community living in FY 2010 include 38 persons with physical disabilities, 4 persons with a traumatic brain injury, 25 individuals with developmental disabilities, and 40 persons that are elderly.

Executive Order 10-01; Kansas Neurological Institute and Parsons State Hospital Consolidation

On January 28, 2010, after considerable review and thought, Governor Parkinson responded to the report of the Kansas Facilities Realignment and Closure Commission by issuing Executive Order 10-01. That order set the stage for focused work that will eventually lead to the downsizing and consolidation of the two remaining state developmental disability hospitals in Kansas: Kansas Neurological Institute (KNI) and Parsons State Hospital (PSH).

Since the Executive Order was issued SRS has been working both internally and with stakeholder representatives to implement the 11 directives of the order, all designed to enhance opportunities for Kansans with developmental disabilities to experience effective community services.

One of the first activities conducted was convening parent and guardian listening sessions. In order to effectively capture a broad array of information and input from the parents and guardians of people currently receiving state hospital services, SRS worked with the Wichita State University Center for Community Support and Research to conduct listening sessions with the parent/guardian groups at both KNI and PSH. The concerns and suggestions identified in these sessions were provided to the Executive Order Advisory Group to

consider as they developed recommendations, and also will be used by SRS as the implementation of consolidation continues.

The second action taken by SRS was to convene an advisory group which was charged with assessing and developing recommendations regarding the directives in the Executive Order. The PSH/KNI Executive Order Advisory Group was comprised of parents/guardians, CDDO Directors, community service providers, the hospital superintendents, and SRS representatives.

After working from March 4, 2010 through May 13, 2010, the advisory group developed 15 recommendations that will significantly support the consolidation of KNI/PSH services and the successful transition to community services for people who are well prepared to make that change. In summary, the recommendations include robust information/education processes for people who currently receive state hospital services; effective transition planning and the safety net features that will help ensure strong and person-centered community services for each person making the change; and post-move monitoring processes that will support long-term success for each person and their parents/guardians.

The Executive Order Advisory Group report has been presented to Governor Parkinson and SRS will continue to use the report as a guide for implementation of the Executive Order.

This concludes my testimony; I will stand for questions.

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

27-8

Attachment A - Overview of Medicaid Home & Community Based Services Waivers Operated by DBHS/CSS and KDOA

Updated 8-11-10

Long Term Care Services	DEVELOPMENTAL DISABILITY WAIVER	PHYSICAL DISABILITY WAIVER	TRAUMATIC BRAIN INJURY WAIVER	FRAIL ELDERLY WAIVER (operated by KS dept. on Aging)
Institutional Equivalent	Intermediate Care Facility for Persons with Mental Retardation	Nursing Facility	Head Injury Rehabilitation Facility	Nursing Facility
Eligibility	➢ Individuals age 5 and up ➢ Meet definition of mental retardation or developmental disability ➢ Eligible for ICF/MR level of care	➢ Individuals age 16-64* ➢ Determined disabled by SSA ➢ Need assistance with the activities of daily living. ➢ Eligible for nursing facility care **Those on the waiver at the time they turn 65 may choose to stay on the waiver*	➢ Individuals age 16-65 ➢ Have traumatic, non-degenerative brain injury resulting in residual deficits and disabilities ➢ Eligible for in-patient care in a Head Injury Rehabilitation Hospital	➢ Individuals age 65 or older ➢ Choose HCBS ➢ Functionally eligible for nursing care ➢ No waiver constraints
Point of Entry	Community Developmental Disability Organization	Case management Entities	Case management Entities	Case management Entities
Financial Eligibility Rules	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ For individuals under age 18, parent's income & resources are not counted, but are considered for the purpose of determining a family participation fee ➢ Income over $727 per month must be contributed towards the cost of care	➢ Only the individual's personal income & resources are considered ➢ Income over $727 per month must be contributed towards the cost of care

KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

27-9

	DEVELOPMENTAL DISABILITY WAIVER	PHYSICAL DISABILITY WAIVER	TRAUMATIC BRAIN INJURY WAIVER	FRAIL ELDERLY WAIVER (operated by Kansas Department on Aging)
Services/ Supports Additional regular Medicaid services are provided	➢ Assistive Services ➢ Day Services ➢ Medical Alert Rental ➢ Sleep Cycle Support ➢ Personal Assistant Services ➢ Residential Supports ➢ Supported Employment ➢ Supportive Home Care ➢ Wellness Monitoring	➢ Personal Services ➢ Assistive Services ➢ Sleep Cycle Support ➢ Personal Emergency Response ➢ Personal Emergency Response Installation	➢ Personal Services ➢ Assistive Services ➢ Rehabilitation Therapies ➢ Transitional Living Skills ➢ Sleep Cycle Support ➢ Personal Emergency Response ➢ Personal Emergency Response Installation	➢ Adult Day Care ➢ Assistive Technology* ➢ Attendant Care Services ➢ Comprehensive Support* ➢ Medication Reminder ➢ Nursing Evaluation Visit ➢ Oral Health* ➢ Personal Emergency Response ➢ Sleep Cycle Support* ➢ Wellness monitoring *demotes suspended service; must meet crisis exception
Average Monthly Number Persons Served FY 10	7669	6964	323	5813
FY 10 Expenditures (All funds)	$311,275,963	$140,511,241	$13,085,895	$74,476,067
Estimated Average **Waiver** expenditure Mo/year	$3,382 / $40,589	$1,681 / $20,176	$3,376 / $40,514	$ 1,068/ $12,812
Institutional Setting Total Cost / Annually Per Person	Private ICF/MR $13,606,580 / $79,571 Public ICF/MR (combined)* $54,088,890 / $154,540	Nursing Facilities $358,545,585/ $33,863 (Includes persons who are aging)	Head Injury Rehab Facility $10,047,478 / $257,628	Nursing Facilities $358,545,585/ $33,863 (Includes persons with Physical disabilities)

KNI/Parsons FY 2010 Expenditures & Daily Census Data

KANSAS
DEPARTMENT ON AGING

Legislative Budget Committee

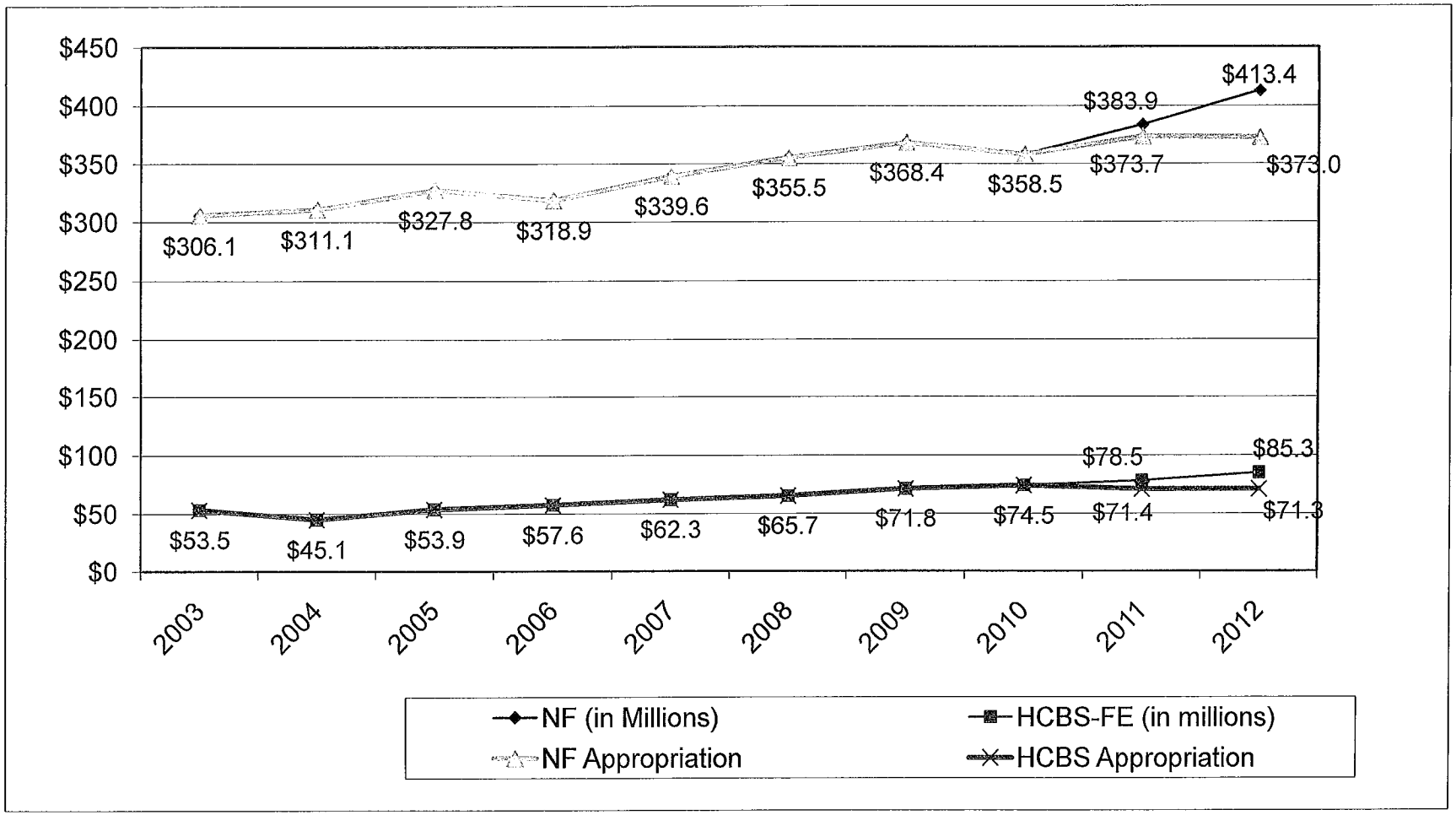
Aug. 27, 2010

Update on
Home and Community-Based Waivers:
Frail Elderly

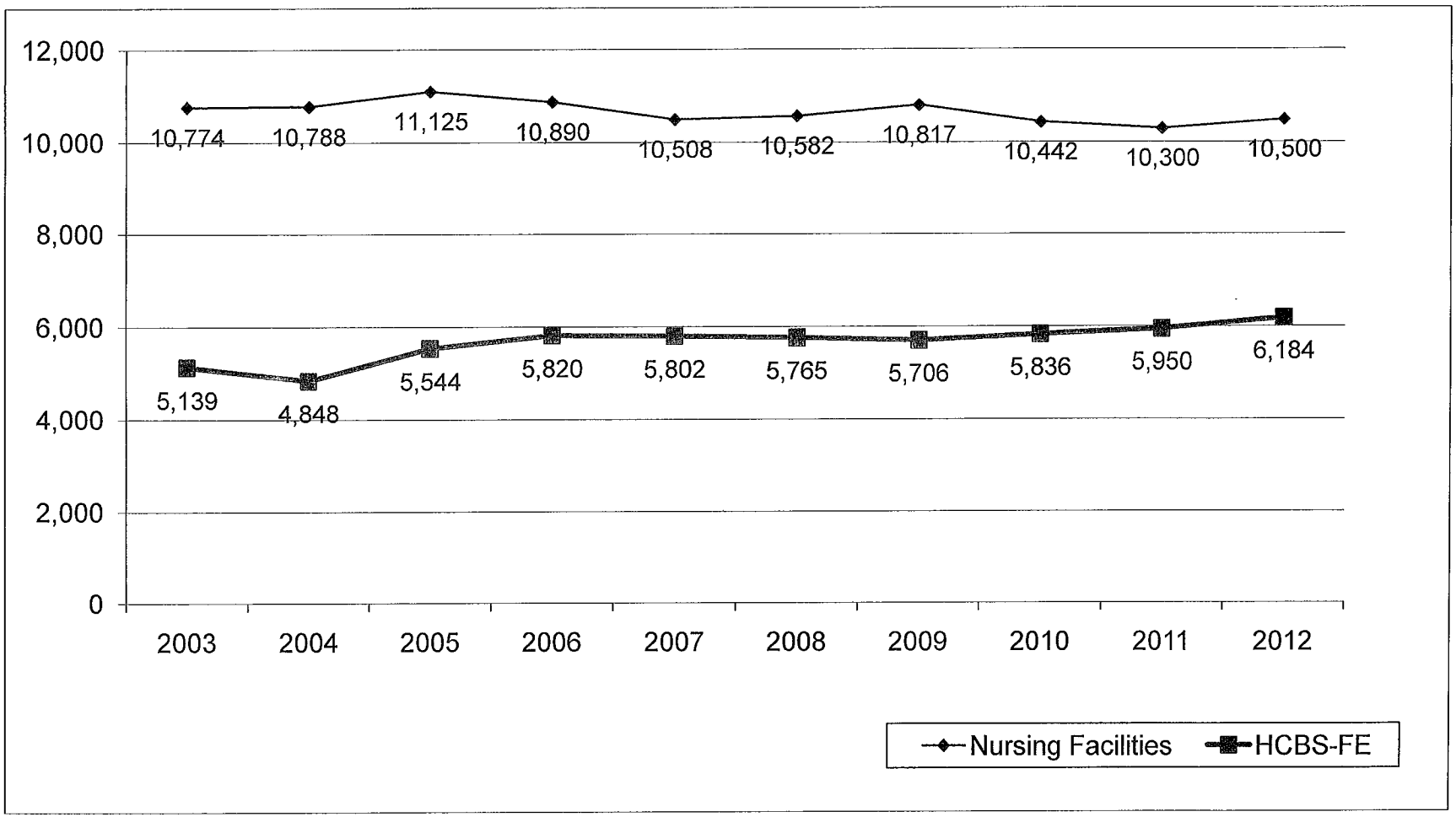
Martin Kennedy, Secretary

28-2

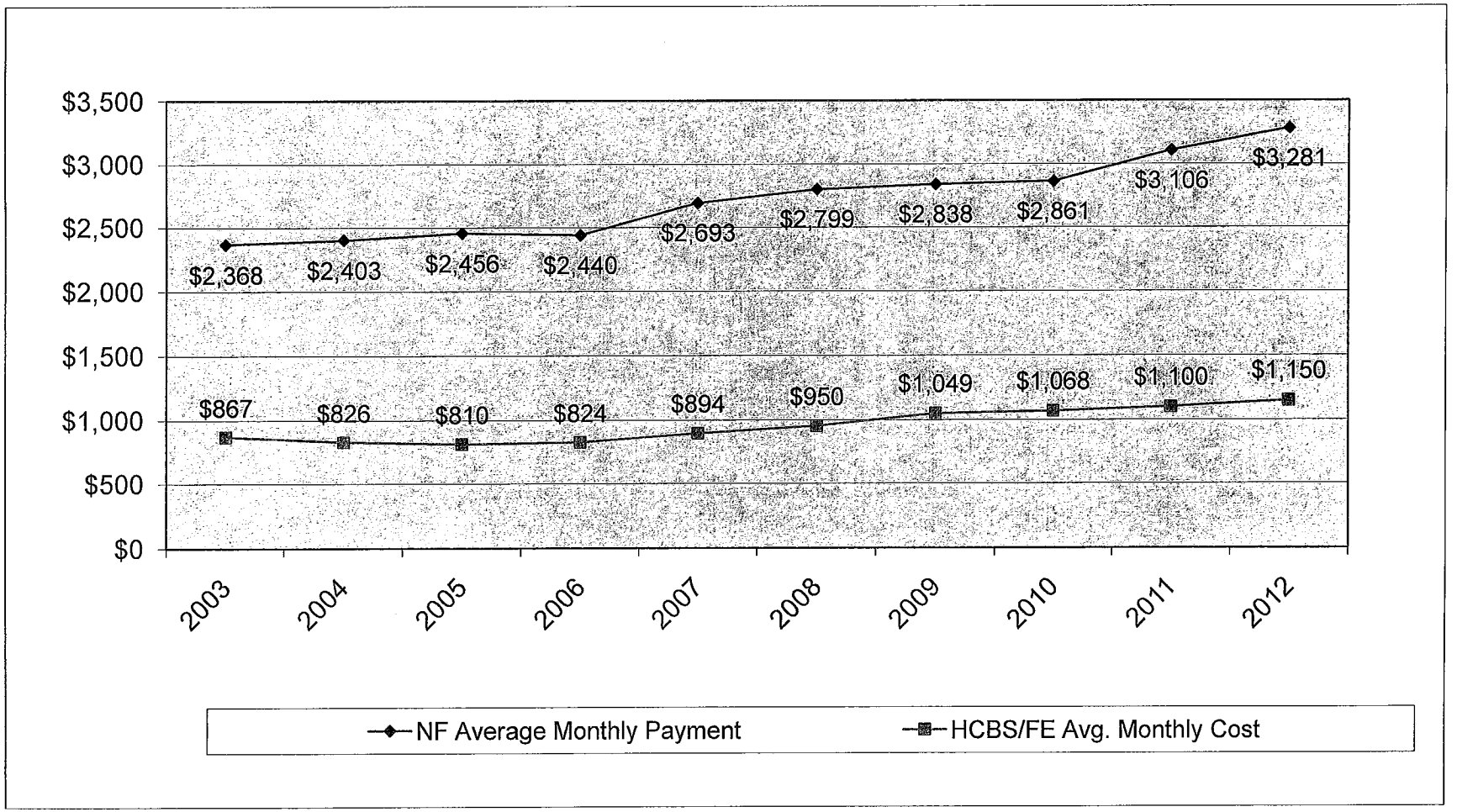
Kansas Long Term Care Medicaid Expenditures (dollars in millions)



Kansas Long Term Care
Medicaid Average Caseload



Kansas Long Term Care
Medicaid Monthly Expenditure



28-5

Discontinued HCBS-FE Service

Service	SGF	All Funds
Oral Health	$347,063	$974,076
Sleep Cycle	663,325	1,871,704
Comprehensive Support	639,997	1,796,232
Assisted Technology	265,079	743,976
Telehealth	390,149	1,095,000
Total	**$2,305,613**	**$5,385,988**

KANSAS
AREA AGENCIES
ON AGING
ASSOCIATION

Meeting the Needs of Older Kansans

2910 SW TOPEKA BOULEVARD • TOPEKA, KS 66611 • 785-267-1336 • FAX - 785-267-1337

Legislative Budget Committee

August 27, 2010

The Kansas Area Agencies on Aging Association (K4A) represents the 11 Area Agencies on Aging (AAA) in Kansas that collectively serve all 105 counties in the state.

The Area Agencies on Aging in Kansas are part of a national network of 629 AAAs and 246 Title VI organizations. Area Agencies on Aging established under the Older Americans Act (OAA) in 1973 to respond to the needs of seniors and caregivers in every local community. The services available through the Area Agencies on Aging fall into five broad categories: Information and Access services, Community Services, In-Home services, Housing and Elder Rights. Within each category a range of programs are available.

Whether you are an older Kansan or a caregiver concerned about the well-being and independence of an older adult, Area Agencies on Aging are ready to help. Area Agencies on Aging in communities across Kansas plan, coordinate and offer services that help older adults remain in their home - if that is their preference. Services such as home delivered meals and a range of in-home services make independent living a viable option. Area Agencies on Aging make a range of options available so that seniors choose the services and living arrangement that best suits them.

Area Agencies on Aging offer programs that make a difference in the lives of all older adults from the frail senior who can remain at home if they receive the right services to those who are healthy and can benefit from social activities and volunteer opportunities provided by community-based programs.

Budget cuts to in-home service system over the last two sessions threaten even the minimal services many frail elderly need to remain living in their communities.

Below are budget cuts over the last two years and their impact on community programs for Kansas seniors.

Home and Community Based Services - Frail Elderly Waiver

- **$5-$7 Million projected shortfall in HCBS-FE waiver funding in FY 2011.** Likely resulting in a waiting list for services. Average annual cost $12,588 per person annually. Waiting list projection: 397 frail elders at $5 million, 556 frail elders at $7 million based upon annual cost.
- $750,000 - Elimination of ALL Base funding for Kansas Area Agencies on Aging in fiscal year 2010.
- January 1, 2010 - Four in-home services were eliminated for low income seniors including sleep cycle support, assistive technology, comprehensive supports and oral health care. **$2,084,541 reduction**

($625,362 SGF). Resulted in frail elders being moved into nursing homes from community services.

- SRS Funded Targeted Case Management Rate Study Shows Reimbursement Shortfall
  - A recently released SRS study indicated in FY 2010 an unreimbursed shortfall of $10.20 hr
  - The projected shortfall in FY 2011 is $12.00 hr

Senior Care Act - Senior Care Act program provide services for seniors that assist seniors to remain living in their home.

- $1.3 million reduction- 18% reduction in Senior Care Act in the last two state fiscal years. **Cut from roughly $7.6 million to $6.3 million**
- **121 seniors on the waiting list as of July 31st.**

There is simply no question that, given the magnitude of budget reductions, access to health care and in-home services in our state have been impaired, resulting in Kansas seniors receiving care in more expensive settings or not receiving care at all.

We would appreciate the opportunity to discuss these issues with you. Inquiries may be directed to:

Craig Kaberline, Executive Director
Kansas Area Agencies on Aging Association
(785) 267-1336

email: Craig@k4a.org
website: www.k4a.org

Statewide Toll-Free Resource Line
1-866-457-2364

INTERHAB

INDEPENDENCE
INCLUSION
INNOVATION

August 27, 2010

TO: Members of the Joint Legislative Budget Committee

FROM: Tom Laing, Executive Director, InterHab

RE: Update on Home and Community Based (HCBS) Waivers

Thank you Chairman Emler and members of the committee.

In the interests of time, I have attached my comments provided to the HCBS Committee earlier this month, and ask you to take time to review them, and I offer only a reprise of those comments today and some general recommendations for your consideration.

First, we owe you and members of the legislature thanks for your efforts to prevent further cuts to human service programs during the 2010 session. We recognize such efforts were difficult, but appreciate that both houses and representatives of the administration discussed these issues in a more complete manner than in previous years. Such efforts notwithstanding, we have miles to go to redress years of inattention to two major issues, reimbursement rates for HCBS DD service providers which have remained largely unaddressed for a number of years, and the dramatic waiting list numbers that were only marginally addressed in recent years.

Attached also is an InterHab paper that defines the "Quality Based Community Expansion" (Q-Base) approach we have discussed in recent years which we urge you to consider now in planning for 2011. Simply put, we propose that both major issues (rates and waiting lists) be addressed annually in the coming years, if we are to catch up and meet the statutory, constitutional and moral imperatives of Kansas services and supports for persons with developmental disabilities. Please note that the Q-Based paper also calls that you and we and persons with disabilities are entitled to better outcomes in the delivery of such services and supports. We are not mission-driven to simply move money from the state to the community, we want the allocation of such resources to be invested in ways that meet the requirements of the DD Reform Act which calls for a focus on integration, inclusion, independence and productivity.

An additional matter of concern, which we hope you will consider, is that HCBS alone does not constitute the entirety of resources needed for fulfillment of our efforts in the DD arena. We lag in a number of funding areas due to prior years of poorly-prioritized budgets, as well as from the currently budgetary malaise with which you and we struggle.

Legislative Budget Committee
Date 8-26/27-2010
Attachment 30

700 SW JACKSON ST., SUITE 803 TOPEKA, KANSAS 66603 |P|785.235.5103

The 2011-2012 Legislature must:

- *Pay greater heed to the unadjusted State financial commitment to the tiny-k program.*
- *Give greater attention to the near elimination of SGF-only programs which address significant (albeit less expensive) supports for persons ineligible for the HCBS programs.*
- *Recognize that local property tax pressures have harmed community programs, and that private charitable giving has been depressed as well.*
- *Inspect closely the performance of other state agencies whose work should be more mindful of the needs of citizens with disabilities – today's hearing on the sudden elimination of attendant care services for school children reveals a frustrating lack of understanding for the importance of such programs.*

We appreciate this committee's historic interest in how to address the needs outlined above, and in the attached comments. It was this committee that proposed in its report to the 2007 Legislature, that immediate and multi-year infusions of new funds were needed for the state's DD services to bring rates into line with economic realities, and to reduce the growing waiting lists for persons needing DD services. It is our hopes that this committee will again take the lead in renewing a meaningful and productive dialog about these issues.

INDEPENDENCE
INCLUSION
INNOVATION

INTERHAB

August 16, 2010

TO: Senator McGinn & Representative Bob Bethell, Vice Chairs
Members, Joint Committee on Home and Community Based Services

FR: Tom Laing, Executive Director
InterHab

RE: Home and Community Based Services for Kansans with Developmental Disabilities

The 2010 Legislative Session was important in that both parties, both Houses and the administration spoke out about the crisis facing human services. The crisis could have deepened, but it didn't thanks to your efforts.

The dialog you initiated on the needs of Kansans with developmental disabilities was long overdue as an acknowledgement of the importance of these issues. It was a message that a significant number of Kansas citizens had longed to hear from the Statehouse. It was a message that all of Kansas needed to hear. For your work last session, and for the funds appropriated to begin whittling down the State's DD waiting lists, we are appreciative.

However, the community network of supports for Kansans with developmental disabilities is still in crisis.
In particular, the legislature must not ignore the reimbursement crisis which threatens to destroy decades of collaborative work by the State and community partners in building supports for the developmentally disabled.

Reimbursement for community services continues to be funded at a rate far behind the costs providers now face. HCBS reimbursement has been allowed to fall behind every economic indicator, and virtually no adjustments have been made to enable us to keep pace with the basic costs of doing business. Utility, transportation, insurance, and so on ... all costs have gone up and next to nothing has been done to respond to this annually identified concern.

Direct Support Professional wages in the community are the largest cost of providing service, and they continue to lag more than $3.00/hour behind the standard you have set for wages in the State's institutional settings. Nationally compiled data underscores this fact. MSN recently reported that direct support positions were among the 8 lowest paying jobs in America.

While this is a national crisis, we cannot ignore that, among all the states, our relative standing has fallen perhaps further than any other state, when one considers our per-person investment

30-3

700 SW JACKSON ST., SUITE 803 TOPEKA, KANSAS 66603 |P|785.235.5103 |F|785.235.0020 WWW.INTERHAB.ORG

in DD programs (for persons not in institutions). In 1993 we were 23rd in the nation. When these numbers were last compiled in 2008, we had fallen to 40th in the nation. Since 2008, we have continued to serve more persons, but at the same reimbursement rate, so our relative standing has almost certainly fallen further.

Fundamental to making this matter right is the need, which we and the State are addressing, to revamp our nearly 20-year-old rate setting methodology which has become irrelevant in the face of a changing service demographic.

Q-Base:
We have discussed the reimbursement crisis and you have heard today from the Director of the DD Council regarding the waiting list crisis. We strongly believe that these two issues must be considered as one, because the issues are interlinked.

To address the challenges facing the State in the DD arena requires not just serving more persons, and not just more money for reimbursement rates, but an investment in both, simultaneously, to create a quality-based approach to community expansion. We call the concept ***'Q-Base'***.

Quality Based Community Expansion (Q-Base) is predicated on the fact that, to provide services to more persons also requires an expanded investment into the community system that is being asked to continue to expand. Our approach recognizes that it must be a multi-year effort. It is unrealistic and almost certainly unwise to attempt to restore these losses hurriedly.

We will continue to advocate that legislators consider this ***Q-Base*** approach in rebuilding the DD system, and in doing so, we call out the need for quality enhancement as a part of that goal. We are ready and willing to invest new funding in an expanded commitment - not just to wages - but to meet the training and service needs of our workers as well. This is necessary in order that they can better serve the growing numbers of persons with DD entering the service system who have challenging behaviors and other highly specialized, challenging needs. We also will advocate for a renewal of the State's commitment to employment and training services for so many of the men and women we serve who want to work in the community, but who need assistance to make that happen.

It would be misleading, however, if we talked only of the HCBS funding issues we face:
The cuts from outside the HCBS funding stream have been significant. Among the most damaging is the continued trend to cut SGF-only programs.

These numbers illustrate it adequately: In FY2010, roughly $14.1 million was invested in SGF grants for persons in the community who do not qualify for the HCBS program. In FY2011, that amount will have fallen to $3.5 million. Persons who were served by these dollars included hundreds of children and families, as well as persons who only needed a little bit of help to maintain their independence.

Add to these cuts the loss of funding from many counties, from many charitable donors, from business contractors who assist the persons we serve in employment training settings, from many United Way efforts in many communities, categorical aid from schools to our infant and toddler programs, and so on. The downturn in the economy has affected all these funding sources, some more than others.

So how did we judge the outcome of the 2010 session? We evaluated it in the only fair manner, by the facts that have been presented to you.
From the thousands still on the State's waiting lists, now totaling more than 4,500 children and adults with developmental disabilities, the 2010 session found funds for less than 200. That number is smaller than the number of new persons who will be eligible for service in FY 2011. In other words, we are still going backwards, slower perhaps, but backward.

For the thousands of community workers whose principal funding stream is the HCBS waiver, the legislature and the Governor provided zero relief. Though the current economy shows only modest attrition in spending power, it is a fact that the DD system continues to lag behind. Community service providers have had to cut benefits, or pass benefit costs onto employees, or both. Health Care Reform has created a further hurdle regarding benefits, by mandating that employers must provide benefits at current level with no further cuts.

We continue to call these matters a crisis because they constitute an ongoing and unresolved crisis.
It's a personal crisis, a program crisis, a constitutional crisis and a moral crisis:

- *For families and persons waiting for service.*
- *For community workers who are being forced to find other careers where there is some promise of at least some modest growth in financial opportunity.*
- *For community leaders, who are left holding a very heavy bag of liability – both moral and legal – for promises made by this State that are not being kept.*

Last session you showed great determination to slow down the avalanche of growing need and to rekindle a dialog that more honestly discussed the challenges we have raised today. We thank you for that.

Nevertheless, in this coming session (no matter what is said during the election campaigns) you need to lead with a renewed legislative determination to support these programs more adequately and more reasonably. We ask only that you show the same determination that has been shown by persons with disabilities, their families, and community service leaders, who have all kept up their end of the deal.

American Network of Community Options and Resources

A National Network of Providers Offering Quality Supports to People with Disabilities

Direct Support Professional Wage Facts-2009[1]
KANSAS

NATIONAL FACTS:

Medicaid is the largest source of financing for disabilities services in the United States. For people with disabilities and for those who provide their care, Medicaid serves as a safety net for the provision of services and directly tied to this are the wages paid to Direct Support Professionals (DSPs).

Direct Support Professionals (DSPs) are healthcare professionals who provide "hands on" daily supports, training and habilitative services to persons with developmental and physical disabilities. This workforce is responsible for the health, safety and emotional support of the individuals being served. DSPs ensure compliance with state regulatory requirements for the delivery of these critical supports, as well as provider policies and procedures. For purposes of this study, DSPs employed by private providers are compared with those who work for State-Run programs.

NATIONAL IMPACT:

NATIONAL	ENTRY WAGE	ANNUALIZED ENTRY WAGE	FEDERAL POVERTY LEVEL	DOLLAR VALUE($) DIFFERENCE	PERCENT (%) DIFFERENCE
PRIVATE PROVIDER	$9.37	$19,498.00	$18,454.00	$1,041.00	6.00%
STATE PROVIDER	$12.57	$26, 143.00	$18,454.00	$7,654.00	41.00%
DIFFERENCE BETWEEN STATE AND PRIVATE PROVIDER	$3.20	$6,645.00		$6,613.00	35.00%

KANSAS IMPACT:

KANSAS	ENTRY WAGE	ANNUALIZED ENTRY WAGE	FEDERAL POVERTY LEVEL	DOLLAR VALUE($) DIFFERENCE	PERCENT (%) DIFFERENCE
PRIVATE PROVIDER	$8.29	$17,243.00	$18,310.00	-$1,607.00	-6.00%
STATE PROVIDER	$11.13	$23,150.00	$18,310.00	$4,840.00	26.00%
DIFFERENCE BETWEEN STATE AND PRIVATE PROVIDER	$2.84	$5,907		$6,447.00	32.00%

In Kansas, a DSP working for a Private Provider who is a single parent of three would earn $1,607 below the federal poverty level. This compared to a State employed DSP who earns $4,840 a year more. This means a State employed DSP earns 32% more above the federal poverty level as compared to private providers. In addition, a DSP working for a private provider would earn only $1.04 an hour more as compared to the $7.25 minimum wage in Kansas.

Research shows that better pay is critical to ensuring the adequacy and stability of the direct-care workforce. There is nothing inherent about these jobs that make them low quality. In fact, they are the jobs of the future...they can't be outsourced; they are recession-proof and they can be powerful economic drivers improving the lives of many low-income families and spurring community revitalization.

Providing decent paying jobs for direct-care workers is the key to ensuring quality of life and quality of care for millions of Americans with disabilities and chronic illnesses.

Our long-term care system faces a huge recruitment challenge – a challenge made more difficult by the poor pay of many direct-care jobs. On average vast majority of Direct Support Professionals earn wages around $9.37 per hour . Coupled with the national average for high turnover of 38.2%, Direct Support Professionals leave the field for better compensated, more stable work that is less emotionally and physically demanding.

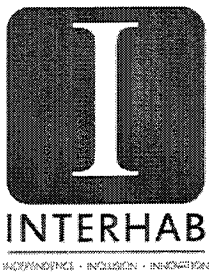
The future of intellectual and developmental disability services hinges on the recruitment and retention of quality direct support professionals. Without these qualified staff no provider will be able to serve.

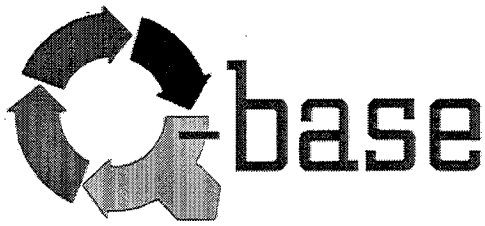
30-6

1 ANCOR 2009 Direct Support Professionals Wage Study: A report on national wage, turnover and retention comparisons. Prepared for the ANCOR National Advocacy Campaign by the Mosaic Collaborative for Disabilities Public Policy and Practice

Table 3.14 Medicaid ICF-MR, HCBS and Combined Per Person Expenditures in FY 1993 and FY 2008

State	1993					2008				
	ICF/MR Expenditures	ICF/MR Residents	HCBS Expenditures	HCBS Recipients	Combined Per Person Costs	ICF/MR Expenditures	ICF/MR Residents	HCBS Expenditures	HCBS Recipients	Combined Per Person Costs
AL	$79,030,041	1,266	$22,182,047	2,184	$29,337	$36,179,938	236	$267,362,504	5,670	$51,396
AK	10,362,069	85	0	0	121,907	0	0	76,806,107	1,061	72,390
AZ	16,911,180	298	114,161,800	6,071	20,580	15,370,880	209	619,467,289	20,154	31,176
AR	89,553,111	1,724	10,391,122	453	45,909	147,860,176	1,601	97,104,703	3,360	49,378
CA	356,304,904	11,025	92,414,694	11,085	20,295	610,506,432	9,379	1,709,007,000	75,867	27,210
CO	50,704,123	737	63,448,347	2,407	36,308	22,289,078	128	311,354,728	7,275	45,069
CT	181,959,971	1,272	139,890,550	2,069	96,334	236,997,479	1,116	475,540,000	7,905	78,987
DE	26,574,433	370	9,667,487	290	54,912	29,834,083	138	83,576,384	817	118,754
DC	63,961,219	804	0	0	79,554	82,083,747	533	54,469,781	1,203	78,660
FL	192,151,682	3,207	38,671,466	6,009	25,046	338,699,599	3,129	945,063,427	30,939	37,682
GA	116,223,419	1,933	15,068,108	359	57,283	103,532,026	984	381,689,803	11,296	39,513
HI	6,155,659	117	8,620,253	450	26,060	9,027,307	86	104,462,436	2,531	43,366
ID	38,497,578	494	2,700,000	174	61,673	62,009,912	535	68,119,007	2,233	47,012
IL	531,667,554	12,160	34,477,962	2,850	37,718	659,781,238	9,023	461,700,000	14,496	47,684
IN	283,528,589	6,213	483,489	447	42,644	304,804,854	4,099	443,949,814	10,247	52,193
IA	160,959,092	1,890	2,477,295	170	79,338	288,092,999	2,134	303,613,019	13,205	38,575
KS	106,648,757	1,837	36,813,107	1,066	49,418	63,193,294	584	274,843,524	7,373	42,483
KY	69,885,596	1,053	24,505,668	855	49,471	111,177,567	524	226,531,475	3,161	91,644
LA	324,034,343	4,678	13,087,458	1,134	58,004	480,841,734	5,059	322,451,876	6,834	67,543
ME	59,821,344	630	23,606,982	509	73,247	65,103,006	210	248,956,942	2,867	102,067
MD	60,767,020	894	64,502,005	2,437	37,607	55,148,164	279	517,577,519	10,831	51,550
MA	315,569,399	3,520	74,222,387	3,288	57,255	234,838,072	901	583,547,891	11,381	66,633
MI	149,187,111	3,342	78,234,680	2,885	36,522	16,728,240	81	381,731,216	7,987	49,388
MN	288,650,678	5,072	107,234,621	3,408	46,685	178,358,058	1,832	925,198,681	14,563	67,311
MS	79,043,314	2,038	0	0	38,785	285,877,979	2,623	38,013,057	1,975	70,442
MO	113,792,154	1,709	75,838,414	2,622	43,784	129,144,945	965	392,751,282	8,729	53,837
MT	10,387,598	165	13,515,850	504	35,730	13,044,028	55	78,281,028	2,268	39,313
NE	34,216,508	721	24,169,388	991	34,104	68,217,464	510	147,500,141	3,589	52,627
NV	26,810,867	208	2,295,417	186	73,874	18,993,803	105	65,416,400	1,591	49,770
NH	5,364,387	74	53,026,255	1,032	52,794	3,005,371	25	155,729,108	3,580	44,032
NJ	286,201,207	3,892	113,719,749	4,191	49,477	633,120,543	2,878	505,880,000	10,048	88,117
NM	42,832,979	681	7,552,177	612	38,968	23,171,893	181	267,982,051	3,777	73,561
NY	1,927,559,462	21,850	163,595,442	3,398	82,825	2,675,003,359	7,752	3,825,876,515	58,560	98,035
NC	316,571,784	4,662	16,223,347	1,190	56,869	461,931,336	4,176	457,750,000	9,700	66,279
ND	37,077,368	618	20,585,690	1,362	29,123	70,722,378	585	77,570,212	3,657	34,958
OH	449,570,809	8,222	26,512,352	1,120	50,962	691,974,985	6,418	813,795,687	18,106	61,400
OK	132,075,921	2,415	43,728,032	1,287	47,489	126,917,256	1,486	267,877,651	5,548	56,127
OR	80,043,415	468	86,645,986	2,023	66,917	12,240,527	32	438,537,585	10,879	41,314
PA	500,105,694	6,768	169,500,650	3,795	63,392	578,710,845	3,854	1,224,627,946	29,357	54,299
RI	105,169,194	457	74,432,864	1,192	108,916	8,737,800	40	251,288,605	3,217	79,836
SC	165,306,409	3,232	14,702,477	586	47,147	154,255,458	1,477	213,200,000	5,652	51,544
SD	29,613,205	504	20,474,218	923	35,100	22,366,550	150	86,921,676	2,733	37,908
TN	117,122,556	2,328	10,133,905	587	43,656	241,018,741	1,180	553,899,151	7,467	91,930
TX	508,053,498	12,143	10,741,860	968	39,569	890,443,032	11,177	698,358,386	18,409	53,701
UT	45,245,234	938	29,537,055	1,476	30,979	69,802,718	797	126,595,282	4,062	40,419
VT	11,213,196	79	28,628,023	598	58,850	979,000	6	121,270,835	2,270	53,713
VA	148,246,524	2,669	12,350,227	537	50,093	273,332,795	1,627	443,732,502	8,106	73,674
WA	206,468,229	1,650	79,960,529	1,711	85,221	150,434,481	760	352,550,599	9,205	50,475
WV	14,607,955	640	38,188,818	637	41,344	60,128,913	477	222,657,003	3,891	64,740
WI	207,826,034	3,887	50,139,752	2,017	43,693	128,508,098	946	504,234,866	13,405	44,091
WY	6,224,937	90	17,308,645	459	42,866	18,312,242	82	93,970,241	2,082	51,887
US Total	9,185,859,310	147,729	2,180,368,650	86,604	48,505	11,962,854,423	93,164	22,310,392,935	525,119	55,433





Quality-Based Community Expansion - "Q-Base"

The Kansas Developmental Disabilities (DD) Reform Act (KSA 39-1806), passed in 1995, mandates development of a community network of supports that foster independence, inclusion, integration and productivity for Kansans with developmental disabilities. Significant and sustained efforts must be undertaken by the State of Kansas, in partnership with community providers, in order to build the infrastructure required to carry out this commission.

While small increases in needed resources have been championed by the legislature in recent years, no organized effort has been initiated by policy makers to either address the glaring needs of the community DD system or meet the mandates of the KS DD Reform Act. Strong leadership is now needed to steer the State into a new era of sustained investment in a community-based system of supports for Kansans with developmental disabilities that will finally answer the call of the KS DD Reform Act.

The beginning steps of such a sustained effort must include the elimination of the State's waiting lists for DD services, which now number more than 4,000 children and adults with developmental disabilities.

However, policy makers must understand that in order to end the State's waiting lists, community service capacity must be dramatically enhanced - both programmatically and in terms of human resources infrastructure.

The following is a broad proposal that we believe must be embraced if we are to meet the mandates of the DD Reform Act. This proposal is based on a simple but critical premise, i.e. waiting lists and rate increases must be addressed in combination if the State and its Community partners are to significantly expand community services for persons with developmental disabilities.

Proposing new resources to fund "stand alone items" ignores the reality that waiting list funding alone will not enable community service providers (CSP) to meet the needs of persons on the waiting list, e.g.:

- In several areas of the State CSPs are unable to hire staff to serve new consumers due to low starting wages.
- Other CSPs are without enough supervisory staff, due to turnover, to safely oversee a business expansion.

- Requests that a CSP serve a person with challenging behavioral issues may be turned down due to the relative inexperience of existing staff, or

- Other requests that a CSP serve a person with challenging medical issues may be turned down due to a shortage of persons on staff with adequate training to safely provide the ancillary support tasks of tube feeding or tracheotomy-cleaning.

To provide increasing amounts of services requires the State/Community partnership to expand service capacity and enhance service quality in amounts commensurate with the needs of persons to be served, ahead of the curve of service expansion.

To increase service without this consideration invites quality erosion and exacerbates safety risks to all consumers, not just the consumers funded by new waiting list dollars.

Only with sufficient rate increases, in combination with creative and flexible program management, can the State/Community partnership insure a quality-based approach to community service expansion.

InterHab proposes that any new system dollars – for waiting list reduction and rate increases – be creatively utilized to address four program components:

- Stewardship

- Quality enhancement

- Capacity expansion

- Waiting lists

Community Stewardship:

Community leadership have long been tasked with combining state/federal resources with local resources to make community DD programs work to the maximum attainment of the statutory and regulatory expectations of the participating funding authorities. To that extent, the following are the stewardship activities that we believe are vital to assure the long term financial sustainability for the coming years:

- State and community efforts must be increased to assure an expanded effort in the community to promote employment and employment related training for persons with developmental disabilities.

- Programs such as 'tiny-k' infant and toddler services which perform vital early intervention for children with disabilities and their families must be enhanced, thereby ensuring a better quality of life for thousands of Kansas children who could be diverted from further need of State-funded assistance.

- State and community efforts must collaboratively develop new family service models that satisfy basic family needs, in order that families are not diverted into the most available funding stream (the current HCBS DD Waiver) but are assisted by options (including the Family Subsidy model, a new Family Services waiver, or other models).

- State and community efforts must be redoubled to increase the maximization of freedom and control that someone can bring to their life.

- State oversight must position its structure, within the philosophical framework of the Developmental Disability Reform Act, to be supportive of community flexibility in adjusting programs, services and staffing to suit the wide spectrum of both proven current needs and possible future needs of populations served.

Quality Enhancement:

The State and community collaboration of the past, which ushered in a high degree of professionalism and expertise in all areas of the delivery of community services and supports, has taken a back seat to a struggle to maintain 21st century quality enhancement momentum with 20th century resources. This trend must be reversed.

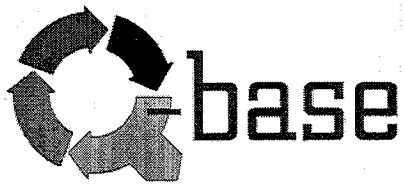
Further, additional emphasis and resources must be brought to bear on the State's efforts to encourage self-advocacy among Kansans with Developmental Disabilities.

Finally, in order to fill a vital community education and oversight role, the State should pursue creation of a Kansas DD Ombudsman. This ombudsman would provide information to persons served and their families regarding community service and provider options, as well as collect needed data on community provider customer service, quality of service and service access issues.

A significant resource commitment must be made in the following areas of training:

- Training initiatives to assist in the delivery of high-quality services to the increasing numbers of persons with health, behavioral or age-related challenges,

- Training initiatives to upgrade the skill-set of every supervisor of community direct care staff, and



30-10

- A comprehensive review must be undertaken to assess the core quality related proficiencies of the current network of service providers.

The expansion of services, the expansion of non-licensed providers, and the lack of adherence to core standards among newly licensed providers – all of these factors give rise to a concern among community leadership that standards of service intended to safeguard the interests of consumers have been sacrificed due to resource shortages. Minimum standards must be established, and reimbursement rate structures must reflect a commitment to such standards.

In the era of increased self-sufficiency among persons receiving service, ensuring the adherence to statutory and departmental quality benchmarks such as the core components of the DDRA (integration, inclusion, independence and productivity) is vital. The State must undertake a development process to implement full oversight of these new service choices, in order to determine that established statutory and departmental outcomes are met.

The State's Waiting Lists:

State and community leaders must better assess and present the characteristics of persons' needs who are waiting for services. Merging the two lists into one list would acknowledge that individuals' needs cannot be arbitrarily prioritized by who is and who isn't currently receiving some services.

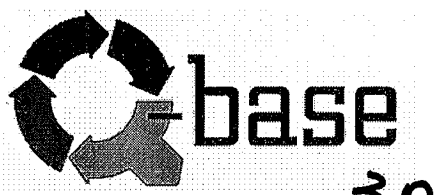
State and community leaders must also re-emphasize the generic community supports that do exist, and persons waiting for services, and their advocates, must be assisted in accessing such generic supports. Generic supports can, and often do, mitigate some of the negative effects of waiting for service, and sometimes can become a non-paid alternative to paid services.

Capacity Expansion:

Community service providers have few tools with which to develop the human resource capacity needed to serve significant new numbers of persons, given that the principal energy of human resource professionals in the system is spent in the constant battle to overcome high-turnover and staff shortages that arise as a direct result of low wages.

True capacity building can only result from significant upward adjustments in the wage base to reduce the stigmatization of such jobs as low-wage, no-advancement jobs. Reducing such stigma removes the initial barrier faced by HR staff, i.e. that persons entering the job market routinely do not apply for our jobs because they are known to be hard jobs with low pay.

Obviously, the foundation of HR capacity building is the foundation upon which the community service policies rise or fall. It is critical, but still woefully under-addressed, that the State must provide resources adequate to enable service providers to recruit, train, and retain high-quality



30-11

direct care staff. Current reimbursement rates are neither adequate nor reasonable to make better wages and benefits possible.

HR capacity building is additionally needed to enable focusing in the following ways:

- To ensure that community developmental disability service providers are reimbursed at a rate which allows them to offer wages and benefits commensurate with attracting and retaining quality direct support staff.

- To utilize higher qualified and/or more experienced staff for the increasing numbers of consumers served whose diagnostic characteristics include (a) significant health needs, (b) increases of the early onset of age-related illness, principally Alzheimer's and other forms of dementia, (c) behavioral challenges of such significance that the failure to provide adequate staff to serve such persons could easily constitute risks to the consumers or the community at large;

- To increase the development of community generic support to help meet individual needs with non-paid services; and,

- To better educate community employers to see workers with DD as a resource to be utilized, and to provide the informal short term assistance to make that happen, as well as the intermittent long-term follow up to assure the viability of those employment experiences.

- To fully-fund supported employment services for persons with developmental disabilities in order to assist them in becoming independent, contributing members of their communities.

30-12

Statewide Independent Living Council of Kansas SILCK

700 S.W. Jackson, Suite 212, Topeka, KS 66603 ☎ (785) 234-6990 voice/TDD ☎ (785) 234-6651 FAX

Testimony to
Legislative Budget Committee
August 27, 2011

Mr. Chairman and Members of the Committee:

My name is Shannon Jones. I am the director of the Statewide Independent Living Council of Kansas, (SILCK). The SILCK envisions a world in which people with disabilities are valued equally and participate fully. To realize that vision, the SILCK works closely with the 12 Centers for Independent Living to promote productivity and economic self sufficiency for people with all types of disabilities.

In response to this committee's request to report on the impact of the 10% Medicaid rate reductions applied to all Medicaid services delivered on or after January 1, 2010, in one word; it has been ***devastating***. Every service delivered under Kansas Department of Social and Rehabilitation Services (SRS) Home and Community Based Services (HCBS) Medicaid waiver program was reduced by 10%. That includes personal care attendant services, assistive services, sleep cycle support and others.

To date, we know of at least ***70 people who have died*** while waiting for services.

- The 10% cut and previous state budget reductions have resulted in a ***PD Waiver waiting list of 2,286 people as of August 1, 2010.*** These individuals on the waiting list need attendant services due to conditions such as: congestive heart failure, chronic obstructive pulmonary disease, muscular dystrophy, degenerative disk disease, cancer and arthritis, kidney failure and diabetes, stroke, spinal cord injury, leukemia, seizure disorder, lung disease and multiple sclerosis.

- On January 1, 2010 SRS also began limiting PD Waiver attendant services to no more than 10 hours per day. Statewide, there are approximately 200 people with significant disabilities who receive personal care attendant services over 10 hours per day based on real needs. This includes people with quadriplegia, some of whom rely on breathing-assist technology. They have active minds and do not belong in a nursing home. Many are in the process of appealing this reduction in service based on the significant impact it will have on health and safety.

- The $35 a night salary rate for night support (i.e. assisting a person with a significant disability to turn in bed during the night, take medication, use the restroom) was cut 10%. Once we pay the attendant $30 for night support, there is not enough money to cover our costs of Workers Comp and FICA. So we're forced to decic
attendant pay for night support, or drop night support services

Legislative Budget Committee
Date 8-26/27-2010
Attachment 31

Night support was completely eliminated for people on the Frail Elderly Waiver.

- Assistance with instrumental activities of daily living (IADL's) such as meal preparation, laundry and shopping has also been reduced.

- Assistive Services, such as grab-bars in the bathroom, ramps, etc., will be limited to those individuals whose situations meet the "critical" condition definition.

- Chore Services, such as snow removal, lawn care, etc., no longer available.

- Loss of Meals-on-Wheels service because providers won't accept the lower reimbursement rate.

- Cuts to wages of personal attendants makes it much more difficult for a person on the PD Waiver to find individuals willing to provide PA services to them.

- The recent series of state cuts to social services has placed the health and safety of people with disabilities who rely on Medicaid services in serious jeopardy. It also forces people with disabilities to decide whether to remain living in their homes in the community with reduced attendant services or to move into nursing homes where they can receive attendant services without a waiting period based on the entitlement in Title XIX of the Social Security Act.

- Home and Community Based Services Medicaid waiver services are ⅓ to ½ the cost of nursing home and other forms of institutional care. Home and Community Based Services show positive results for state money well spent, and the services are consistent with the Supreme Court's *L.C. v. Olmstead* decision.

The Centers for Independent Living (CILs) are gate keepers for the Physically Disabled (PD) home and community based waiver (HCBS). All of the CILs made cuts internally, rather than put their consumer's health and safety at risk. CIL's also looked to absorb as much of the cut as possible in order to stave off, as long as possible, reducing the wages of personal care attendant, who are already making below poverty wages. Following are the operational cuts most CIL members initiated as of January 1, 2010.

- Reduction of work hours for some CIL employees.
- Wage freeze CIL employees.
- Reducing CIL employees' mileage reimbursement.
- 81 CIL employees were laid-offs and requests for voluntary lay-off, retirement.
- Open center positions not being filled.
- Freeze on hiring for all CIL positions.

Beyond the 10% Medicaid cut and its affect on all the consumers CILs serve, the 2011 budget cuts base funding for CILs by $350,000

There are better ways to balance the budget than cutting social services that are essential to the health and well being of Kansans with disabilities.

The SILCK supports including Home and Community Based Services (HCBS) Medicaid waiver programs in the SRS caseload estimating process. This would insure that people eligible for long-term care services have a choice to receive such services either in their homes in the community or in a nursing home/institution.

Currently, Title IXX of the Social Security Act entitles (i.e., guarantees) that a person who is eligible to receive state-funded personal care attendant services in a nursing home or institution can move into such facility and receive services in a timely manner. There is no state law that provides a similar guarantee for eligible individuals who prefer to receive attendant services in their homes in the community.

The nursing home/institution entitlement reflects an out-of-date historical bias in favor of nursing homes and institutions in an era when the vast majority of people with disabilities (of all ages) have a strong preference to receive attendant services in their homes in the community. Sound fiscal policy would favor HCBS attendant services, which are ⅓ to ½ the cost of nursing home and other forms of institutional care.

The Affordable Care Act (ACA) also offers numerous opportunities for seniors and people with disabilities, including new options for states to deliver on the promise of the ADA and adhere to the principles of the Supreme Court's Olmstead decision.

The SILCK will urge the 2011 legislature to take advantage of incentives and new opportunities in the Affordable Care Act to strengthen home- and community-based services (HCBS), so that people who want to live in the community have the ability to make that choice.

These incentives include an increased federal Medicaid matching rate for new home and community based attendant care services, and establishes the Community First Choice Option (CFCO) to provide attendant support services for seniors and PWD.

It also extends the Money Follows the Person (MFP) program to support state efforts to transition individuals from institutional living back to the community.

We encourage policy makers to explore new ways to leverage federal resources to help our states create new opportunities that promote choice and self-determination for individuals with disabilities.

The SILCK stands ready to work side by side with advocates and it's state's partners to deliver on the Affordable Care Act's promise of access to health care and long term care regardless of disability.

In brief summary, these are some of the steps taken to re-open the 128 bed minimum unit in Stockton:

Arrange for Transfer, Re-hiring, Hiring of staff:

> [20 EU staff came to NCF CU to work after suspension of EU operations in April 2009. Of those 20 former EU staff, 17 are returning to work @ EU. Eight (8) current NCF-CU staff have requested transfer to Stockton when the unit opens as they live near Stockton. Due to distribution of supervisory positions, we have had 3 other NCF-CU staff promote into positions and they will transfer to Stockton when the unit opens. We have had 3 existing KDOC staff request transfer to EU from other facilities, and we anticipate re-hiring or hiring 1-2 new staff members to allow us to reach full staffing for EU operations. Additionally, the contracted nurse and food service employees previously employed at EU have returned. We are in the process of hiring staff for NCF-CU in Norton to replace (or back-fill) EU staff leaving to work at the Stockton facility.]

Install sprinkler system to bring housing unit in compliance with current fire codes ($70,000)

Assess facility for presence of asbestos material prior to re-occupation of the living unit (note - this was part of a system-wide effort, so not sure of a local cost).

Reverse "winterization" of plumbing

Install new heating/cooling units ($47,850). (This was a planned project when unit was in use, but deferred when unit operations were suspended in April of 2009).

Purchase inmate bunks, lockers, desks and partitions ($123,669). (The existing EU inmate furniture was dispersed to support expansion of bedspace at LCMHF after EU operations were suspended in April of 2009).

Purchase and install dining and dayroom tables ($13,815). (The existing EU tables were used to complete the new Medium Dining facility at NCF Central Unit).

Replace some flooring in the Administration area offices ($1,517.60).

Repair plumbing fixtures that developed leaks after period of non-use ($668.48).

Refresh operating policies and procedures (Emergency Plans, Post Orders and Living Unit Rules).

Purchase and install networked security cameras and TV monitor ($10,087 - Bond Money).

Purchase new security items - security radios, walk-through metal detector ($19,386 - Bond Money).

Purchase and install new facility phone system to match phone system at NCF Central Unit ($9,283.55).

Install phones for contracted Inmate Calling Service (Embarq)

Install KIOSK for contracted electronic JPay messaging and inmate account access (JPay)

Re-establish Lexis-Nexis terminal for inmate legal library

Re-establish network connections for PC workstations and for EMR access in Clinic ($1,500).

Install Point-of-Sale scanner for inmate canteen (it was necessary to use the existing scanner from EU at Norton when one here became inoperable. We obtained the vendor "back-up" scanner to use at EU).

Arrange for return and/or re-stocking of EU files, office furniture, office supplies, cleaning supplies and inmate linens/clothing for A&D ($14,676.40).

Re-install and service washer and dryer in inmate laundry area

Re-install barber chair and return barbering equipment/supplies to inmate barber shop

Arrange for return of fleet vehicles to support unit operations

Clean and paint as necessary

We anticipate being ready to house offenders September 1, 2010.

KANSAS
DEPARTMENT OF COMMERCE

Fiscal Year 2011 YTD Update

Legislative Budget Committee

By William R. Thornton, Secretary
Friday, August 27, 2010

Divisions

Business Development
Rural Development
Trade Development
Travel & Tourism
Workforce Services

2

Target Industries

The Department works to grow all sectors of the economy, with a focus on the following:

- Advanced Manufacturing (aviation, etc.)
- Value-added Agriculture
- Bioscience (animal science, pharmaceuticals, etc.)
- Energy (traditional and renewable sources)
- Professional Services (banking, engineering, etc.)

3

Business Development Division

Goal:

- To encourage job creation and capital investment in Kansas through the recruitment of out-of-state firms, the expansion of existing Kansas companies and the creation of new companies.

Products and services:

- Financial incentives such as tax credits and loans
- Site location consultation and cost-benefit analysis
- Assistance in working with State regulatory agencies and community organizations

4

Business Development Division

FY2010 recruitment results:

	FY10	FY09
– Projects opened:	178	185
– Successes:	68	42
– Jobs created:	13,870	9,100
– Jobs retained:	1,218	3,546
– Average salary:	$52,000	$60,320
– Payroll:	$721M	$550M
– Capital Investment:	$838M	$900M

5

Business Development Division

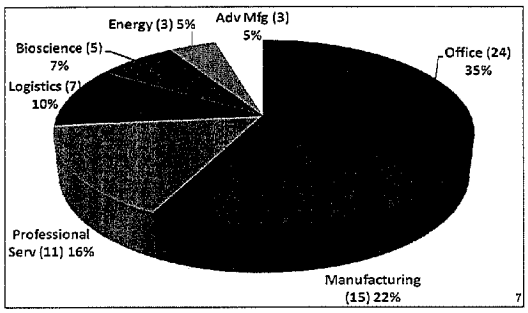
FY2010 recruitment highlights:

- **Cerner**, Kansas City (4,500 jobs, $170M)
- **General Motors**, Kansas City (1,000 jobs, $88M)
- **U.S. Bank**, Overland Park (1,100 jobs, $21M)
- **J.P. Morgan**, Overland Park (650 jobs, $30M)
- **Regent Asset Mgmt.**, Overland Park (1,250 jobs, $2M)
- **Tindall,** Newton (400 jobs, $66M)
- **Redbarn Pet Products**, Great Bend (200 jobs, $2M)
- **Allen Foods**, Topeka (50 jobs, $30M)
- **Jupiter Group**, Junction City (169 jobs, $3.2M)

6

Business Development Division

FY2010 recruitment results by type:



7

Business Development Division

FY2010 retention/expansion results:

	FY10	FY09
– Projects opened:	150	155
– Successes:	42	84
– Jobs created:	5,584	3,548
– Jobs retained:	1,887	3,921
– Average salary:	$39,880	$30,742
– Payroll:	$222.7M	$117.6M
– Capital Investment:	$471.3M	$1B

8

Business Development Division

Combined FY2010 results for recruitment *and* retention/expansion projects:

	FY10	FY09
– Total projects:	328	340
– Successes:	110	126
– Jobs created:	19,454	12,648
– Jobs retained:	3,105	7,467
– Average salary:	$47,986	$49,337
– Payroll:	$943.7M	$667.6M
– Capital Investment:	$1.3 B	$1.9B

9

Business Development Division

FY2010 media accolades and ranks:

- Kansas was named **Top 10** in eight of 20 categories in *Business Facilities*' 2010 Rankings Report, our best-ever finish.
- Kansas was ranked **No.3** in *Southern Business & Development's* "Top Deals and Hot Markets" report, the state's best-ever finish and our second straight Top 5 ranking.
- Kansas was ranked the **No. 7** most pro-business state in the Pollina "Top 10 Pro-Business States" report for the second straight year. It was our third straight Top 10 finish.

10

Business Development Division

FY2010 media accolades and ranks:

- Kansas was ranked **No. 11** in CNBC's annual "America's Top States for Business" report for the second time in three years.
- *Area Development* magazine named Kansas the winner of the **Silver Shovel Award** for excellence in job creation and capital investment. This was our fourth Silver Shovel in five years.
- *Site Selection* magazine named Kansas one of the nation's Top 10 most competitive states for capital investment and facility development. This was our second straight Top 10 finish.

11

Business Development Division

FY2011 YTD recruitment results:

- 1,294 jobs
- $95M in capital investment

FY2011 YTD recruitment highlights:

- KeyBank (300 jobs)
- Hoefer Wysocki Architects (65 jobs, $5.1M)

12

Business Development Division

FY2011 YTD retention/expansion results:

- 922 jobs
- $111.7M in capital investment

FY2011 YTD retention/expansion highlights:

- Bombardier Learjet (300 jobs, $600M)
- Zeolyst International (33 jobs, $83M)

13

Business Development Division

Combined FY2011 YTD results for recruitment *and* retention/expansion projects:

- 2,216 jobs created/retained
- $206.7M in capital investment

14

Rural Development Division

Goal:

- To elevate the focus on rural development and encourage collaboration among rural groups.

Sub-Divisions:

- Agriculture Marketing
- Community Development
- Office of Rural Opportunity

Programs and services:

- Simply Kansas
- Value Added Loan
- CDBG
- Agritourism development
- Main Street
- Tax credits

15

Rural Development Division

FY2011 YTD highlights:

- Continue to advance Connect Kansas, a Recovery Act-funded initiative to increase broadband Internet adoption statewide.
- Planning a second mission trip to Russia to promote the sale of Kansas animal genetics.
- Working with Royal Farms Dairy of Garden City on a virtual farm tour presentation they will give next month at the World Dairy Expo.
- Hosting a series of agritourism workshops in Northeast Kansas.

16

Rural Development Division

FY2011 YTD highlights:

- Finalizing plans for the Kansas State Fair, where we will promote Kansas ag producers, including winemakers and specialty food producers.
- Continuing partnerships with the 25 communities in our Kansas Main Street Program, which saw a significant increase in projects between Fiscal Year 2009 and 2010.

17

Trade Development Division

Goal:

- To help Kansas companies expand sales to foreign markets and recruit foreign companies to set up facilities in Kansas.

Programs and services:

- Organize trade delegations to foreign countries
- Provide export data and foreign market research
- Provide funds for firms to attend trade shows
- Connect Kansas companies with foreign buyers through our international trade offices
- Recruit international companies to locate in Kansas

18

Trade Development Division

FY2011 YTD highlights:

- Arranged for Governor Parkinson to meet with key aviation executives at the Farnborough Air Show in England in July.
- Preparing to attend HUSUM WindEnergy 2010, Europe's largest wind energy trade show, next month. Staff will also visit key companies in Denmark and attend a global wind supply chain conference in Germany.

19

Trade Development Division

FY2011 YTD highlights:

- Organizing an October animal health mission to China, enabling eight Kansas companies to exhibit at the first national convention of the Chinese Veterinary Association in Beijing.
- Working with KSU in their bid to establish a China-U.S. Animal Health Center facility in Kansas.

20

Travel & Tourism Division

Goal:

- To increase tourism expenditures in Kansas

Programs and services:

- Marketing
- Product development
- Research
- Industry outreach and education

21

Travel & Tourism Division

FY2011 YTD highlights:

- Partnering with KDOT on a new Kansas Scenic Byways marketing initiative, featuring a new micro-site, radio and print ads.
- Continuing to work with Kansas Wildlife & Parks on collaborative marketing opportunities.
- Working on a new Tourism Satellite Account report, which will detail the economic impact of tourism on the Kansas economy.

22

Workforce Development Division

Goal:

- To link businesses, job seekers and educational institutions to ensure a pool of skilled Kansas labor

Programs and services:

- KIT, KIR and IMPACT programs
- Workforce Centers
- **KANSAS**WORKS.com
- Registered Apprenticeship
- Trade Adjustment Assistance and Rapid Response

23

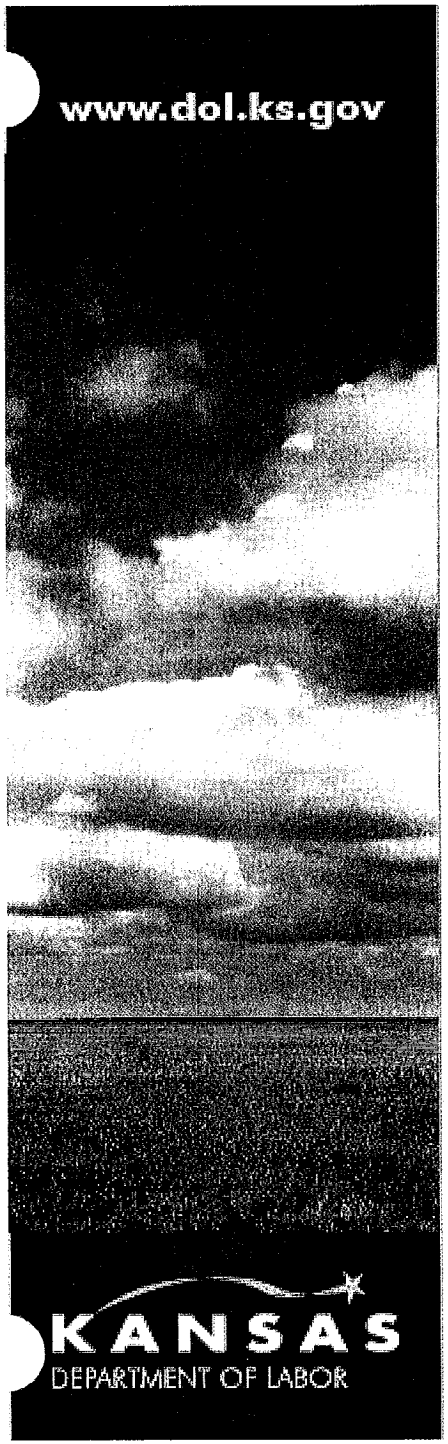
Workforce Development Division

FY2011 YTD highlights:

- Continuing to apply for federal funding to support the state's workforce system. Pending grant applications include:
  - Health Profession Opportunity Grants ($15M)
  - Affordable Care Act State Health Workforce Development Planning Grant ($150,000)
  - Second Chance Grant
- Continuing to advance the $6M State Energy Sector Partnership and Training Grant. Five projects have been approved, and 200 persons have received "green-related" training.

24

33-4

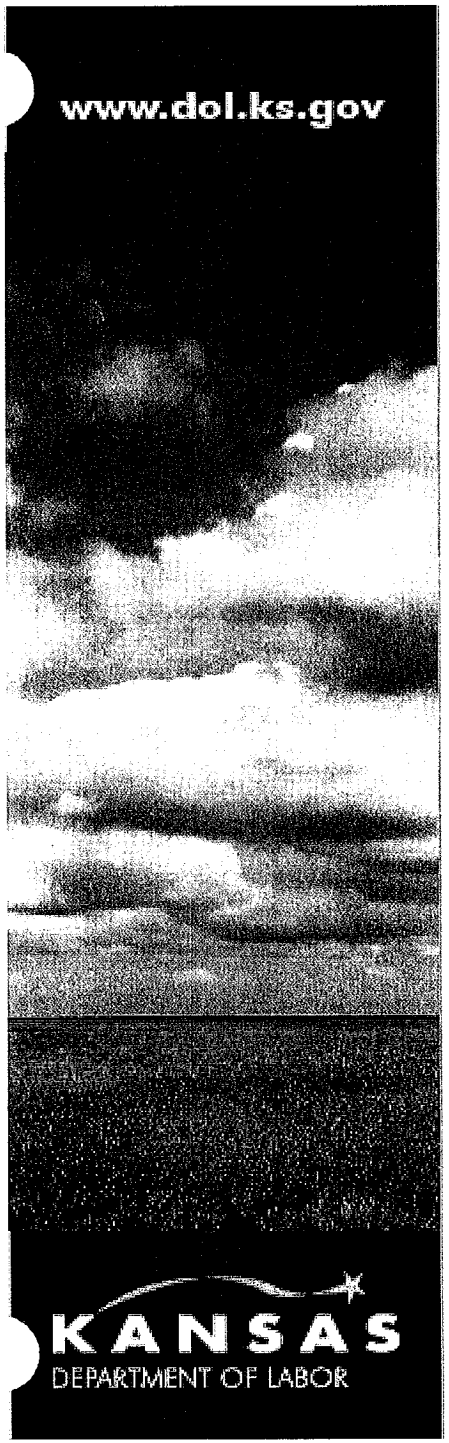


An update on Kansas economic data

Jim Garner, Secretary
Kansas Department of Labor

Legislative Budget Committee
27 August 2010

401 SW Topeka Blvd, Topeka, Kansas 66603 (785) 296-5000



July 2010 Labor Report Overview

Over the year (July 2009 - July 2010) gains

- Gained 1,700 jobs over the year
- First over-the-year gain for total nonfarm employment since October 2008
- Four industries gained jobs over-the-year
  - Construction
  - Government
  - Trade, transportation and utilities
  - Mining and logging

July 2010 Labor Report Overview

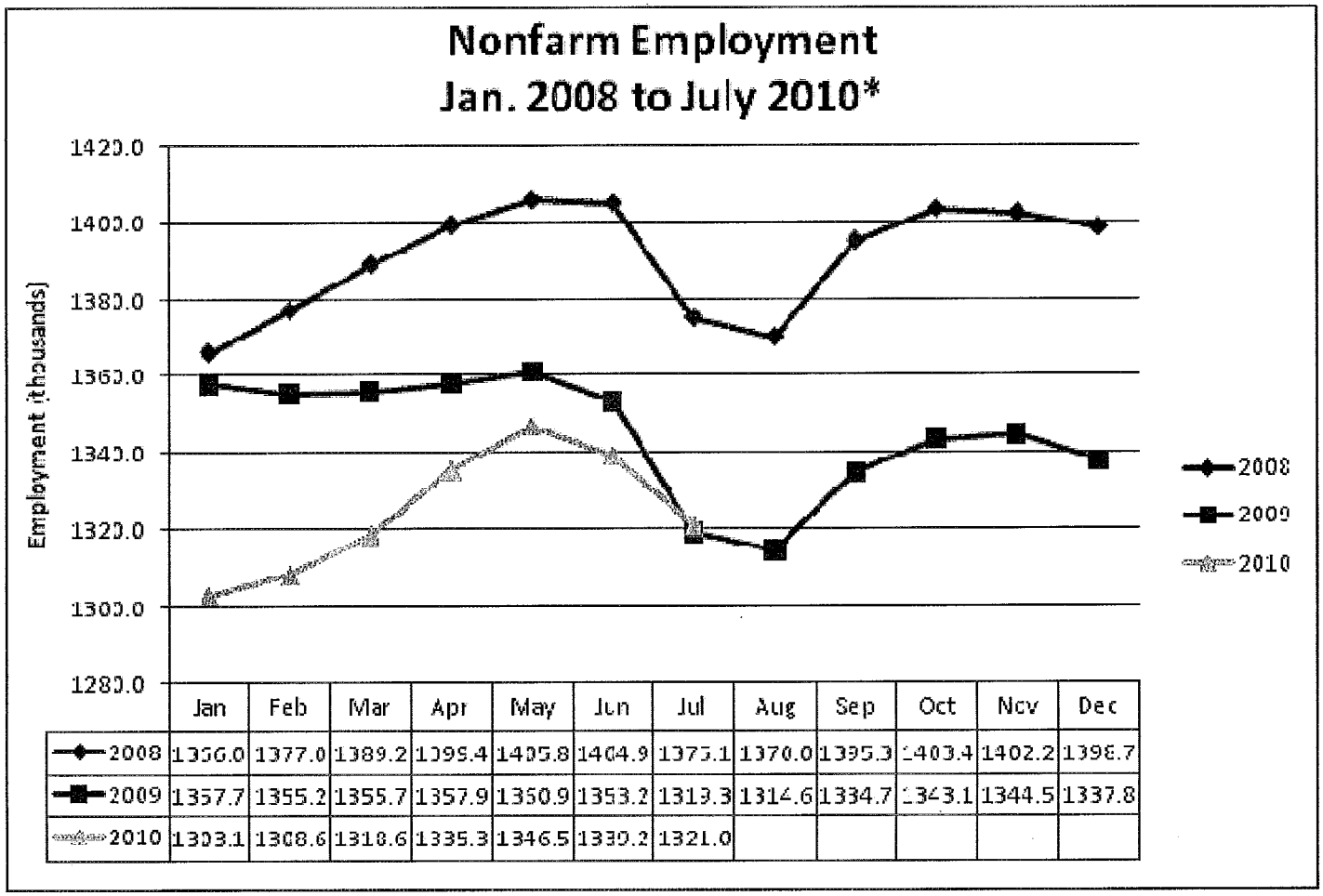
Over the month (June 2010 - July 2010) results

- Lost 18,200 jobs over the month
- Job losses are common from June to July; include the reduction in school personnel during this time
- Six industries reported over-the-month job gains
  - Professional and business services
  - Construction
  - Trade, transportation and utilities
  - Mining and logging
  - Manufacturing
  - Financial Activities

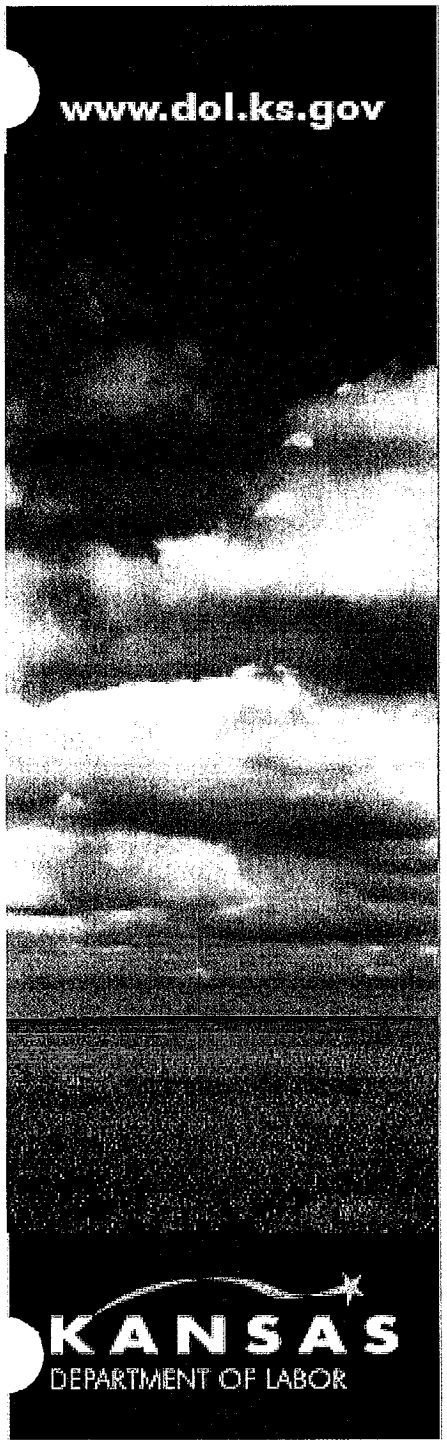
www.dol.ks.gov

KANSAS
DEPARTMENT OF LABOR

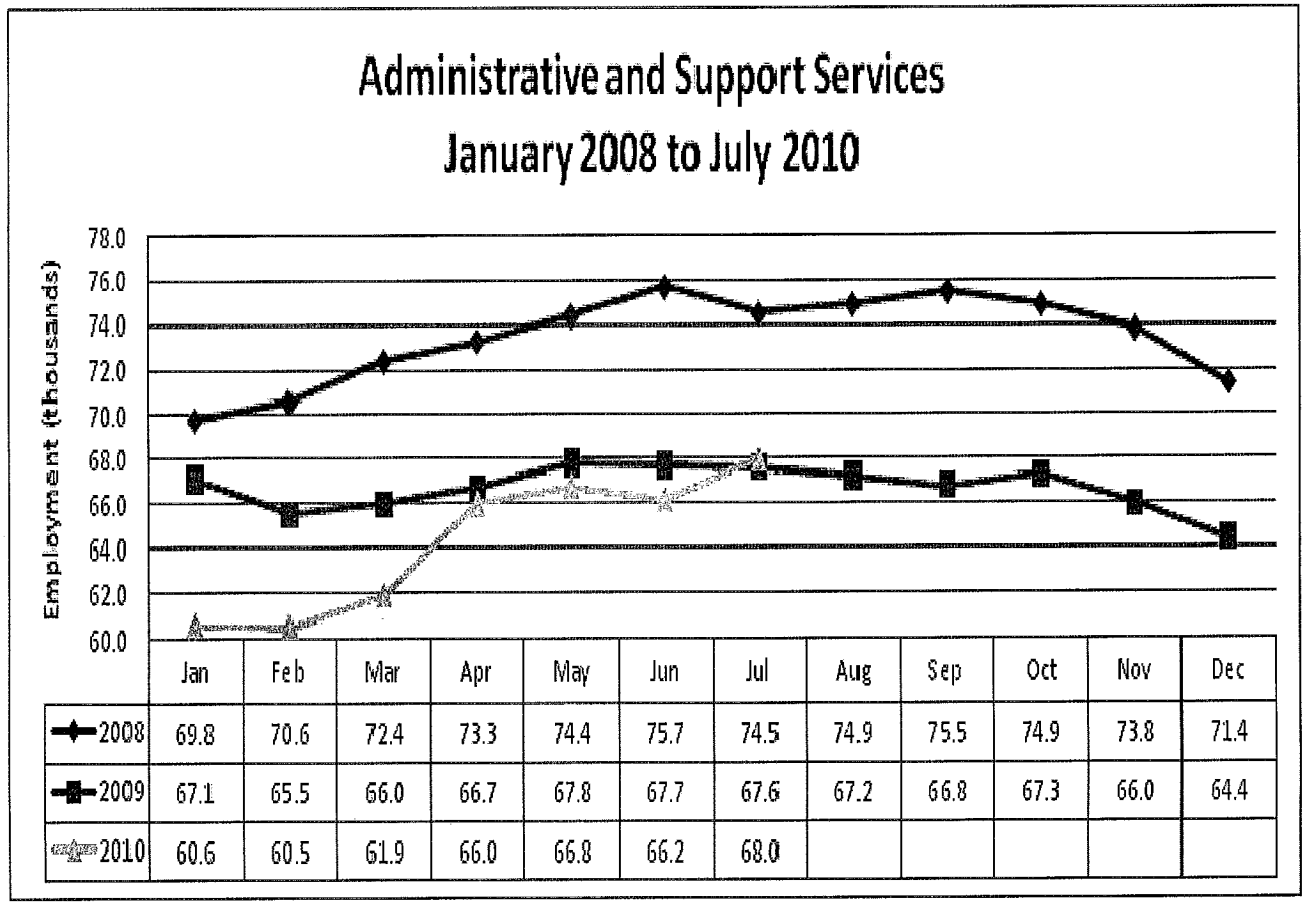
Nonfarm Employment



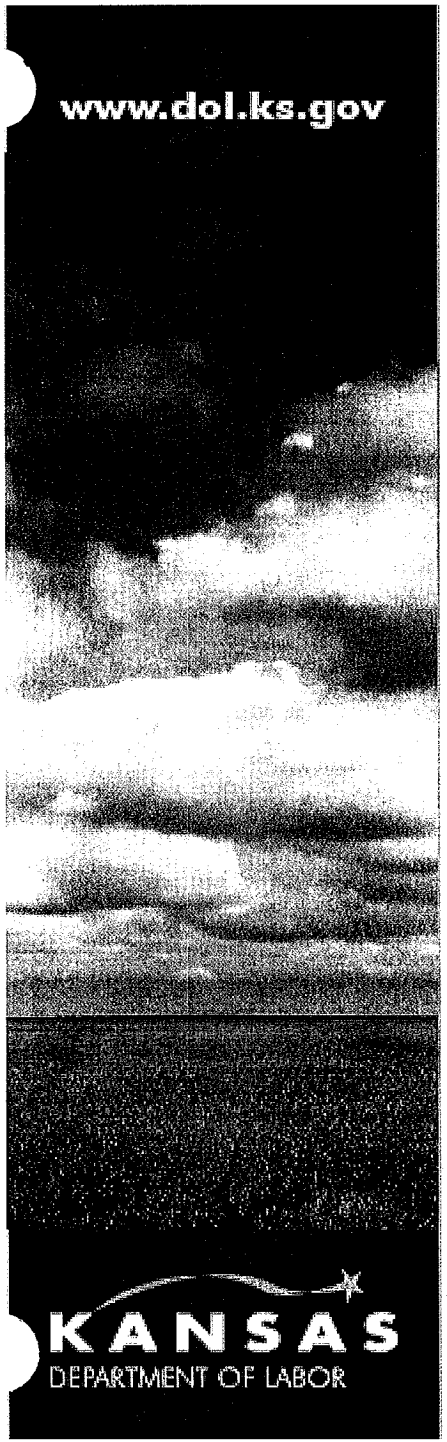
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2008	1396.0	1377.0	1389.2	1395.4	1405.8	1404.9	1373.1	1370.0	1395.3	1403.4	1402.2	1398.7
2009	1357.7	1355.2	1355.7	1357.9	1350.9	1353.2	1319.3	1314.6	1334.7	1343.1	1344.5	1337.8
2010	1303.1	1308.6	1318.6	1335.3	1346.5	1330.2	1321.0					



Nonfarm Employment– Administrative and Support Services

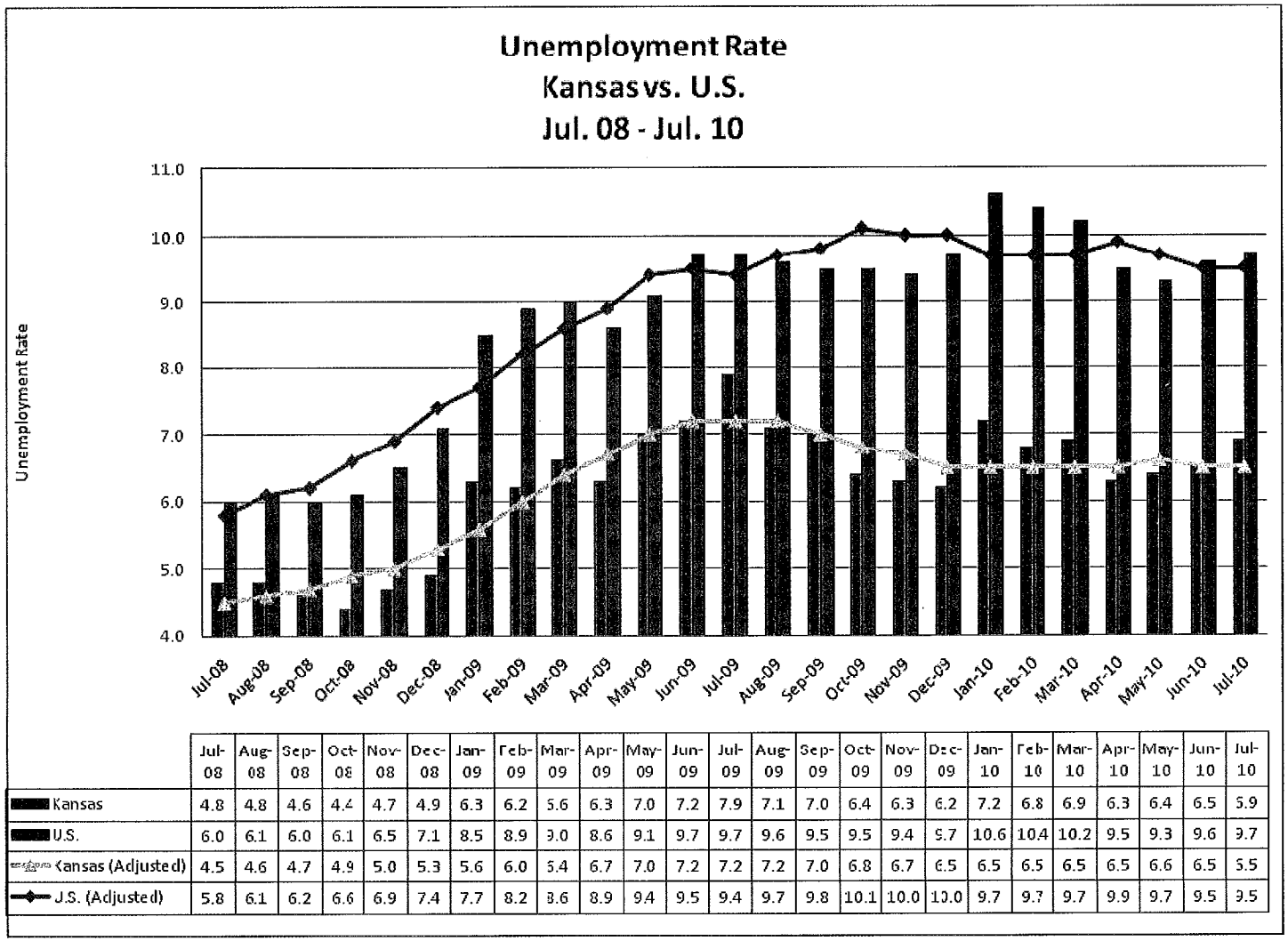


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2008	69.8	70.6	72.4	73.3	74.4	75.7	74.5	74.9	75.5	74.9	73.8	71.4
2009	67.1	65.5	66.0	66.7	67.8	67.7	67.6	67.2	66.8	67.3	66.0	64.4
2010	60.6	60.5	61.9	66.0	66.8	66.2	68.0					

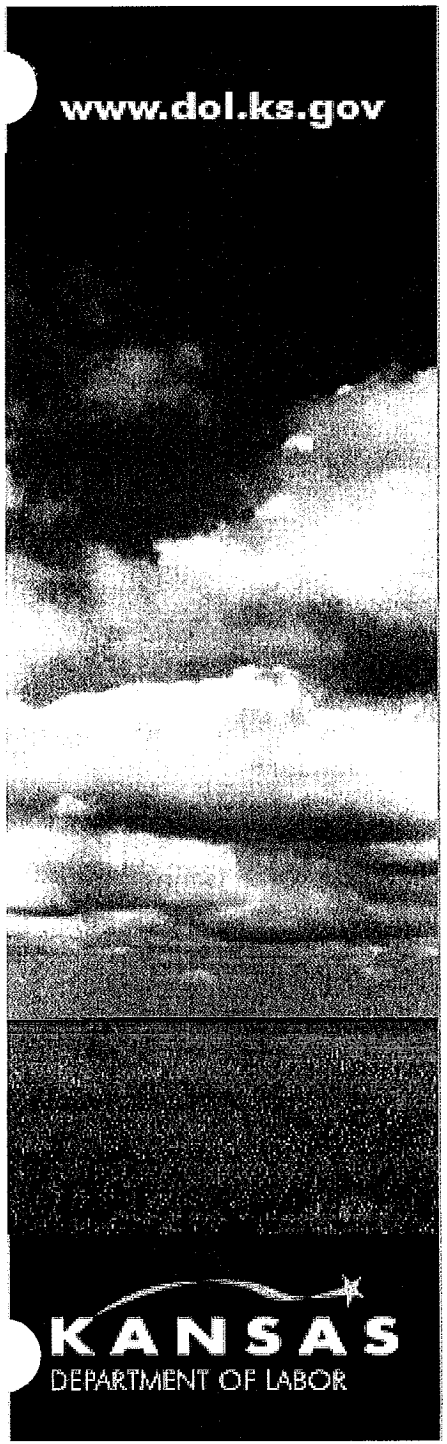


Kansas Unemployment Rate

34-6



	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10
Kansas	4.8	4.8	4.6	4.4	4.7	4.9	6.3	6.2	5.6	6.3	7.0	7.2	7.9	7.1	7.0	6.4	6.3	6.2	7.2	6.8	6.9	6.3	6.4	6.5	6.9
U.S.	6.0	6.1	6.0	6.1	6.5	7.1	8.5	8.9	9.0	8.6	9.1	9.7	9.7	9.6	9.5	9.5	9.4	9.7	10.6	10.4	10.2	9.5	9.3	9.6	9.7
Kansas (Adjusted)	4.5	4.6	4.7	4.9	5.0	5.3	5.6	6.0	6.4	6.7	7.0	7.2	7.2	7.2	7.0	6.8	6.7	6.5	6.5	6.5	6.5	6.5	6.6	6.5	6.5
U.S. (Adjusted)	5.8	6.1	6.2	6.6	6.9	7.4	7.7	8.2	8.6	8.9	9.4	9.5	9.4	9.7	9.8	10.1	10.0	10.0	9.7	9.7	9.7	9.9	9.7	9.5	9.5



July 2010 Unemployment Rate Overview

- Kansas (not adjusted) = 6.9%
- National (not adjusted) = 9.7%
- Kansas (seasonally adjusted) = 6.5%
- June 2010 (not adjusted) = 6.5%
- Peaked in July 2009 (not adjusted) = 7.9%

34-7

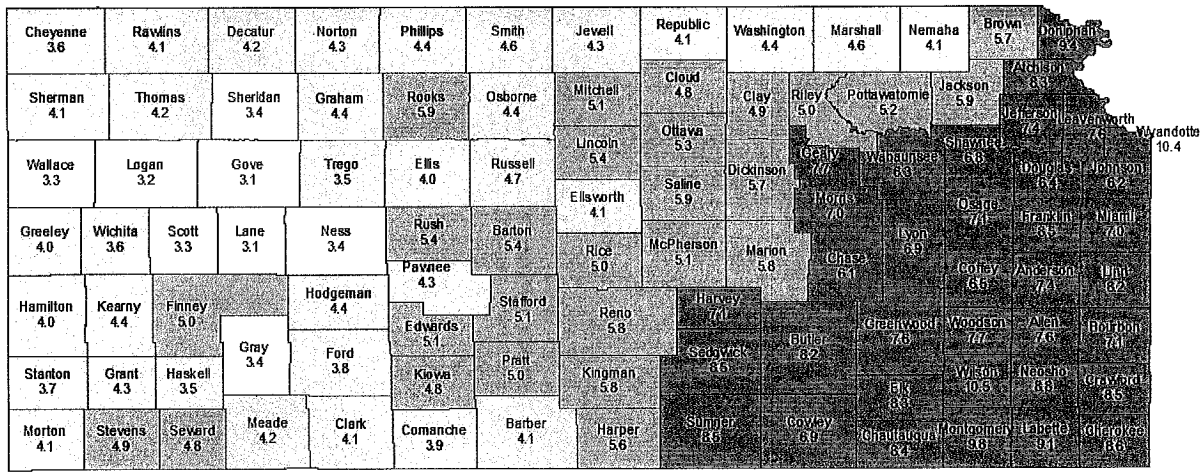
www.dol.ks.gov

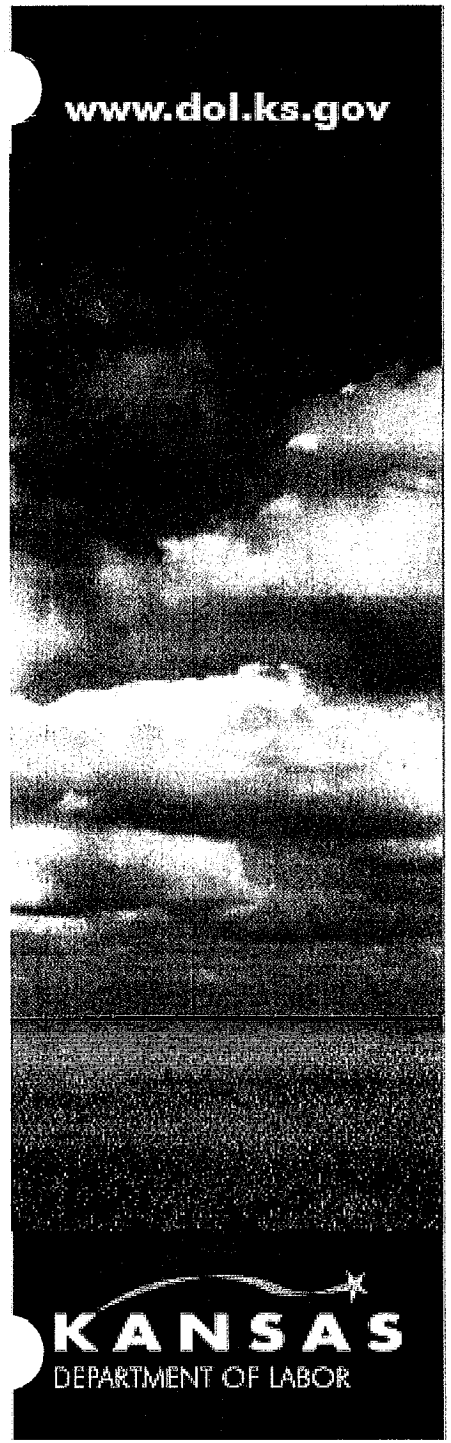
Unemployment Rates by County

UNEMPLOYMENT RATES FOR JULY 2010

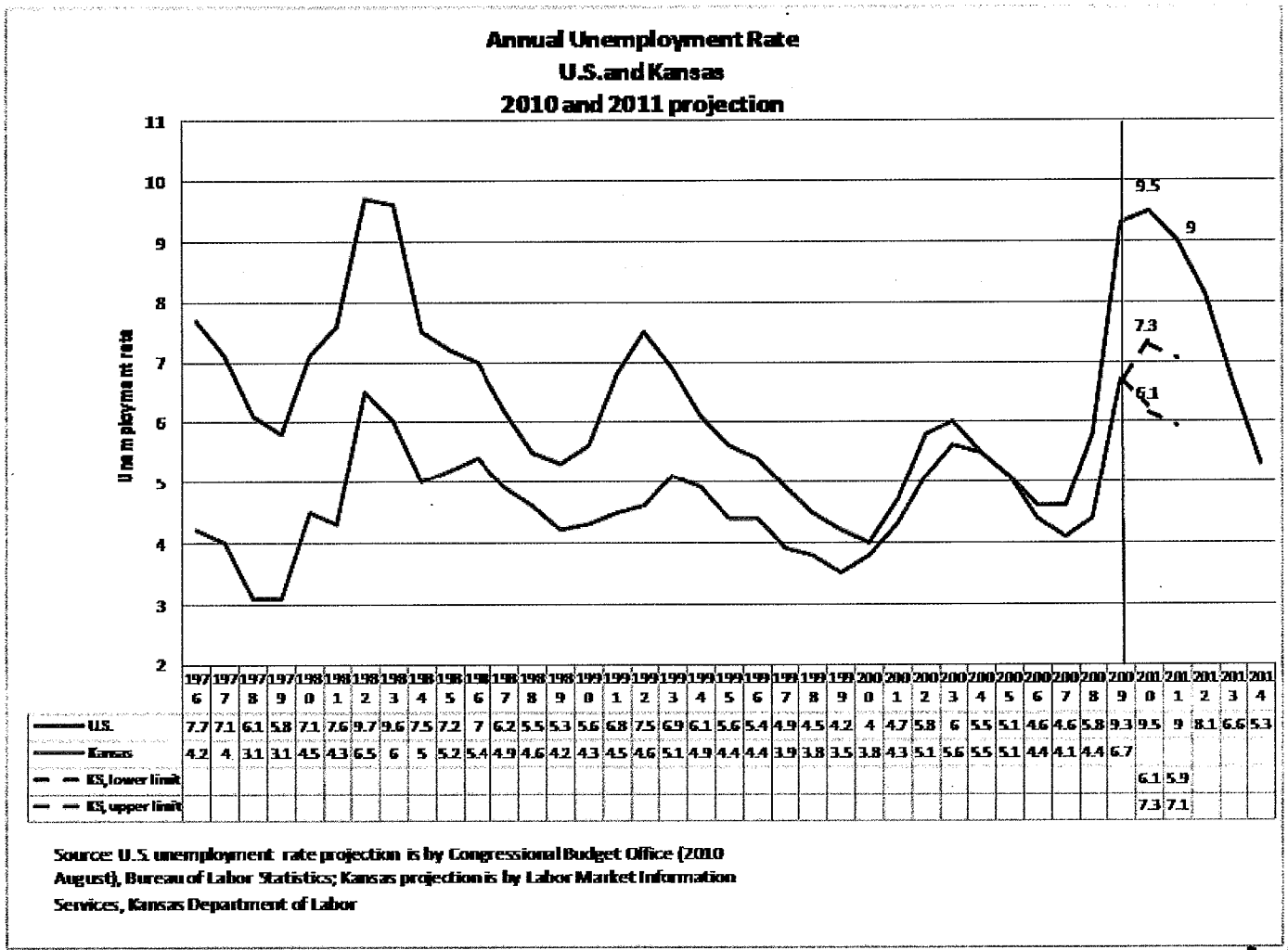
State Rate = 6.9%

Rate
- < 3.5
- 3.5 - 4.7
- 4.8 - 5.9
- >= 6.0



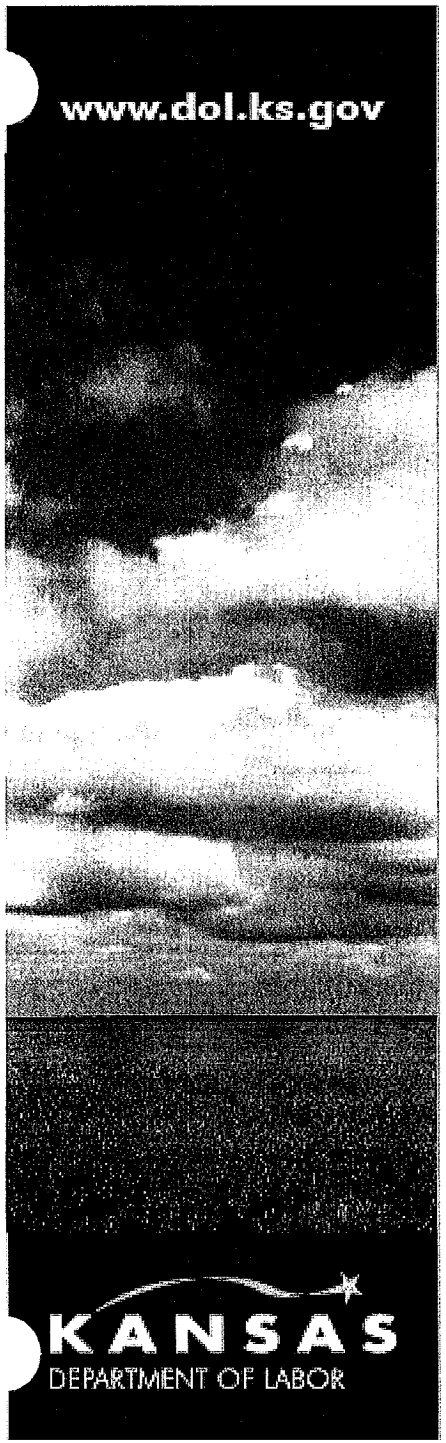


Kansas Unemployment Rate Projections



	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
U.S.	7.7	7.1	6.1	5.8	7.1	7.6	9.7	9.6	7.5	7.2	7	6.2	5.5	5.3	5.6	6.8	7.5	6.9	6.1	5.6	5.4	4.9	4.5	4.2	4	4.7	5.8	6	5.5	5.1	4.6	4.6	5.8	9.3	9.5	9	8.1	6.6	5.3
Kansas	4.2	4	3.1	3.1	4.5	4.3	6.5	6	5	5.2	5.4	4.9	4.6	4.2	4.3	4.5	4.6	5.1	4.9	4.4	4.4	3.9	3.8	3.5	3.8	4.3	5.1	5.6	5.5	5.1	4.4	4.1	4.4	6.7					
KS, lower limit																																			6.1	5.9			
KS, upper limit																																			7.3	7.1			

Source: U.S. unemployment rate projection is by Congressional Budget Office (2010 August), Bureau of Labor Statistics; Kansas projection is by Labor Market Information Services, Kansas Department of Labor



34-10

Unemployment Claims Overview

Initial Claims

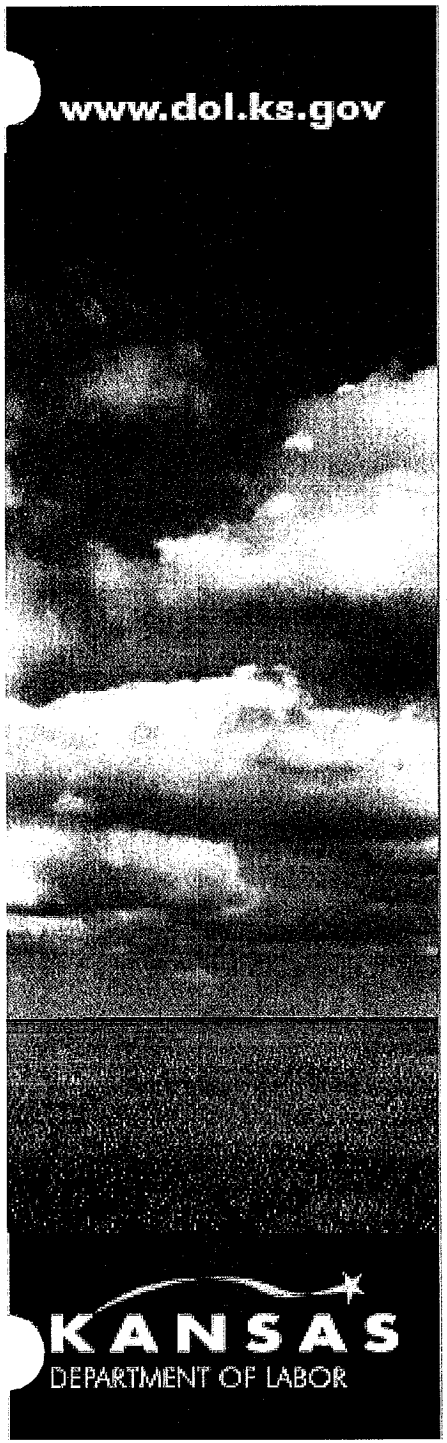
January 2010 - July 2010 = 121,835

January 2009 - July 2009 = 181,552

Continued Claims

January 2010 - July 2010 = 1,113,216

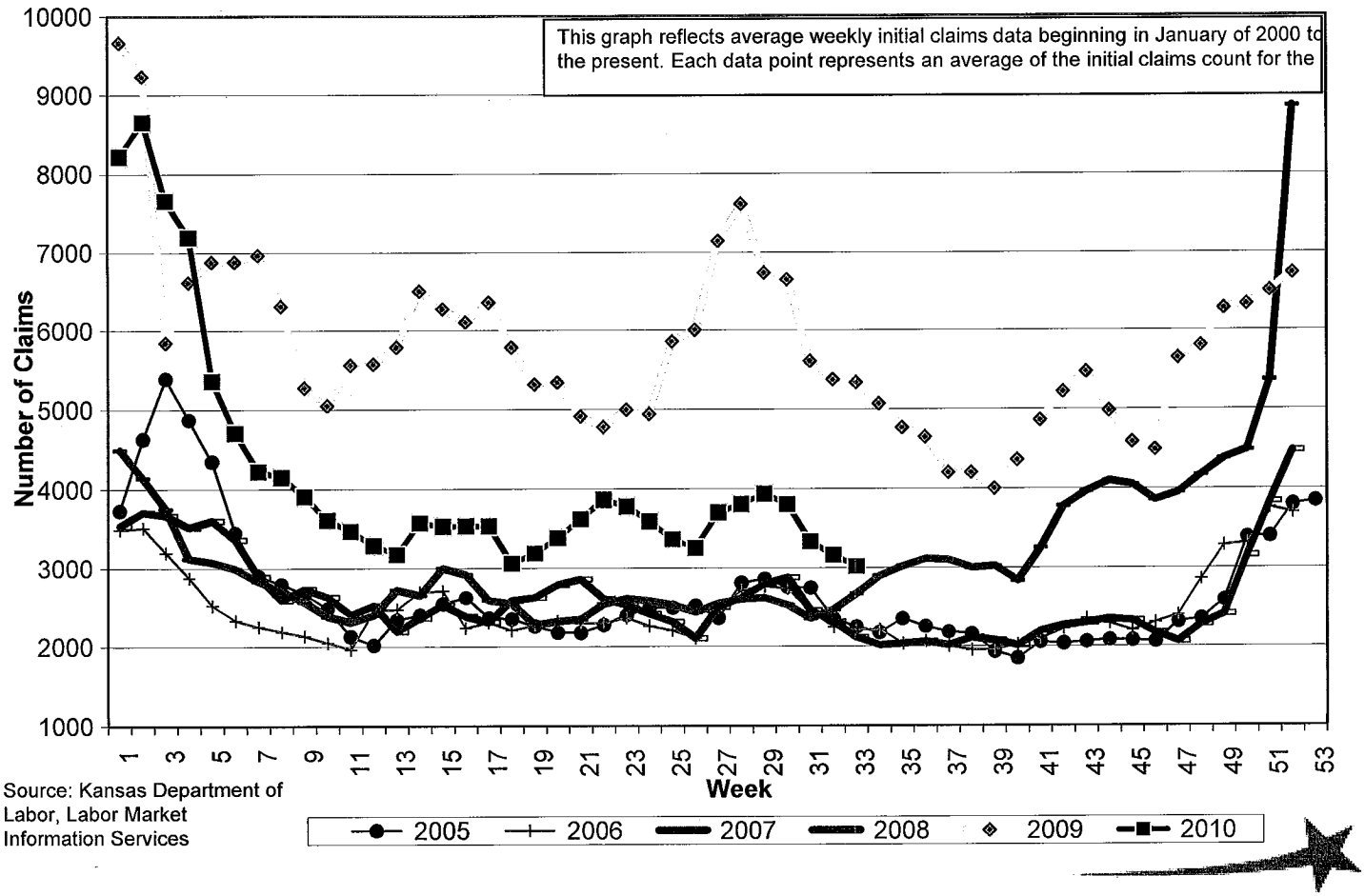
January 2009 - July 2009 = 1,408,027



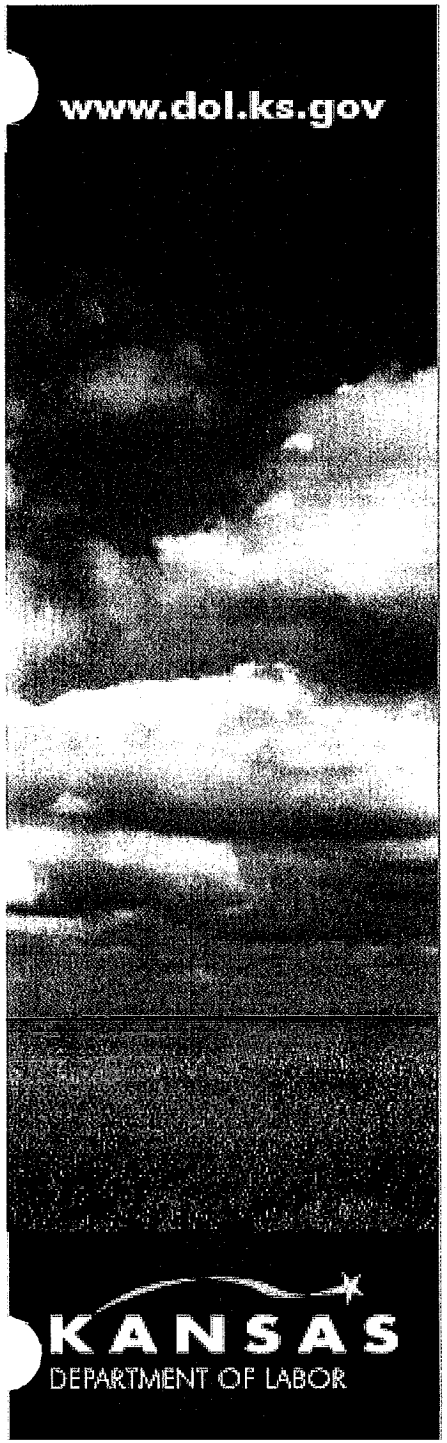
Unemployment Insurance - Initial Claims

34-11

Weekly Initial Claims (4 week moving average)
Kansas
January 2005 - August 21, 2010



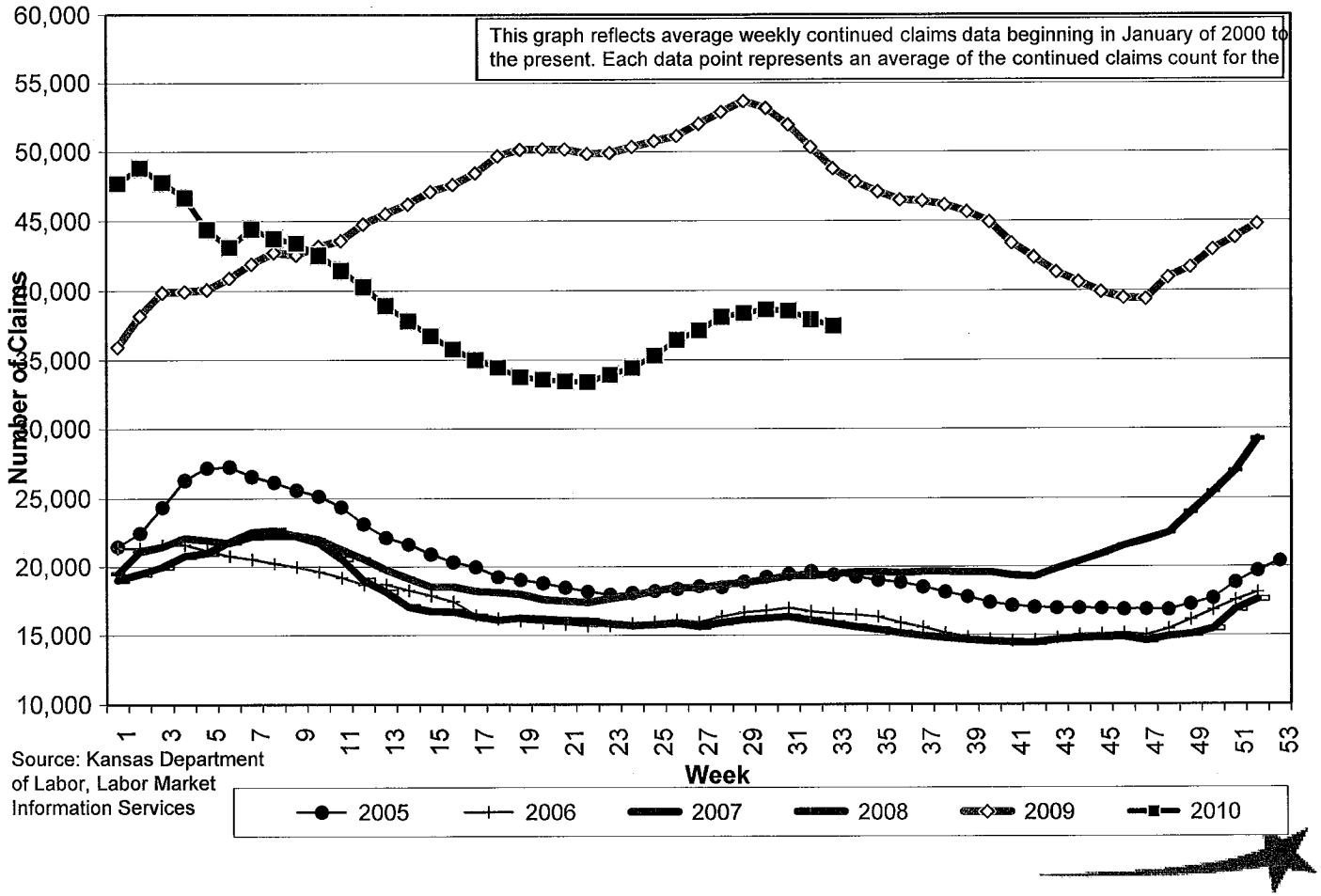
Source: Kansas Department of Labor, Labor Market Information Services



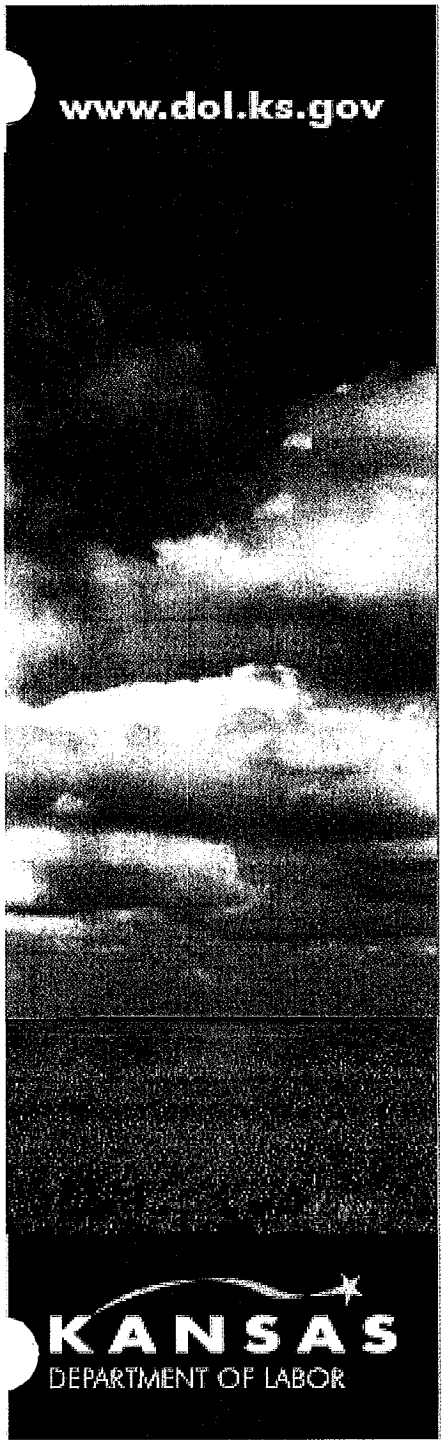
Unemployment Insurance - Continued Claims

34-12

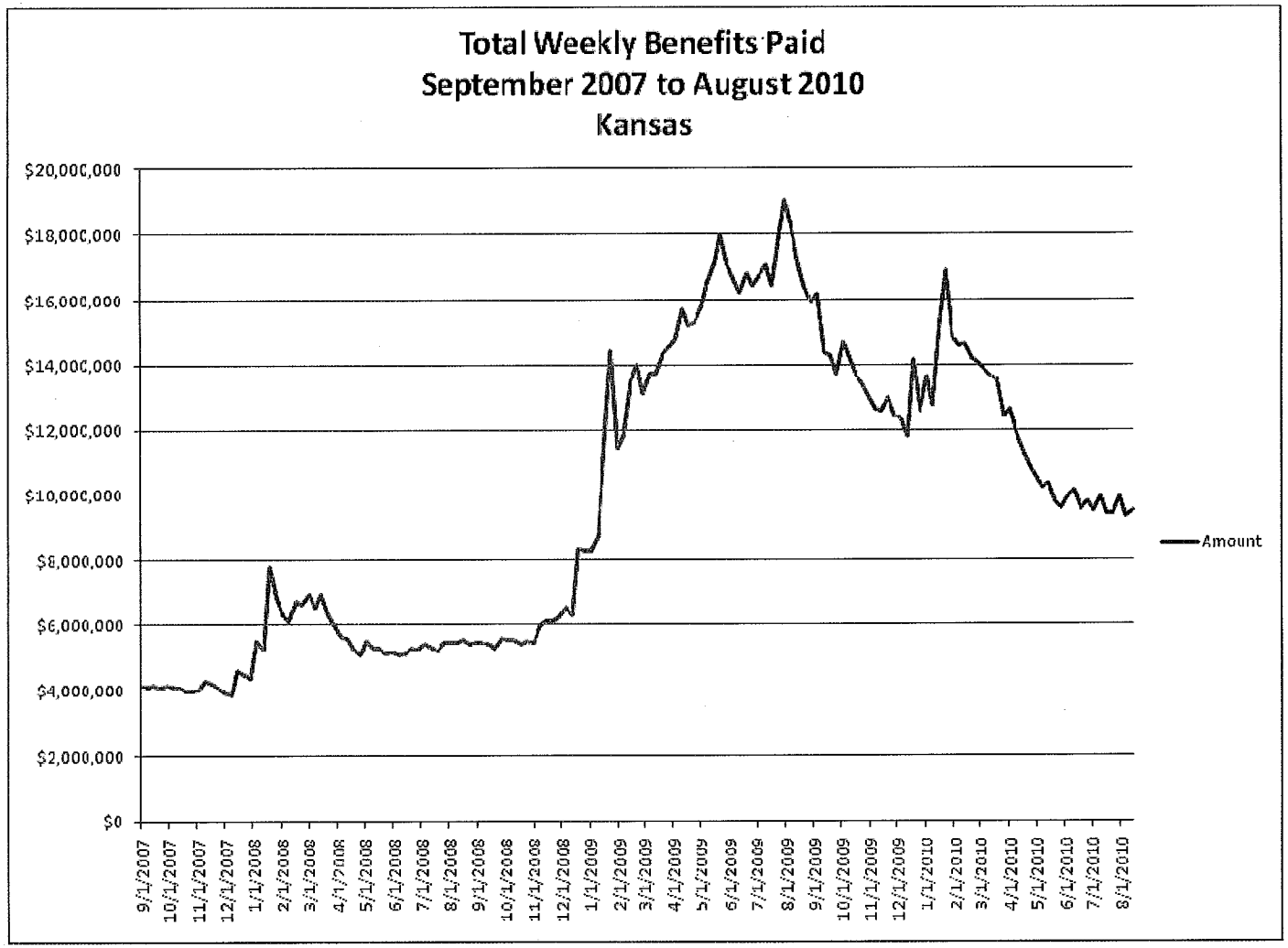
Weekly Continued Claims (4 week moving average)
Kansas
January 2000 - August 21, 2010

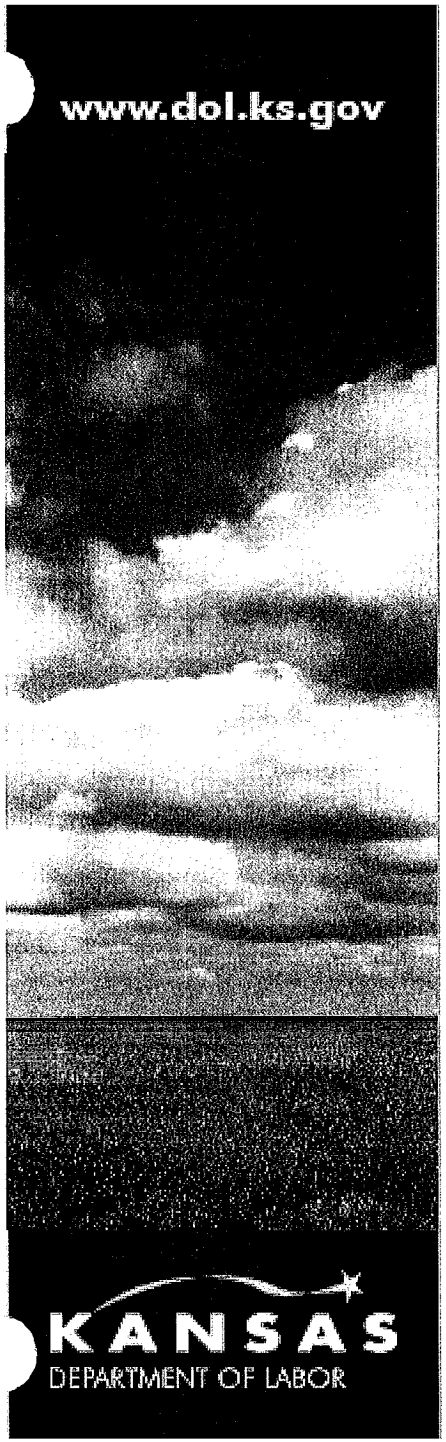


Source: Kansas Department of Labor, Labor Market Information Services



UI Benefit Payments



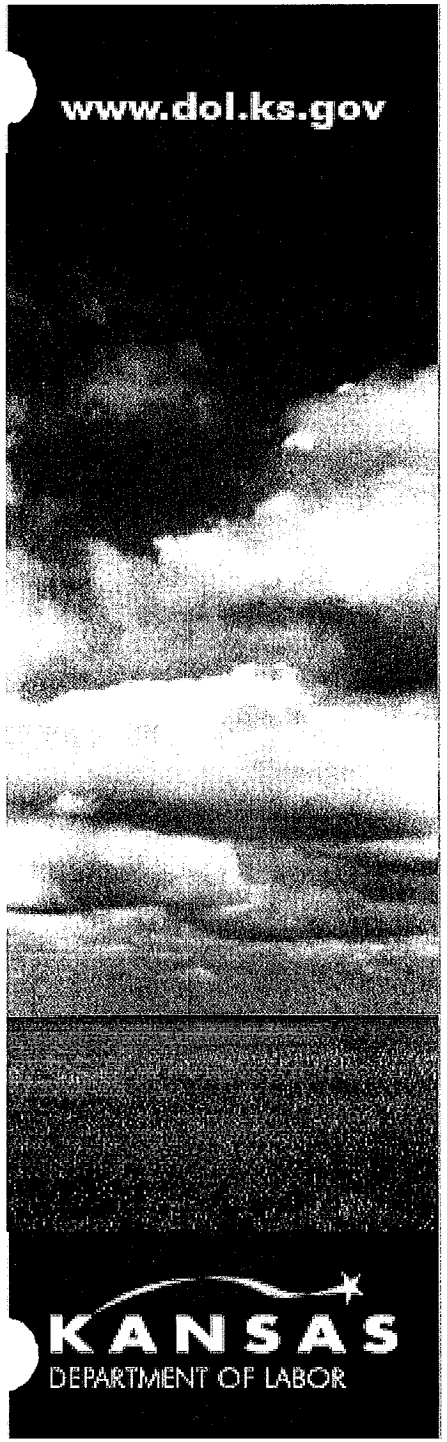


UI Trust Fund Advances

34-14

- 35 States have used federal advances for UI Trust Funds in the current recession
- Approx $40 Billion has been advanced by the U.S. Treasury
- No interest through CY 2010

Alabama	Kansas	Ohio
Arizona	Kentucky	Pennsylvania
Arkansas	Maryland	Rhode Island
California	Massachusetts	South Carolina
Colorado	Michigan	South Dakota
Connecticut	Minnesota	Tennessee
Delaware	Missouri	Texas
Florida	Nevada	Vermont
Georgia	New Hampshire	Virginia
Idaho	New Jersey	Virgin Islands
Illinois	New York	Wisconsin
Indiana	North Carolina	



Kansas UI Trust Fund Balance

34-15

UI Trust Fund Balance

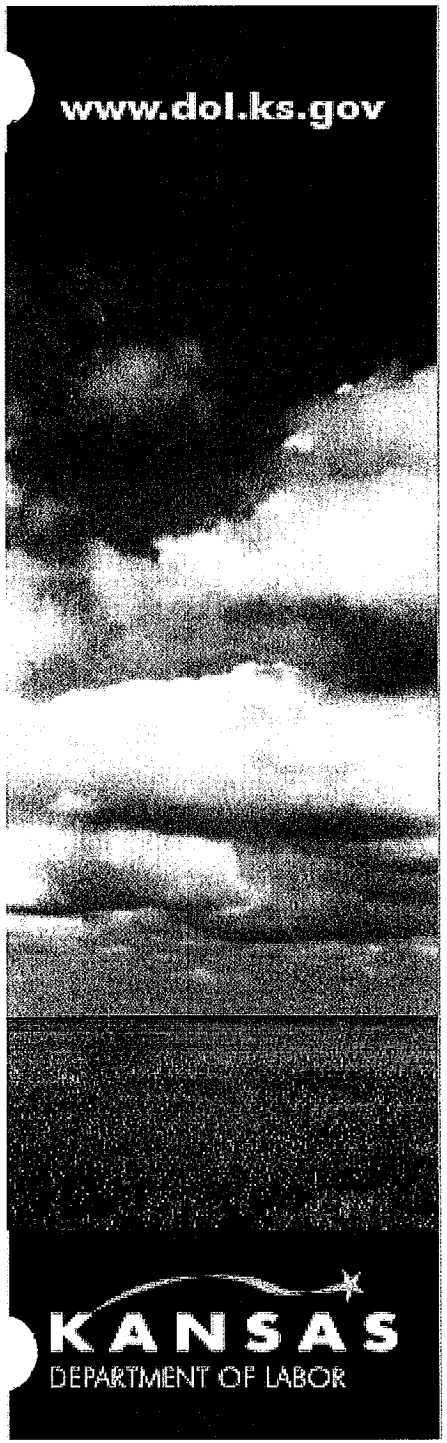
As of week ending August 14th, 2010 : $131 million

UI Trust Fund Advances

As of week ending August 14th, 2010 : $88.2 million

UI Trust Fund Revenue for 2010

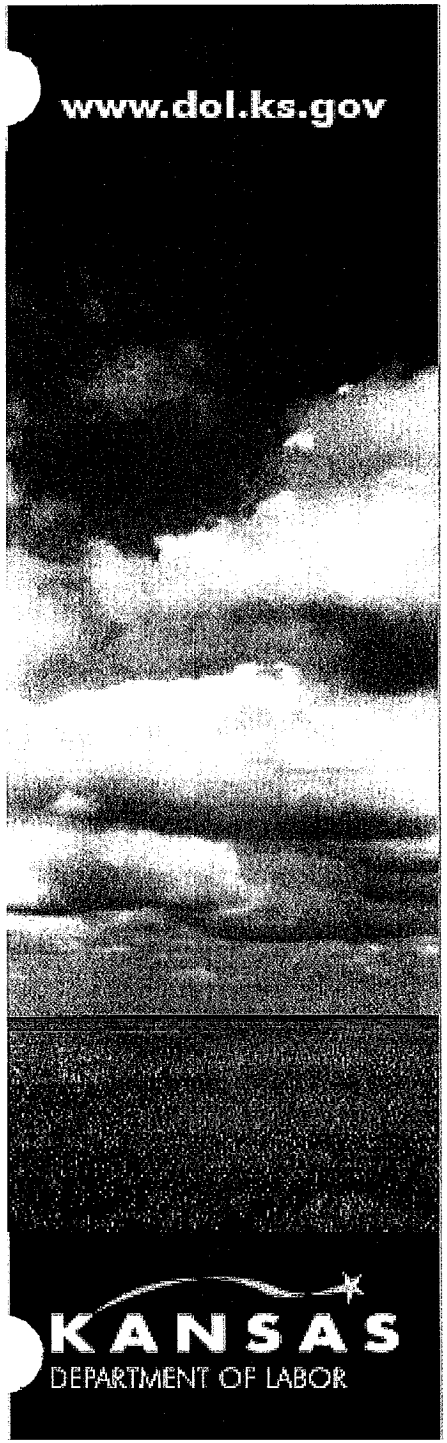
January – July, 2010		Difference	
Expected	Actual	Actual	Percentage
$295,769,420	$282,558,030	$13,211,390	4.47%



34-16

Conclusion

- Over-the-year job gain; first since recession
- Kansas unemployment rate remains below national rate
- Initial and continued claims have steadily decreased since peak of 2009



Jim Garner, Secretary
Kansas Department of Labor

jim.garner@dol.ks.gov
785-296-7474

34-17

Indicators of the Kansas Economy (IKE)

Prepared by

Kansas, Inc.

August 2010

About IKE

The Kansas, Inc. Board of Directors initiated a project with the goal of identifying critical variables that explains the current condition of the Kansas economy relative to its surrounding states and the U.S. The Indicators of the Kansas Economy (IKE) project concept was the result of a perceived need for a single source of objective and consistent information that allows public and private leadership, as well as all interested Kansans to better understand the economy and enhance decision-making capacity.

Working with a broad range professionals, including researchers, university professors, state officials and business leaders, the Kansas, Inc. Board of Directors identified and reviewed a set of variables for their comprehensiveness and ability to depict key elements of the Kansas economy. Whenever possible, regional and national data was included to illustrate how Kansas compares to both the 6-State Region and the U.S. on a 1-, 5-, and 10-year period. The 6-State Region includes: Arkansas, Colorado, Iowa, Missouri, Nebraska and Oklahoma. When identifying variables efforts centered on data:

- Electronically accessible;
- Able to be captured for all states and the U.S.; and,
- Released annually, with a preference to monthly data.

Kansas, Inc. has received two grants from the Information Network of Kansas (INK) to significantly advance the sophistication, outreach and quality of the IKE project. Through these grants, Kansas, Inc. has partnered with University of Kansas, Institute for Policy and Social Research (IPSR); Wichita State University, Center for Economic Development and Business Research (CEDBR); and Kansas Geological Survey, Data Access and Support Center (DASC) to develop the framework for several variables to be displayed both interactively and electronically on a county, state, regional and national level. These efforts have also provided the model for a future IKE website where all data will be dynamically displayed and archived.

Throughout the IKE project an advisory committee, consisting of researchers, university professors, state officials and business leaders has provided insight and suggestions regarding the overall direction of the IKE project, adding significant value to the final product. Included within this version are several suggestions from the advisory committee regarding content, and several suggestions on additional variables, currently in the developmental stage will be included in future versions of IKE.

This updated release is another step in IKE becoming a one-stop resource of economic data for policymakers, university researchers, business leaders and the general public. As the Kansas economy changes, Kansas, Inc. recognizes the IKE project must continue to evolve to meet the needs of all individuals. Kansas, Inc. welcomes feedback to improve the value of the IKE project.

Kansas, Inc.

Indicators of the Kansas Economy
Key Trends

35-3
Aug-10

Employment and Unemployment

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Total Nonfarm Employment *(all employees, thousands)*							
Kansas	1,321.0	1,319.3	1,311.8	1,333.8	0.1%	0.7%	-1.0%
Private Sector Employment *(all employees, thousands)*							
Kansas	1,078.8	1,083.7	1,089.7	1,107.7	-0.5%	-1.0%	-2.6%
Manufacturing Employment *(all employees, thousands)*							
Kansas	161.5	163.4	181.4	200.7	-1.2%	-11.0%	-19.5%
Service Employment *(all employees, thousands)*							
Kansas	843.1	850.9	834.0	830.6	-0.9%	1.1%	1.5%
Public Sector Employment *(all employees, thousands)*							
Kansas	242.2	235.6	222.1	226.1	2.8%	9.0%	7.1%
Unemployment Rate *(%)*							
Kansas	6.9%	7.9%	5.4%	4.0%	-1.0%	1.5%	2.9%
Initial Claims for Unemployment *(all employees)*							
Kansas	16,733	28,437	10,807	8,815	-41.2%	54.8%	89.8%

Wages/Entrepreneurship

Private Establishment Data *(total private establishments, all employee sizes)*

	2009 (p)	2008	2004	1-yr Chg	5-yr Chg
Kansas	81,653	80,276	75,569	1.7%	8.1%

Private Industry Wage Levels *(average annual wages, all employees, all private establishments)*

	2009 (p)	2008	2004	1-yr Chg	5-yr Chg
Kansas	$ 38,511	$ 38,735	$ 33,013	-0.6%	16.7%

Energy

Oil Production and Price *(most recent month of production and price)*

	Apr-10	Apr-09	Apr-05	Apr-00	1-yr Chg	5-yr Chg	10-yr Chg
Production (bbl)	3,423,502	3,272,967	2,824,144	2,835,000	4.6%	21.2%	20.8%
Price ($/bbl)	$ 84.29	$ 49.65	$ 52.98	$ 25.72	69.8%	59.1%	227.7%

Natural Gas Production and Price *(most recent month of production and price)*

Production (mcf)	27,265,194	29,767,086	31,511,956	50,906,982	-8.4%	-13.5%	-46.4%
Price ($/mcf)	$ 3.92	$ 3.43	$ 6.44	$ 2.86	14.3%	-39.1%	37.1%

Agriculture

KFMA Average Net Farm Income by Region

Region	NW	NC	NE	SW	SC	SE	Avg. All Assn.
2008	$ 144,839	$ 104,516	$ 121,891	$ 82,605	$ 132,575	$ 133,820	$ 124,617
2009	$ 117,311	$ 88,274	$ 117,854	$ 84,462	$ 85,983	$ 119,381	$ 104,781
5-yr avg	$ 125,176	$ 73,098	$ 95,502	$ 65,258	$ 81,284	$ 94,246	$ 89,554
10-yr avg	$ 79,677	$ 54,393	$ 66,585	$ 45,922	$ 57,753	$ 74,425	$ 64,772

General Economic Data

Population

	2009	2008	2004	1999	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	2,818,747	2,797,375	2,730,765	2,678,338	0.8%	3.2%	5.2%

Gross State Product *(millions of current dollars)*

	2008	2007	2003	1998	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	122,731	116,986	93,560	76,005	4.9%	31.2%	61.5%
6-State Region	950,154	906,636	728,919	584,370	4.8%	30.4%	62.6%
U.S.	14,165,565	13,715,741	10,886,172	8,679,657	3.3%	30.1%	63.2%

Personal Income Estimates *(millions of dollars)*

	2010 (Q1)	2009	2005	2000	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	109,096	106,875	90,850	76,684	2.1%	20.1%	42.3%
6-State Region	830,982	822,653	707,024	577,785	1.0%	17.5%	43.8%
U.S.	12,167,340	12,015,535	10,476,669	8,554,866	1.3%	16.1%	42.2%

Per Capita Personal Income Estimates *($)*

	2009	2008	2004	1999	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	37,916	38,886	31,922	26,826	-2.5%	18.8%	41.3%
6-State Region	36,511	37,382	31,432	25,668	-2.3%	16.2%	42.2%
U.S.	39,138	40,166	33,881	28,333	-2.6%	15.5%	38.1%

Consumer Price Index

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Midwest Urban	208.2	204.8	188.4	168.8	1.7%	10.5%	23.3%
U.S. City Average	218.0	215.4	195.4	172.8	1.2%	11.6%	26.2%

Chicago Fed National Activity Index (CFNAI)

	Jul-10	Jun-10	May-10	Apr-10	Mar-10	Feb-09	Jul-09
CFNAI	-	(0.70)	0.19	0.17	0.43	(0.53)	(0.07)

Building Permits *(new privately owned housing units authorized)*

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	458	448	1,367	780	2.2%	-66.5%	-41.3%

Sales Tax Collections *($)*

	Apr-10	Apr-09	Apr-05	Apr-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	152,318,833	148,605,999	138,919,576	119,255,618	2.5%	9.6%	27.7%

IKE - Variables

Kansas, Inc.

Indicators of the Kansas Economy
Population

3-5-10
Aug-10

Short-Term (2008 to 2009)
- Kansas population up 21,372 (0.8%)
- 6-State Region population up 214,030 (1.0%)
- U.S. population up 2,631,704 (0.9%)

Long-Term (1999 to 2009)
- Kansas population up 140,409 (5.2%)
- 6-State Region population up 1,893,932 (9.2%)
- U.S. population up 27,966,382 (10.0%)

2009 Population Estimates

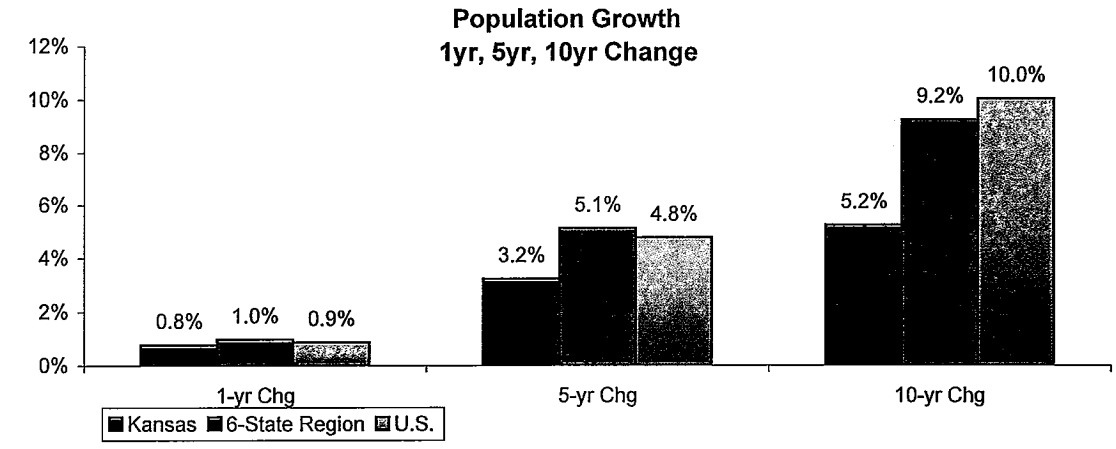
Region	Population
Kansas	2,818,747
Arkansas	2,889,450
Colorado	5,024,748
Iowa	3,007,856
Missouri	5,987,580
Nebraska	1,796,619
Oklahoma	3,687,050
6-State Region	22,393,303
U.S.	307,006,550

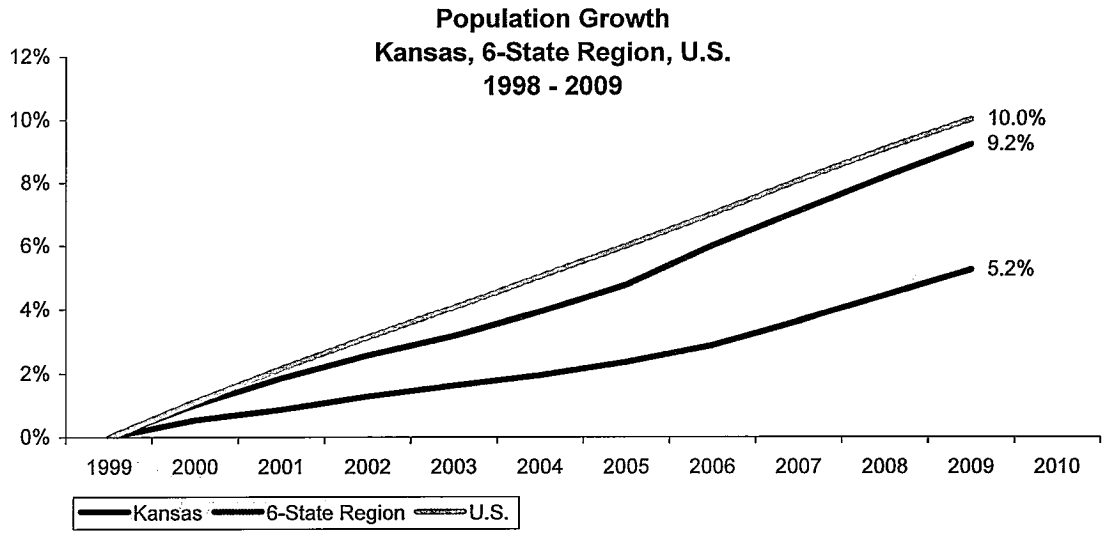
About the data and graphs

The U.S. Census Bureau publishes total resident population estimates and demographic components of change (births, deaths, and migration) each year. The reference date for estimates is July 1. Estimates usually are for the present and the past, while projections are estimates of the population for future dates. These estimates are developed with the assistance of the Federal State Cooperative Program for Population Estimates (FSCPE). These estimates are used in federal funding allocations, as denominators for vital rates and per capita time series, as survey controls, and in monitoring recent demographic changes. With each new issue of July 1 estimates, the estimates are revised for years back to the last census.

Population

	2009	2008	2004	1999	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	2,818,747	2,797,375	2,730,765	2,678,338	0.8%	3.2%	5.2%
6-State Region	22,393,303	22,179,273	21,302,277	20,499,371	1.0%	5.1%	9.2%
U.S.	307,006,550	304,374,846	293,045,739	279,040,168	0.9%	4.8%	10.0%





Source: 2009 annual data
U.S. Census Bureau http://www.census.gov/popest/estimates.html

Kansas, Inc.

Indicators of the Kansas Economy
Gross State Product

Aug-10

35-4

Short-Term (2007 to 2008)
- Kansas GSP up $5,745 million (4.9%)
- 6-State Region GSP up $43,518 million (4.8%)
- U.S. GSP up $449,824 million (3.3%)

Long-Term (1998 to 2008)
- Kansas GSP up $46,726 million (61.5%)
- 6-State Region GSP up $365,784 million (62.6%)
- U.S. GSP up $5,485,908 million (63.2%)

2008 Gross State Product
(millions of current dollars)

Region	Gross State Product
Kansas	$ 122,731
Arkansas	$ 98,331
Colorado	$ 248,603
Iowa	$ 135,702
Missouri	$ 237,797
Nebraska	$ 83,273
Oklahoma	$ 146,448
6-State Region	$ 950,154
U.S.	$ 14,165,565

About the data and graphs

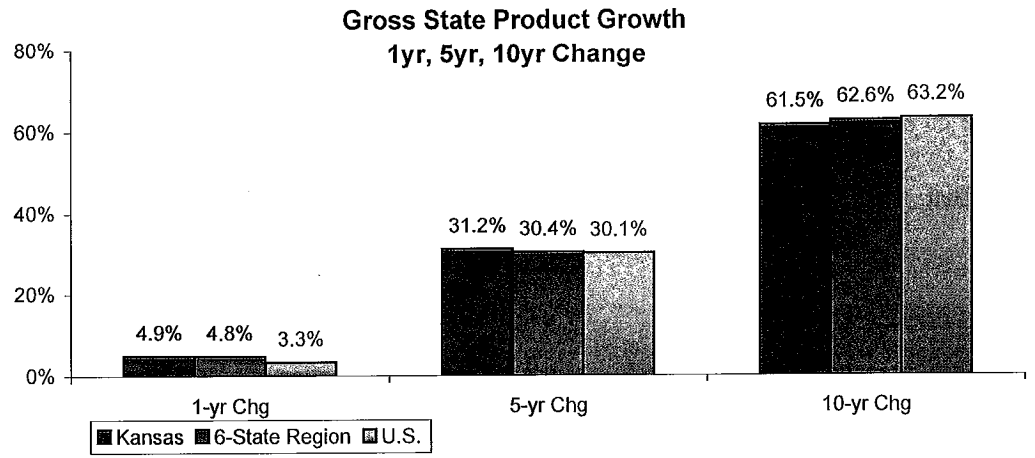
GSP captures state economic growth, providing an overall analysis of the performance of the economy. GSP is the value added in production by the labor and property located in the state.

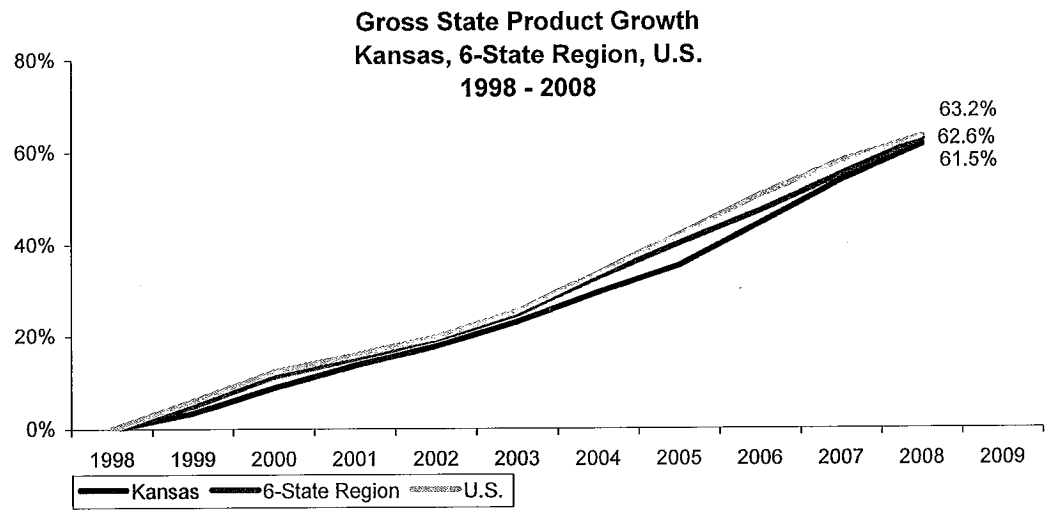
In concept, an industry's GSP, referred to as its "value added," is equivalent to its gross output (sales or receipts and other operating income, commodity taxes, and inventory change) minus its intermediate inputs (consumption of goods and services purchased from other U.S. industries or imported.)

All GSP data is displayed in current dollars and are not adjusted for inflation.

Gross State Product (GSP)
(millions of current dollars)

	2008	2007	2003	1998	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	122,731	116,986	93,560	76,005	4.9%	31.2%	61.5%
6-State Region	950,154	906,636	728,919	584,370	4.8%	30.4%	62.6%
U.S.	14,165,565	13,715,741	10,886,172	8,679,657	3.3%	30.1%	63.2%





Source: 2008 annual data
U.S. Department of Commerce - Bureau of Economic Analysis http://www.bea.gov/regional/

Kansas, Inc.

Indicators of the Kansas Economy
Personal Income/Per Capita Personal Income

Aug-10

35-7

Short-Term (2008 to 2010)

- Kansas PI up $2,221 million (2.1%)
- 6-State Region PI up $8,329 million (1.0%)
- U.S. PI up $151,805 million (1.3%)
- Kansas PCPI down $970 (-2.5%)
- 6-State Region PCPI down $871 (-2.3%)
- U.S. PCPI down $1,028 (-2.6%)

Long-Term (1999 to 2010)

- Kansas PI up $32,412 million (42.3%)
- 6-State Region PI up $253,197 million (43.8%)
- U.S. PI up $3,612,474 million (42.2%)
- Kansas PCPI up $11,090 (41.3%)
- 6-State Region PCPI up $10,843 (42.2%)
- U.S. PCPI up $10,905 (38.1%)

About the data and graphs

Personal income is the income that is received by all persons from all sources and is reported quarterly and is seasonally adjusted at annual rates. Per capita personal income is the annual personal income divided by the population.

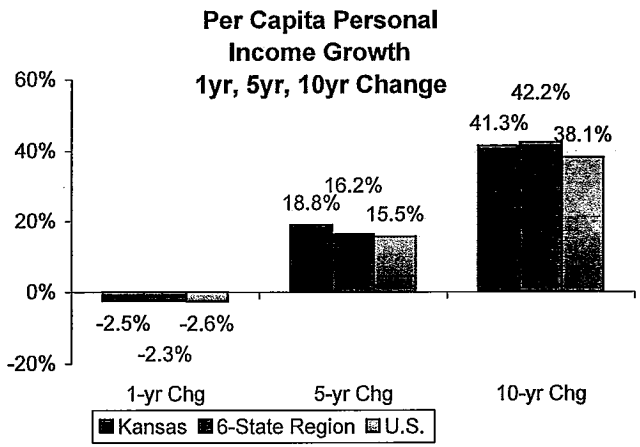
Personal income is calculated as the sum of wage and salary disbursements, supplements to wages and salaries, proprietors' income with inventory valuation and capital consumption adjustments, rental income of persons with capital consumption adjustment, personal dividend income, personal interest income, and personal current transfer receipts, less contributions for government social insurance. The personal income of an area is the income that is received by, or on behalf of, all of the individuals who live in the area; therefore, the estimates of personal income are presented by the place of residence of the income recipients. All state estimates are in current dollars (not adjusted for inflation).

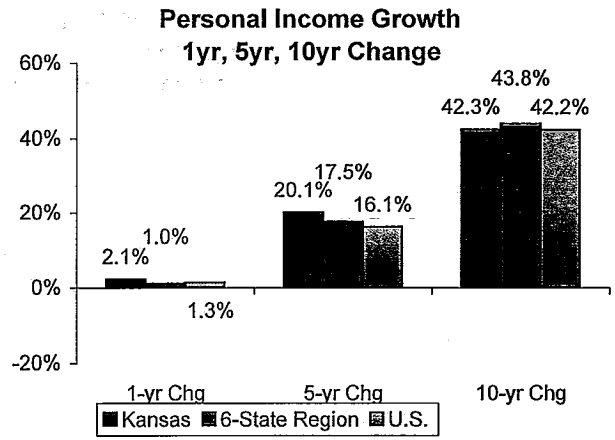
Personal Income Estimates (PI) - (millions of dollars)

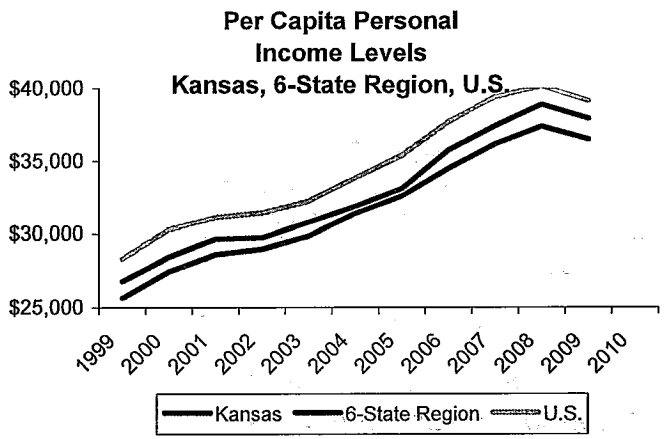
	2010 (Q1)	2009	2005	2000	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	109,096	106,875	90,850	76,684	2.1%	20.1%	42.3%
6-State Region	830,982	822,653	707,024	577,785	1.0%	17.5%	43.8%
U.S.	12,167,340	12,015,535	10,476,669	8,554,866	1.3%	16.1%	42.2%

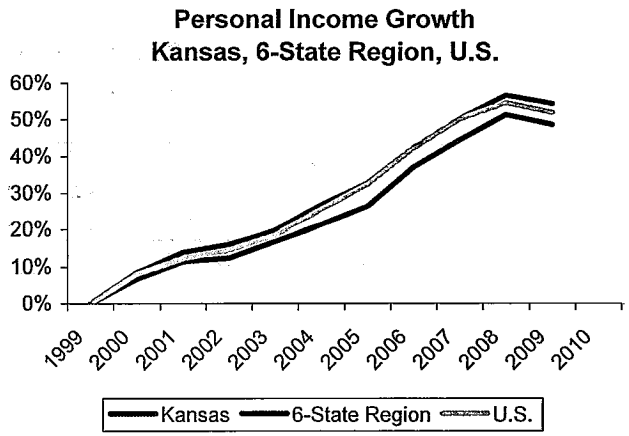
Per Capita Personal Income Estimates (PCPI) - ($)

	2009	2008	2004	1999	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	37,916	38,886	31,922	26,826	-2.5%	18.8%	41.3%
6-State Region	36,511	37,382	31,432	25,668	-2.3%	16.2%	42.2%
U.S.	39,138	40,166	33,881	28,333	-2.6%	15.5%	38.1%









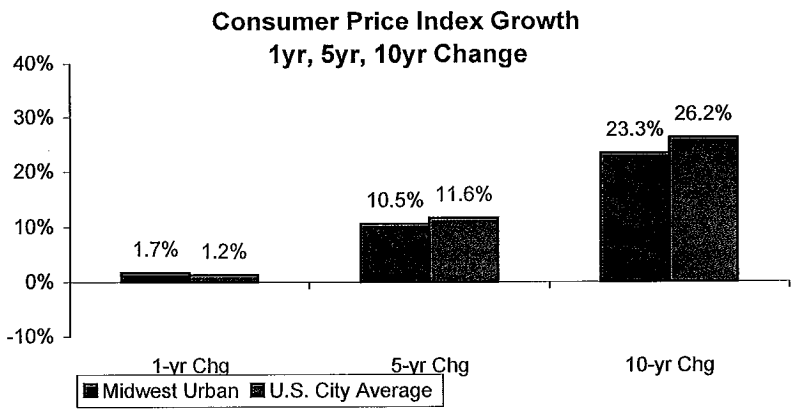
Source: *2009 annual data, 2010 quarterly data*
U.S. Department of Commerce - Bureau of Economic Analysis *http://www.bea.gov/regional/*

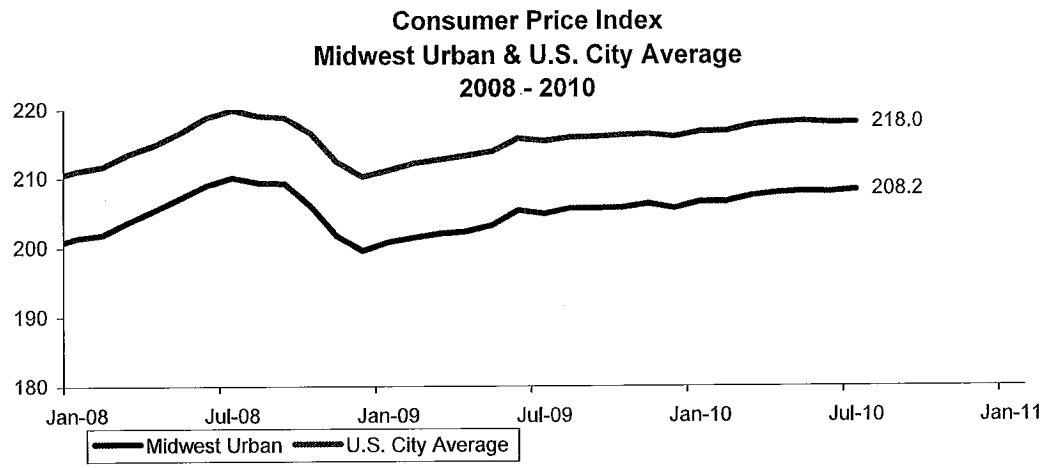
Short-Term (2009 to 2010)
- Midwest Urban CPI up 3.4 (1.7%)
- U.S. City Average CPI up 2.6 (1.2%)

Long-Term (2000 to 2010)
- Midwest Urban CPI up 39.4 (23.3%)
- U.S. City Average CPI up 45.2 (26.2%)

Consumer Price Index (CPI)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Midwest Urban	208.2	204.8	188.4	168.8	1.7%	10.5%	23.3%
U.S. City Average	218.0	215.4	195.4	172.8	1.2%	11.6%	26.2%



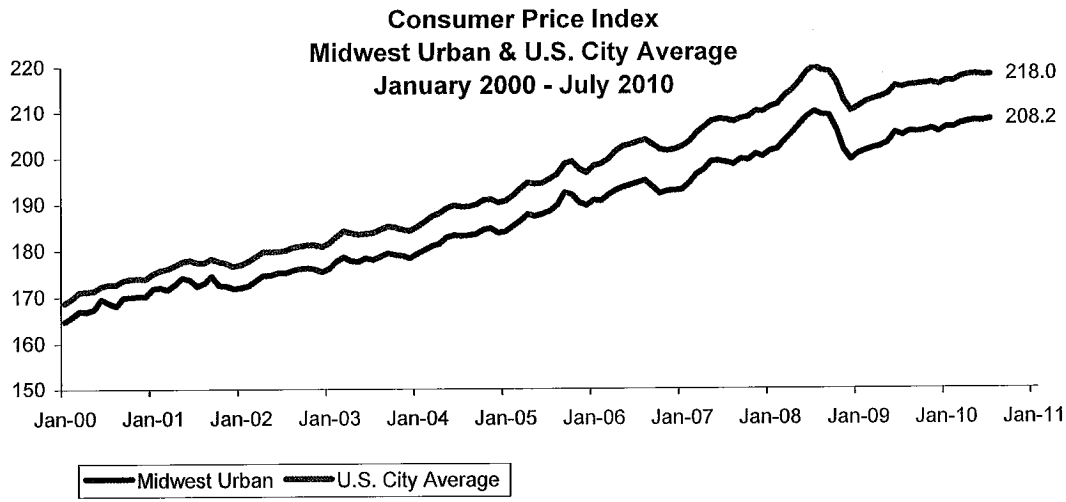


About the data and graphs

The CPI program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services. It is the most widely used measure of inflation.

The U.S. City Average is a measure of the average change over time in the prices paid by urban consumers throughout the United States for a market basket of consumer goods and services. It is adjusted to equal 100 during the base period of 1982-1984. The U.S. City Average CPI reflects spending patterns for all urban consumers, who represent about 87 percent of the total U.S. population.

The Midwest Urban Consumer Price Index is calculated in the same way as the U.S. City Average CPI, however, the Midwest CPI is limited to consumers within the Midwest Census region.



Source: 2010 monthly data
U.S. Department of Labor - Bureau of Labor Statistics

http://stats.bls.gov/cpi/home.htm

Short-Term (2010)

During July 2010, the CFNAI returned to its historical average of zero, up from -0.70 in June. Three of the four broad categories improved from June, but only the production and income category made a positive contribution. Production-related indicators made a contribution of 0.43 to the index in July; employment-related indicators made a neutral contribution to the index in July; sales, orders, and inventories indicators also made a neutral contribution to the index in July; and consumption and housing indicators made a contribution of -0.43 to the index in July. Forty-six of the 85 individual indicators made positive contributions to the index in May, while 39 made negative contributions. Fifty-six indicators improved from April to May, while 28 indicators deteriorated and one remained unchanged.

Long-Term (1990 to 2010)

Since January 1990 the CFNAI has demonstrated excellent predictive power as CFNAI values have fallen substantially prior to each of the two most recent recessions, from July 1990 to March 1991, and from March 2001 to November 2001.

About the data and graphs

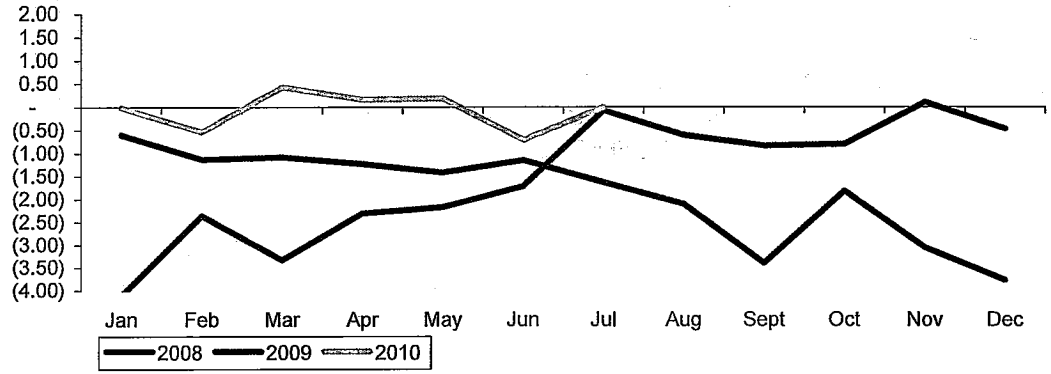
The performance of the U.S. economy has a major impact on the performance of the Kansas economy.

The Chicago Fed National Activity Index (CFNAI) is a monthly U.S. index designed to better gage overall economic activity and inflationary pressure. The index uses 85 economic indicators from four broad categories of data: production and income; employment, unemployment and hours; personal consumption and housing; and sales, orders and inventories. **A positive number indicates above average growth while a negative number indicates below average growth. Sustained CFNAI readings above zero suggest increased inflationary pressures over the coming year.**

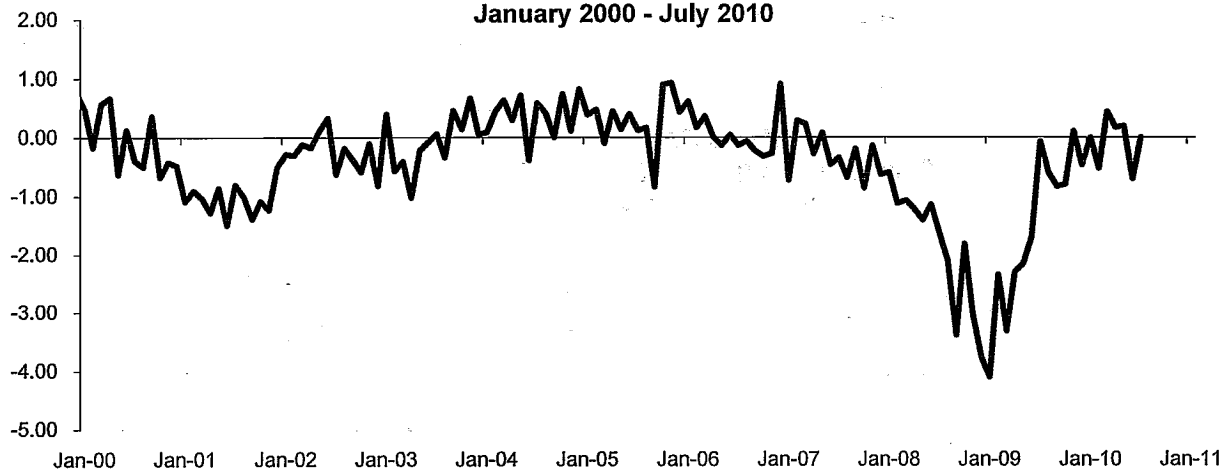
CFNAI

	Jul-10	Jun-10	May-10	Apr-10	Mar-10	Feb-09	Jul-09
CFNAI	0.00	-0.70	0.19	0.17	0.43	-0.53	-0.07

Chicago Federal Reserve National Activity Index
2008 - 2010



Chicago Federal Reserve National Activity Index
January 2000 - July 2010



Source: 2010 monthly data
Federal Reserve Bank of Chicago

http://www.chicagofed.org/webpages/publications/cfnai/index.cfm

Kansas, Inc.

Indicators of the Kansas Economy
Building Permits

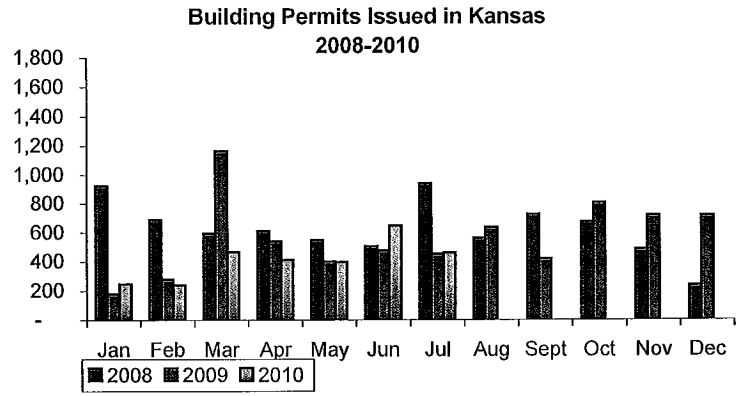
Aug-10

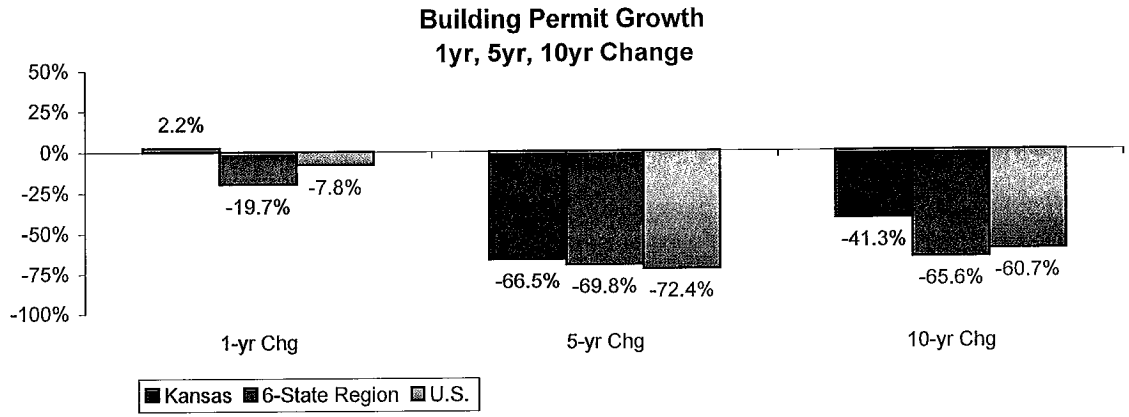
Short-Term (2009 to 2010)
- Kansas building permits up 10 (2.2%)
- 6-State Region building permits down 911 (-19.7%)
- U.S. building permits down 4,267 (-7.8%)

Long-Term (2000 to 2010)
- Kansas building permits down 322 (-41.3%)
- 6-State Region building permits down 7,075 (-65.6%)
- U.S. building permits down 77,898 (-60.7%)

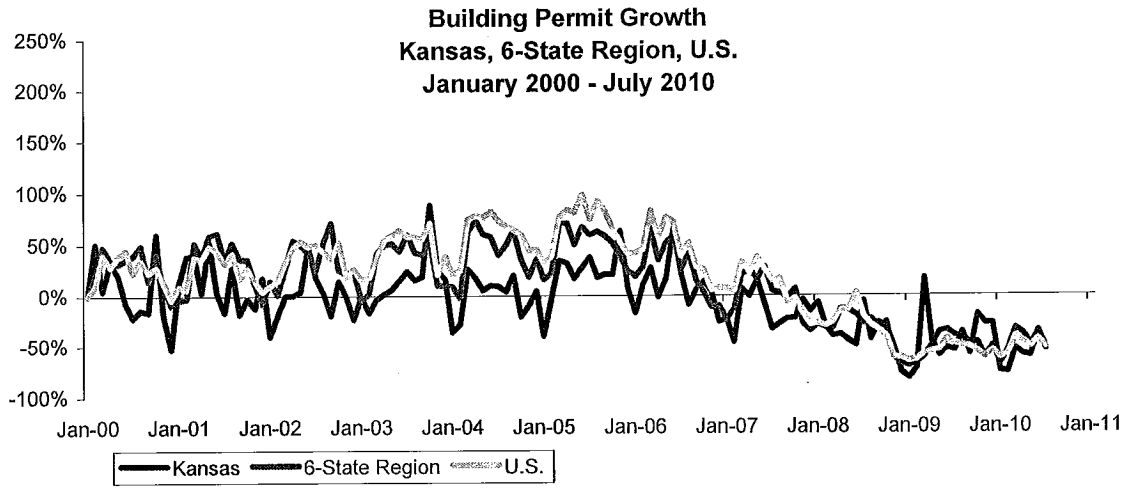
Building Permits
(new privately owned housing units authorized)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	458	448	1,367	780	2.2%	-66.5%	-41.3%
6-State Region	3,716	4,627	12,320	10,791	-19.7%	-69.8%	-65.6%
U.S.	50,420	54,687	182,916	128,318	-7.8%	-72.4%	-60.7%





Regarding building permits, a housing unit is a house, an apartment, a group of rooms or a single room intended for occupancy as separate living quarters. Separate living quarters are those in which the occupants live separately from any other individuals in the building and which have a direct access from the outside of the building or through a common hall.



Source: 2010 monthly data
U.S. Census Bureau *http://www.census.gov/econ/www/index.html*

Kansas, Inc.

Indicators of the Kansas Economy
Kansas Sales Tax Collections

Aug-10

35-11

Short-Term (2009 to 2010)
- Kansas sales tax collections up $3,712,834 (2.5%)
- $583,123,753 collected ytd through April 2010
- $1,866,223,078 collected total during 2009

Long-Term (2000 to 2010)
- Kansas sales tax collections up $33,063,215 (27.7%)
- $1,475,405,439 collected total during 2000

Sales Tax Collections

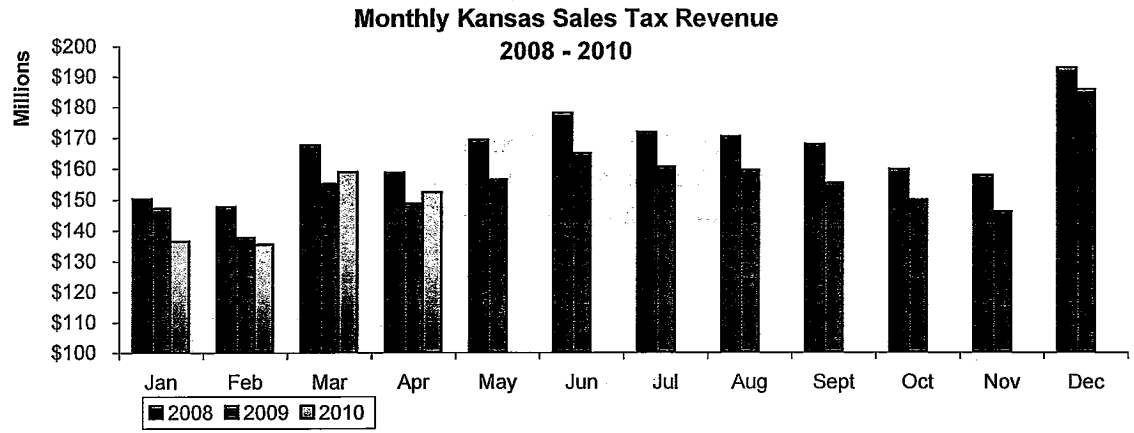
	Apr-10	Apr-09	Apr-05	Apr-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	$ 152,318,833	$ 148,605,999	$ 138,919,576	$ 119,255,618	2.5%	9.6%	27.7%

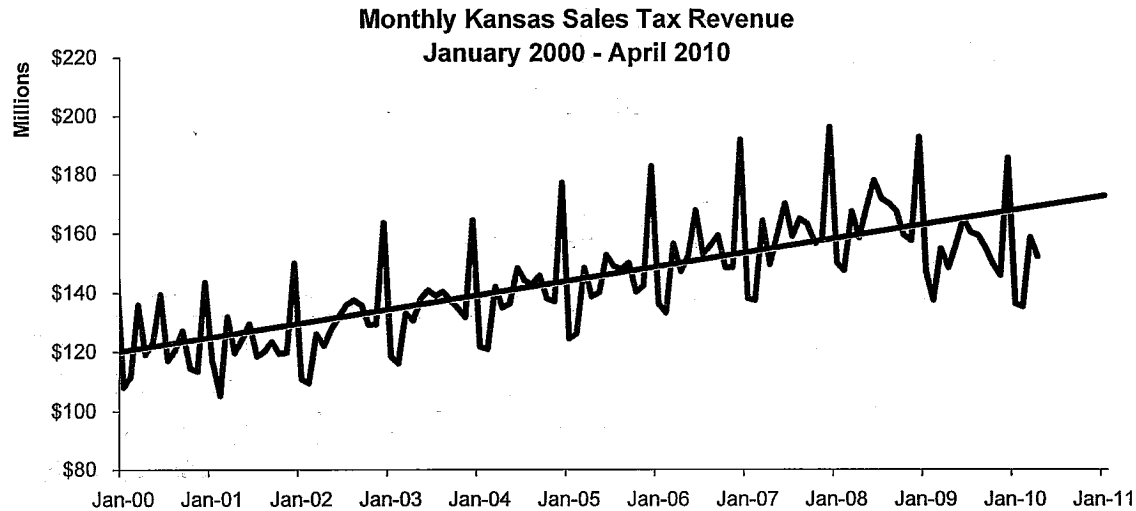
About the data and graphs

Monthly sales tax collections have trended higher as the economy has grown and two sales tax rate increases have been enacted. Annually, December typically collects the highest sales tax revenue, with January and February collecting the least. Consumers tend to delay purchases during a downturn in the economy, which can be reflected in lower sales tax collections in months proceeding and during a recession. Monthly sales tax collections tend to increase as the economy improves and consumer spending increases.

Tracking sales tax collections in Kansas gives insight into consumer behavior and demand. Sales tax collections can fluctuate widely from month to month. Since January 1990, state sales tax rates have increased on **three** occasions. In June 1992, the state sales tax rate increased from 4.25% to 4.90%; in July 2002 the state sales tax rate increased to 5.30%; **and in July 2010 the state sales tax rate increased to 6.30%.**

Various cities and counties in Kansas have an additional local sales tax. The entire listing of local sales tax rates is available at http://www.ksrevenue.org/salesratechanges.htm





Source: *2010 monthly data*
Kansas Department of Revenue http://www.ksrevenue.org/salesreports.htm

IKansas, Inc.

Indicators of the Kansas Economy
Total Nonfarm Employment

Aug-10

Short-Term (2009 to 2010)

- Kansas total nonfarm employment up 1,700 (0.1%)
- 6-State Region total nonfarm employment down 4,100 (-0.0%)
- U.S. total nonfarm employment down 17,000 (-0.0%)

Long-Term (2000 to 2010)

- Kansas total nonfarm employment down 12,800 (-1.0%)
- 6-State Region total nonfarm employment down 8,200 (-0.1%)
- U.S. total nonfarm employment down 1,822,000 (-1.4%)

July 2010 Total Nonfarm Employment Levels

(all employees, thousands)

State	Employment
Kansas	1,321.0
Arkansas	1,158.2
Colorado	2,211.8
Iowa	1,461.7
Missouri	2,646.1
Nebraska	947.0
Oklahoma	1,528.5

About the data and graphs

The Bureau of Labor Statistics (BLS) publishes several monthly data series on employment by sector from its Current Employment Statistics (CES) program. Data for the series come from a monthly survey of employers. The data are subject to major and minor revisions. The series counts the number of jobs in the state or region, not the number of employed people. Hence a person with two jobs, one in the manufacturing sector and one in the service sector, would be counted in both sectors. The data series chosen for IKE are not adjusted for seasonal variation.

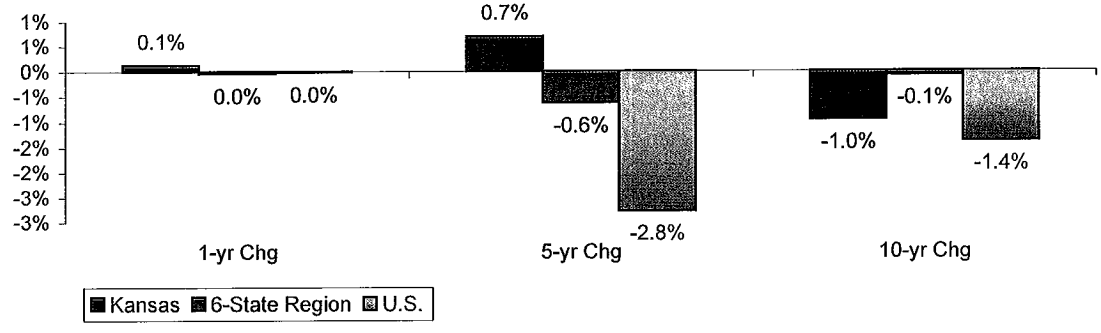
BLS total nonfarm employment calculations does not include non-civilian employment.

Total Nonfarm Employment

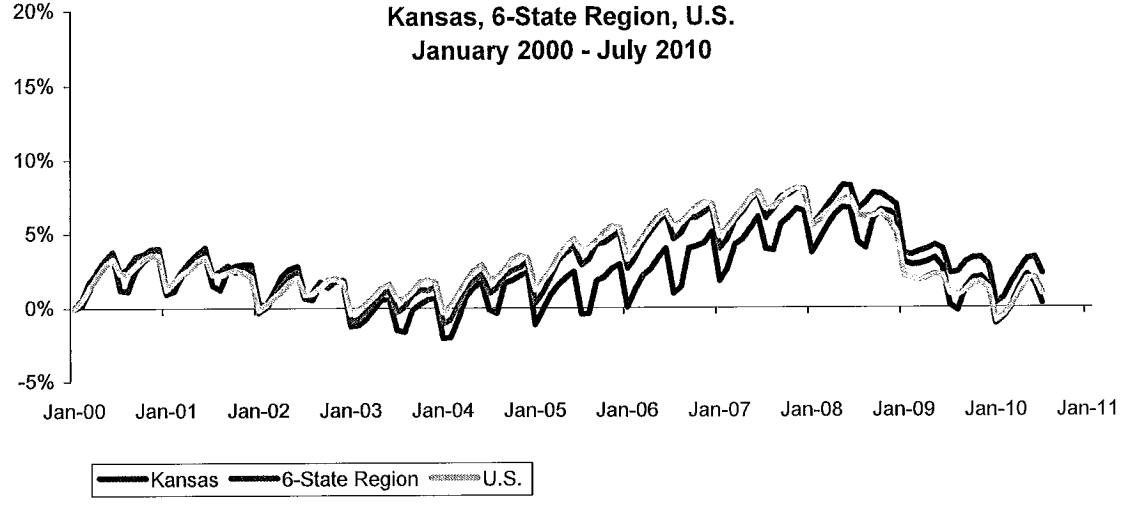
(all employees, thousands)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	1,321.0	1,319.3	1,311.8	1,333.8	0.1%	0.7%	-1.0%
6-State Region	9,953.3	9,957.4	10,015.4	9,961.5	0.0%	-0.6%	-0.1%
U.S.	129,954.0	129,971.0	133,665.0	131,776.0	0.0%	-2.8%	-1.4%

Total Nonfarm Employment Growth
1yr, 5yr, 10yr Change



Total Nonfarm Employment Growth
Kansas, 6-State Region, U.S.
January 2000 - July 2010



Source: *2010 monthly data*
U.S. Department of Labor - Bureau of Labor Statistics http://www.bls.gov/bls/employment.htm
Kansas Department of Labor - Labor Market Information http://laborstats.dol.ks.gov/

Short-Term (2009 to 2010)

- Kansas private sector employment down 4,900 (-0.5%)
- 6-State Region private sector employment down 10,200 (-0.1%)
- U.S. private sector employment up 34,000 (0.0%)

Long-Term (2000 to 2010)

- Kansas private sector employment down 28,900 (-2.6%)
- 6-State Region private sector employment down 182,900 (-2.2%)
- U.S. private sector employment down 3,297,000 (-2.9%)

July 2010 Private Sector Employment Levels

(all employees, thousands)

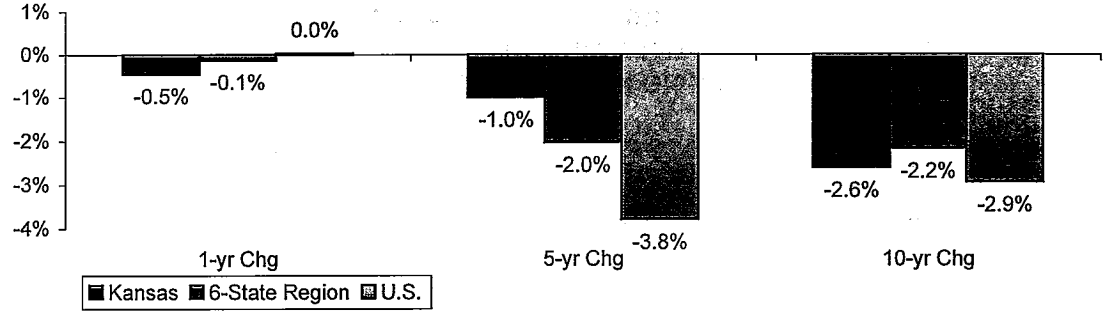
State	Employment
Kansas	1,078.8
Arkansas	954.0
Colorado	1,838.2
Iowa	1,230.8
Missouri	2,226.2
Nebraska	784.7
Oklahoma	1,209.5

Private Sector Employment

(all employees, thousands)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	1,078.8	1,083.7	1,089.7	1,107.7	-0.5%	-1.0%	-2.6%
6-State Region	8,243.4	8,253.6	8,414.5	8,426.3	-0.1%	-2.0%	-2.2%
U.S.	108,731.0	108,697.0	113,015.0	112,028.0	0.0%	-3.8%	-2.9%

Private Sector Employment Growth
1yr, 5yr, 10yr Change

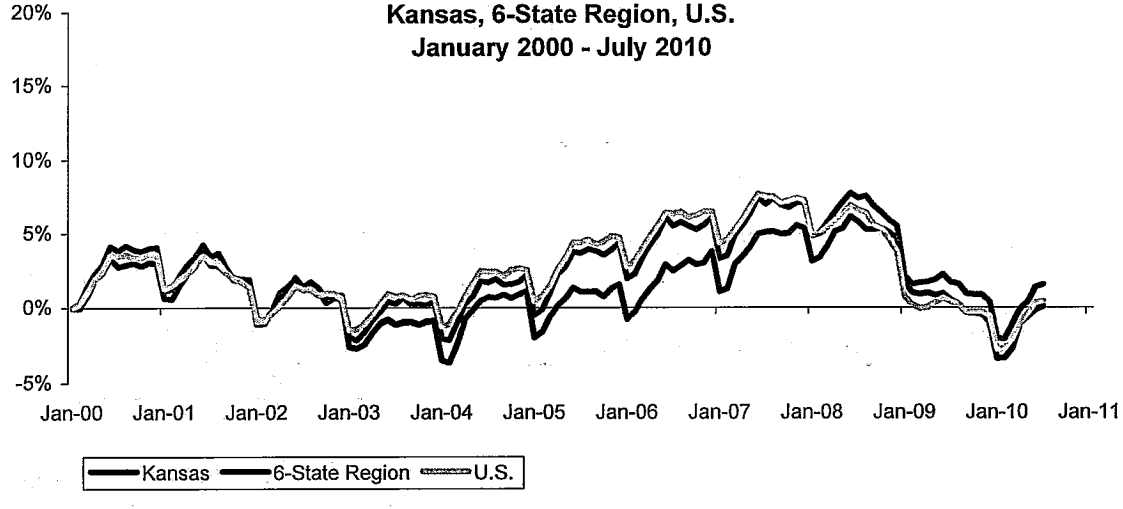


About the data and graphs

The Bureau of Labor Statistics (BLS) publishes several monthly data series on employment by sector from its Current Employment Statistics (CES) program. Data for the series come from a monthly survey of employers. The data are subject to major and minor revisions. The series counts the number of jobs in the state or region, not the number of employed people. Hence a person with two jobs, one in the manufacturing sector and one in the service sector, would be counted in both sectors. The data series chosen for IKE are not adjusted for seasonal variation.

BLS private sector calculations include all nonfarm sectors, while excluding Federal, State, and Local government sectors.

Private Sector Employment Growth
Kansas, 6-State Region, U.S.
January 2000 - July 2010



e: 2010 monthly data
U.S. Department of Labor - Bureau of Labor Statistics http://www.bls.gov/bls/employment.htm
Kansas Department of Labor - Labor Market Information http://laborstats.dol.ks.gov/

Kansas, Inc.

Indicators of the Kansas Economy
Manufacturing Employment

Aug-10

35-14

Short-Term (2009 to 2010)

- Kansas manufacturing employment down 1,900 (-1.2%)
- 6-State Region manufacturing employment up 2,000 (0.2%)
- U.S. manufacturing employment down 1,000 (-0.0%)

Long-Term (2000 to 2010)

- Kansas manufacturing employment down 39,200 (-19.5%)
- 6-State Region manufacturing employment down 376,200 (-28.1%)
- U.S. manufacturing employment down 5,574,000 (-32.2%)

Manufacturing Employment

(all employees, thousands)

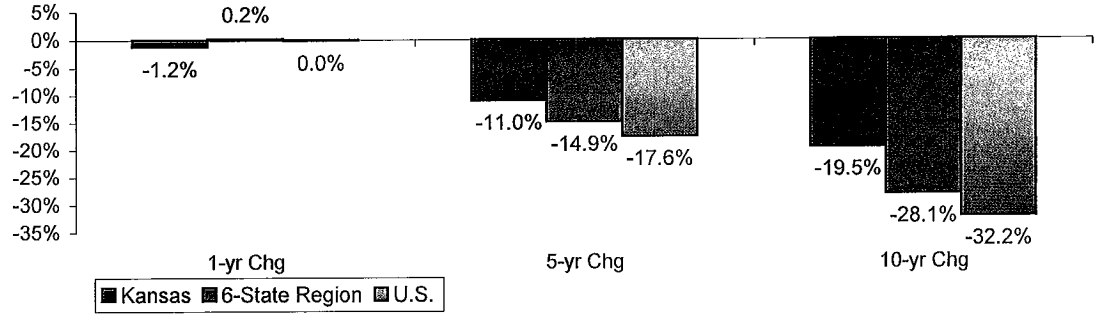
	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	161.5	163.4	181.4	200.7	-1.2%	-11.0%	-19.5%
6-State Region	962.5	960.5	1,131.5	1,338.7	0.2%	-14.9%	-28.1%
U.S.	11,744.0	11,745.0	14,250.0	17,318.0	0.0%	-17.6%	-32.2%

July 2010 Manufacturing Employment Levels

(all employees, thousands)

State	Employment
Kansas	161.5
Arkansas	167.1
Colorado	124.0
Iowa	206.1
Missouri	249.5
Nebraska	92.2
Oklahoma	123.6

Manufacturing Employment Growth
1yr, 5yr, 10yr Change

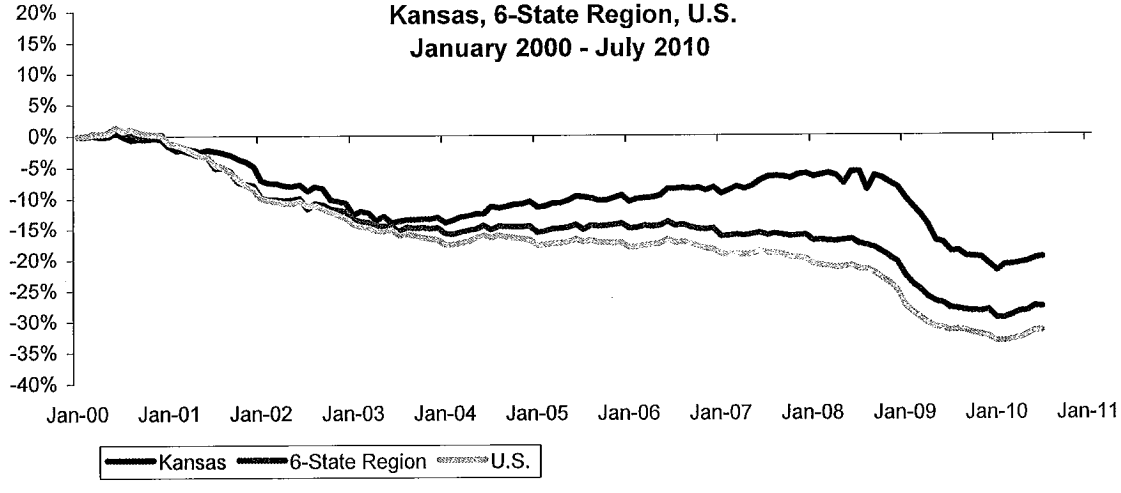


About the data and graphs

The Bureau of Labor Statistics (BLS) publishes several monthly data series on employment by sector from its Current Employment Statistics (CES) program. Data for the series come from a monthly survey of employers. The data are subject to major and minor revisions. The series counts the number of jobs in the state or region, not the number of employed people. Hence a person with two jobs, one in the manufacturing sector and one in the service sector, would be counted in both sectors. The data series chosen for IKE are not adjusted for seasonal variation.

The manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products.

Manufacturing Employment Growth
Kansas, 6-State Region, U.S.
January 2000 - July 2010



Source: *2010 monthly data*
U.S. Department of Labor - Bureau of Labor Statistics http://www.bls.gov/bls/employment.htm
Kansas Department of Labor - Labor Market Information http://laborstats.dol.ks.gov/

Kansas, Inc.

Indicators of the Kansas Economy
Service Employment

Aug-10

35-15

Short-Term (2009 to 2010)
- Kansas service employment down 7,800 (-0.9%)
- 6-State Region service employment up 18,300 (0.3%)
- U.S. service employment up 353,000 (0.4%)

Long-Term (2000 to 2010)
- Kansas service employment up 12,500 (1.5%)
- 6-State Region service employment up 248,200 (3.8%)
- U.S. service employment up 3,393,00.0 (3.9%)

July 2010 Service Employment Levels

(all employees, thousands)

State	Employment
Kansas	843.1
Arkansas	722.8
Colorado	1,575.2
Iowa	953.3
Missouri	1,864.2
Nebraska	641.8
Oklahoma	969.4

About the data and graphs

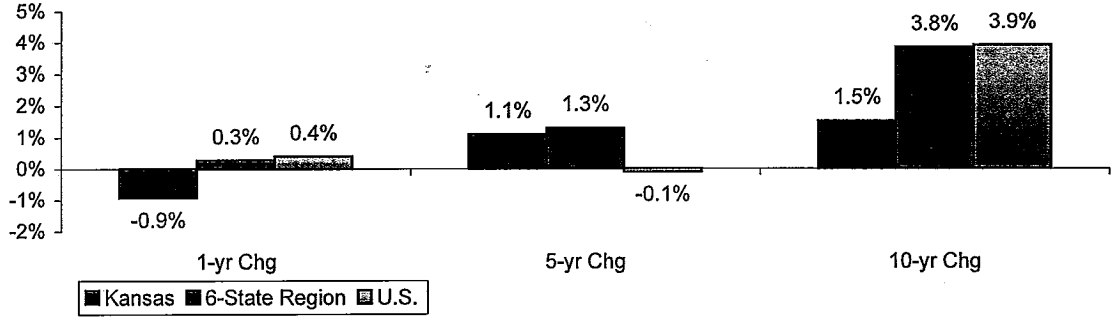
The Bureau of Labor Statistics (BLS) publishes several monthly data series on employment by sector from its Current Employment Statistics (CES) program. Data for the series come from a monthly survey of employers. The data are subject to major and minor revisions. The series counts the number of jobs in the state or region, not the number of employed people. Hence a person with two jobs, one in the manufacturing sector and one in the service sector, would be counted in both sectors. The data series chosen for IKE are not adjusted for seasonal variation. While BLS service sector calculations include government, *Kansas, Inc., has defined the overall service sector to include the following BLS sectors: trade, transportation, and utilities; information; finance; professional and business; education and health; leisure and hospitality; and other services.*

Service Employment

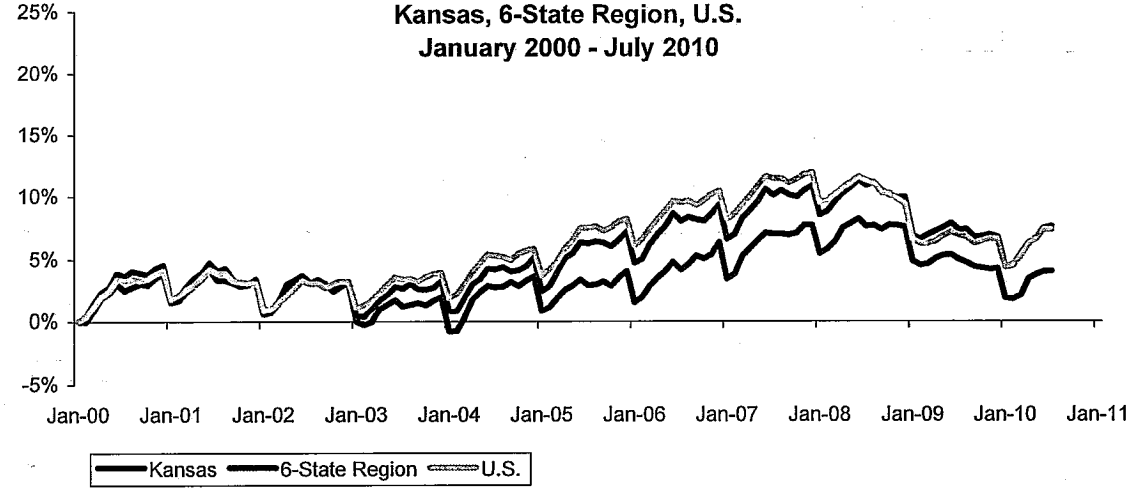
(all employees, thousands)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	843.1	850.9	834.0	830.6	-0.9%	1.1%	1.5%
6-State Region	6,726.7	6,708.4	6,641.2	6,478.5	0.3%	1.3%	3.8%
U.S.	90,383.0	90,030.0	90,476.0	86,990.0	0.4%	-0.1%	3.9%

Service Employment Growth
1yr, 5yr, 10yr Change



Service Employment Growth
Kansas, 6-State Region, U.S.
January 2000 - July 2010



Source: 2010 monthly data
U.S. Department of Labor - Bureau of Labor Statistics http://www.bls.gov/bls/employment.htm
Kansas Department of Labor - Labor Market Information http://laborstats.dol.ks.gov/

Kansas, Inc.

Indicators of the Kansas Economy
Public Employment

Aug-10

35-16

Short-Term (2009 to 2010)
- Kansas public sector employment up 6,600 (2.8%)
- 6-State Region public sector employment up 6,100 (0.4%)
- U.S. public sector employment down 51,000 (-0.2%)

Long-Term (2000 to 2010)
- Kansas public sector employment up 16,100 (7.1%)
- 6-State Region public sector employment up 174,700 (11.4%)
- U.S. public sector employment up 1,475,000 (7.5%)

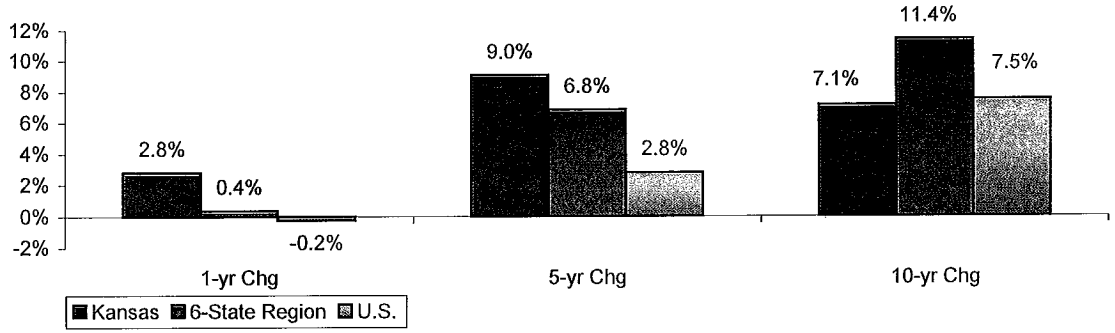
July 2010 Public Sector Employment Levels
(all employees, thousands)

State	Employment
Kansas	242.2
Arkansas	204.2
Colorado	373.6
Iowa	230.9
Missouri	419.9
Nebraska	162.3
Oklahoma	319.0

Public Sector Employment
(all employees, thousands)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	242.2	235.6	222.1	226.1	2.8%	9.0%	7.1%
6-State Region	1,709.9	1,703.8	1,600.9	1,535.2	0.4%	6.8%	11.4%
U.S.	21,223.0	21,274.0	20,650.0	19,748.0	-0.2%	2.8%	7.5%

Public Sector Employment Growth
1yr, 5yr, 10yr Change

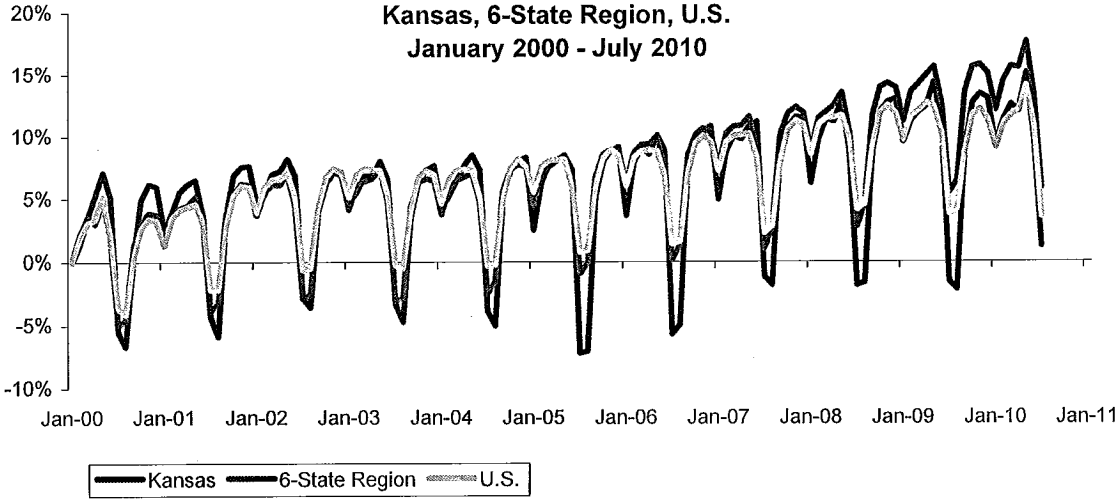


About the data and graphs

The Bureau of Labor Statistics (BLS) publishes several monthly data series on employment by sector from its Current Employment Statistics (CES) program. Data for series come from a monthly survey of employers. The data are subject to major and minor revisions. The series count the number of jobs in the state or region, not the number of employed people. Hence a person with two jobs, one in the public sector and one in retail, would be counted in both sectors.

The data series chosen for IKE are not adjusted for seasonal variation; hence the short term employment graph shows substantial decreases in July and August when many public school personnel are off the job. *Kansas, Inc. has included Federal, State, and Local Government.*

Public Sector Employment Growth
Kansas, 6-State Region, U.S.
January 2000 - July 2010



Source: *2010 monthly data*
U.S. Department of Labor - Bureau of Labor Statistics http://www.bls.gov/bls/employment.htm
Kansas Department of Labor - Labor Market Information http://laborstats.dol.ks.gov/

Kansas, Inc.

Indicators of the Kansas Economy
Unemployment and Unemployment Rate

Aug-10

35-17

Short-Term (2009 to 2010)

- Kansas unemployment down 18,248 (-14.9%)
- 6-State Region unemployment down 7,427 (-1.0%)
- U.S. unemployment down 64,000 (-0.4%)
- Kansas unemployment rate down (-1.0%)
- 6-State Region unemployment rate up (0.1%)
- U.S. unemployment rate unchanged (0.0%)

Long-Term (2000 to 2010)

- Kansas unemployment up 46,811 (81.5%)
- 6-State Region unemployment up 442,528 (134.2%)
- U.S. unemployment up 9,109,000 (151.1%)
- Kansas unemployment rate up (2.9%)
- 6-State Region unemployment rate up (4.2%)
- U.S. unemployment rate up (5.5%)

About the data and graphs

The unemployment rate represents the number unemployed as a percent of the labor force. As defined in the Current Population Survey, unemployed persons are persons aged 16 years and older who had no employment during the reference week, were available for work, except for temporary illness, and had made specific efforts to find employment sometime during the 4-week period ending with the reference week. Persons who were waiting to be recalled to a job from which they had been laid off need not have been looking for work to be classified as unemployed.

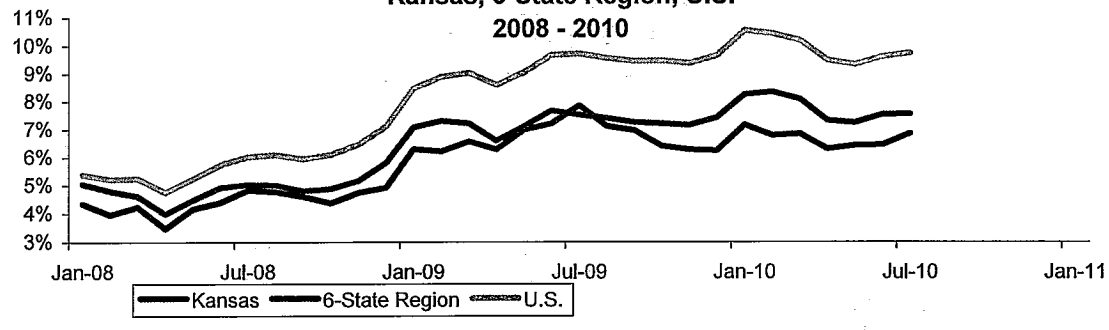
The unemployment rate contains a seasonal component, it rises during summer as new high school and college graduates enter the civilian labor force and in January, when retailers lay off holiday employees. The unemployment rate also contains a business cycle component, rising during recessionary periods when people currently in the labor force lose jobs.

Unemployment and Unemployment Rate

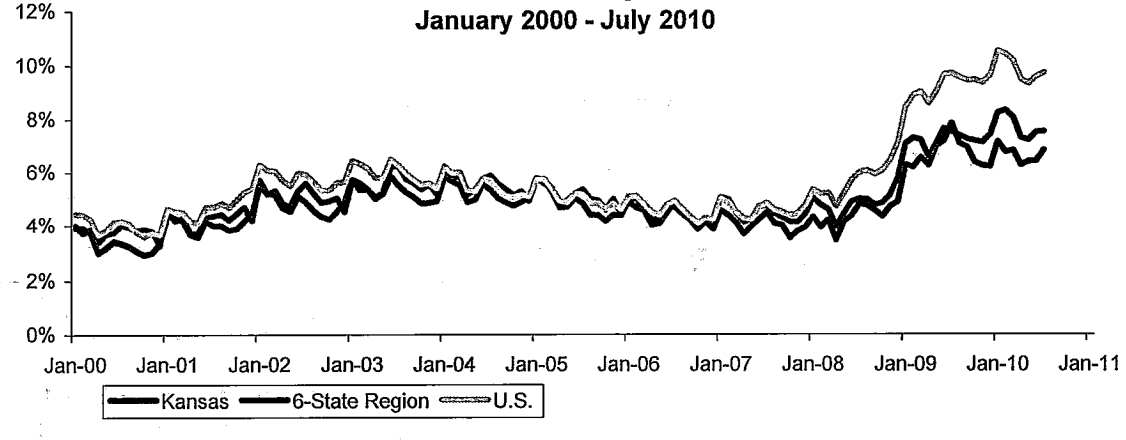
(all employees)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	104,248	122,496	80,183	57,437	-14.9%	30.0%	81.5%
6-State Region	772,357	779,784	493,029	329,829	-1.0%	56.7%	134.2%
U.S.	15,137,000	15,201,000	7,839,000	6,028,000	-0.4%	93.1%	151.1%
Kansas (%)	6.9%	7.9%	5.4%	4.0%	-1.0%	1.5%	2.9%
6-State Region (%)	7.6%	7.5%	4.9%	3.4%	0.1%	2.7%	4.2%
U.S. (%)	9.7%	9.7%	5.2%	4.2%	0.0%	4.5%	5.5%

Unemployment Rate
Kansas, 6-State Region, U.S.
2008 - 2010



Unemployment Rate
Kansas, 6-State Region, U.S.
January 2000 - July 2010



e: 2010 monthly data
U.S. Department of Labor - Bureau of Labor Statistics
Kansas Department of Labor - Labor Market Information

http://www.bls.gov/bls/employment.htm
http://laborstats.dol.ks.gov/

Kansas, Inc.

Indicators of the Kansas Economy
Initial Claims for Unemployment

Aug-10

35-18

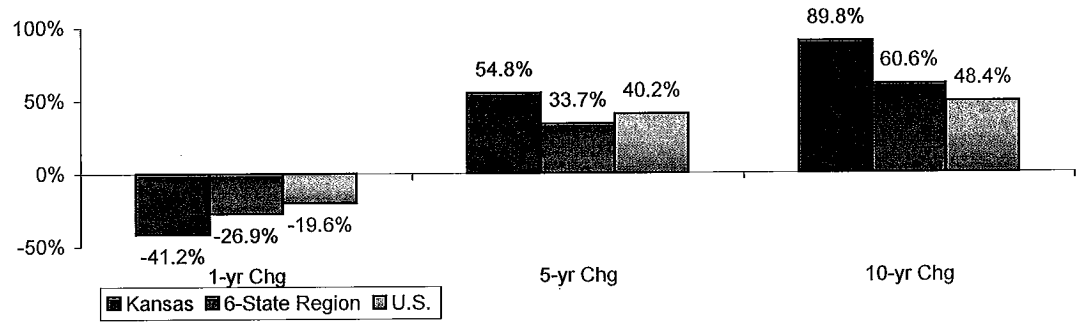
Short-Term (2009 to 2010)
- Kansas initial claims down 11,704 (-41.2%)
- 6-State Region initial claims down 45,592 (-26.9%)
- U.S. initial claims down 488,714 (-19.6%)

Long-Term (2000 to 2010)
- Kansas initial claims up 7,918 (89.8%)
- 6-State Region initial claims up 46,662 (60.6%)
- U.S. intial claims up 655,168 (48.4%)

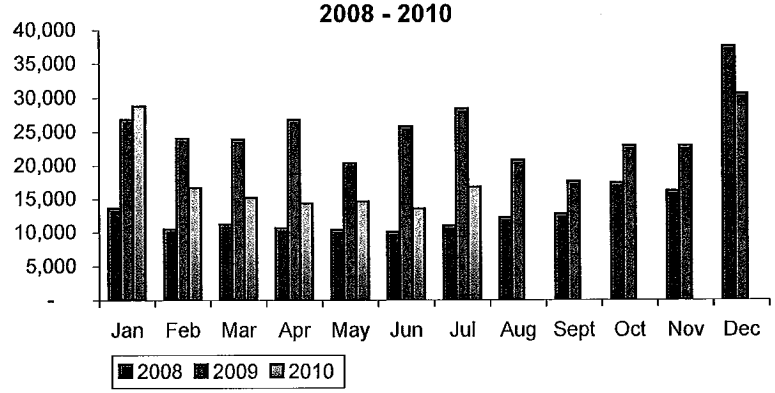
Initial Claims for Unemployment
(all employees)

	Jul-10	Jul-09	Jul-05	Jul-00	1-yr Chg	5-yr Chg	10-yr Chg
Kansas	16,733	28,437	10,807	8,815	-41.2%	54.8%	89.8%
6-State Region	123,697	169,289	92,527	77,035	-26.9%	33.7%	60.6%
U.S.	2,007,892	2,496,606	1,431,771	1,352,724	-19.6%	40.2%	48.4%

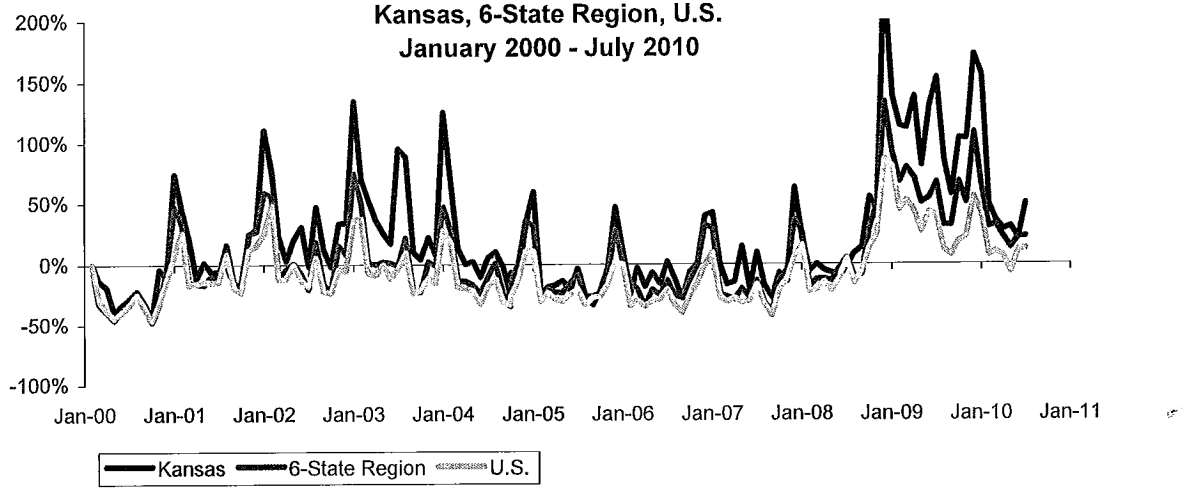
Initial Claims for Unemployment Growth
1yr, 5yr, 10yr Change



Initial Claims for Unemployment in Kansas
2008 - 2010



Initial Claims For Unemployment Growth
Kansas, 6-State Region, U.S.
January 2000 - July 2010



About the data and graphs

Initial claims for unemployment count the number of applications of workers who separated from their jobs and who wish to begin unemployment compensation or to extend the period of eligibility. The data are collected by the U.S. Department of Labor, Employment and Training Administration. The data produced by this agency are not seasonally adjusted. Initial claims for unemployment typically rise as the economy moves into recession and fall as the economy recovers. Initial claims for unemployment traditionally peak in the winter months of November, December, and January.

Source: 2010 monthly data
U.S. Department of Labor - Employment and Training Administration http://workforcesecurity.doleta.gov/unemploy/claimssum.asp

Indicators of the Kansas Economy
Private Industry Wage Levels

35-19

Short-Term (2008 to 2009)

- Kansas private industry wage level down $224 (-0.6%)
- 6-State Region private industry wage level up $43 (0.1%)
- U.S. private industry wage level down $225 (-0.5%)

Mid-Term (2004 to 2009)

- Kansas private industry wage level up $5,498 (16.7%)
- 6-State Region private industry wage level up $5,538 (16.8%)
- U.S. private industry wage level up $6,012 (15.4%)

2009 (p) Private Industry Wage Levels

(average annual wages, all employees, all private establishments)

State	Annual Wage
Kansas	$ 38,511
Arkansas	$ 35,122
Colorado	$ 46,813
Iowa	$ 36,316
Missouri	$ 40,179
Nebraska	$ 36,062
Oklahoma	$ 36,954

(p) - 2009 1st, 2nd, 3rd quarter avg weekly wage mulitplied by 52 weeks

About the data and graphs

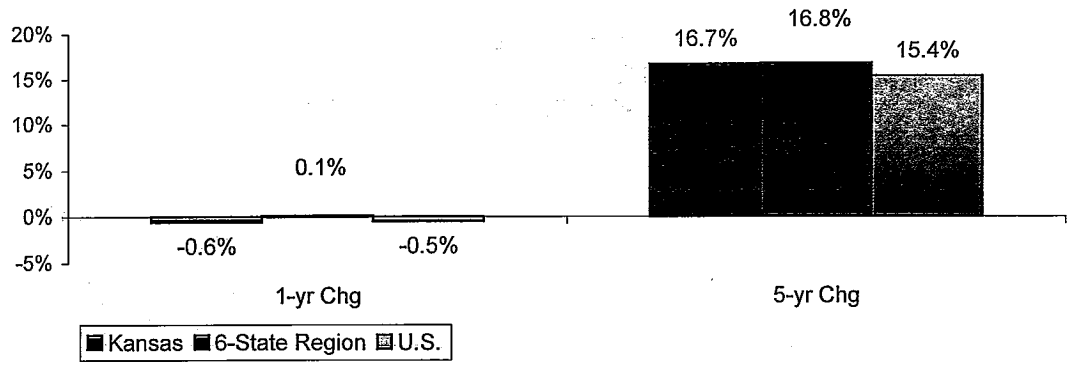
The Quarterly Census of Employment and Wages Program is a cooperative program involving the Bureau of Labor Statistics (BLS) of the U.S. Department of Labor and the State Employment Security Agencies (SESAs). The QCEW program produces a comprehensive tabulation of employment and wage information for workers covered by State unemployment insurance (UI) laws and Federal workers covered by the Unemployment Compensation for Federal Employees (UCFE) program. *Private Industry wage levels were calculated using QCEW program data. Wage levels were calculated as an average of all private industries and establishments.*

Private Industry Wage Levels

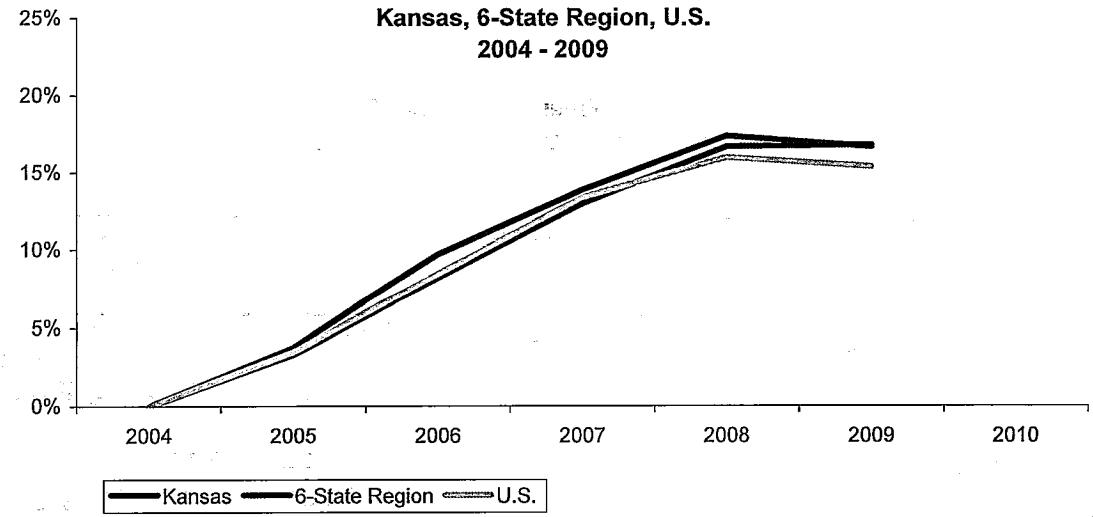
(average annual wages, all employees, all private establishments)

	2009 (p)	2008	2004	1-yr Chg	5-yr Chg
Kansas	$ 38,511	$ 38,735	$ 33,013	-0.6%	16.7%
6-State Region	$ 38,574	$ 38,531	$ 33,036	0.1%	16.8%
U.S.	$ 45,146	$ 45,371	$ 39,134	-0.5%	15.4%

Private Industry Wage Growth
1yr, 5yr, Change



Private Industry Wage Growth
Kansas, 6-State Region, U.S.
2004 - 2009



Source: 2009 annual data
U.S. Department of Labor - Bureau of Labor Statistics

http://www.bls.gov/bls/employment.htm

Kansas, Inc.

Indicators of the Kansas Economy
Private Establishment Data

Aug-10

35-20

Short-Term (2008 to 2009)
- Kansas total establishments up 1,377 (1.7%)
- 6-State Region total establishments down 1,986 (-0.3%)
- U.S. total establishments down 57,436 (-0.7%)

Mid-Term (2004 to 2009)
- Kansas total establishments up 6,084 (8.1%)
- 6-State Region total establishments up 47,216 (7.7%)
- U.S. total establishments up 652,913 (8.1%)

Kansas Private Establishment Data
(total private establishments, by employee size)

Year	1-9	10-49	50-99	100+
2004	56,780	15,216	1,995	1,578
2005	57,852	15,206	2,029	1,599
2006	59,890	15,209	2,057	1,662
2007	59,748	15,549	2,114	1,691
2008	60,803	15,650	2,110	1,713
2009 (p)	62,386	15,592	2,087	1,588
1-yr Chg	2.6%	-0.4%	-1.1%	-7.3%
5-yr Chg	9.9%	2.5%	4.6%	0.6%

(p) - preliminary

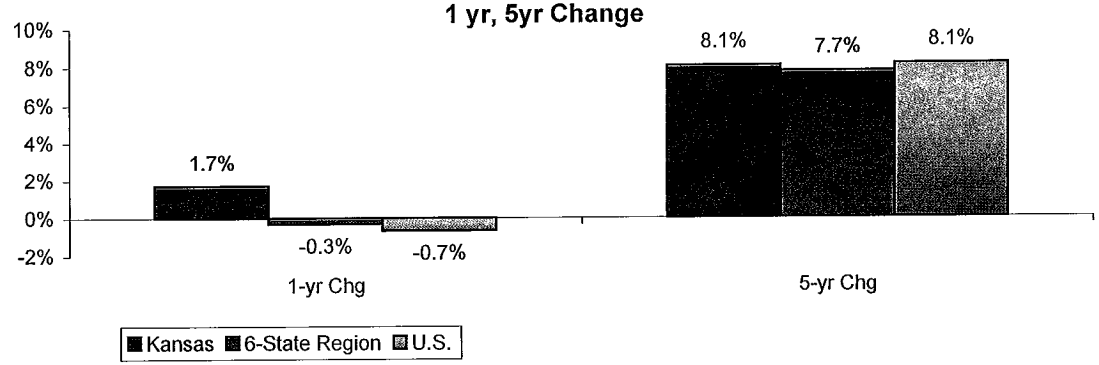
About the data and graphs

According to the U.S. Small Business Administration, small businesses provide approximately 75 percent of the net new jobs added to the economy and employ 50.1 percent of the private work force. This data tracks the number of business establishments by employee size to help understand what size businesses are growing. The Quarterly Census of Employment and Wages (QCEW) program includes data on the number of establishments, monthly employment, and quarterly wages, by NAICS industry, by county, by ownership sector, for the entire United States. *This variable includes private establishments only, as determined by the QCEW program.*

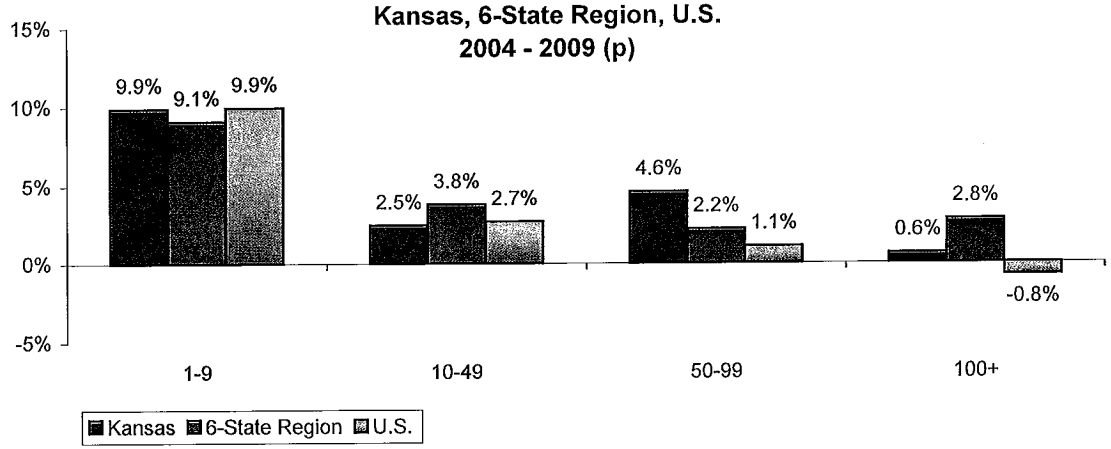
Private Establishment Data
(total private establishments, all employee sizes)

	2009 (p)	2008	2004	1-yr Chg	5-yr Chg
Kansas	81,653	80,276	75,569	1.7%	8.1%
6-State Region	656,540	658,526	609,324	-0.3%	7.7%
U.S.	8,679,773	8,737,209	8,026,860	-0.7%	8.1%

Private Establishment Growth
1 yr, 5yr Change



Private Establishment Growth by Employee Size
Kansas, 6-State Region, U.S.
2004 - 2009 (p)

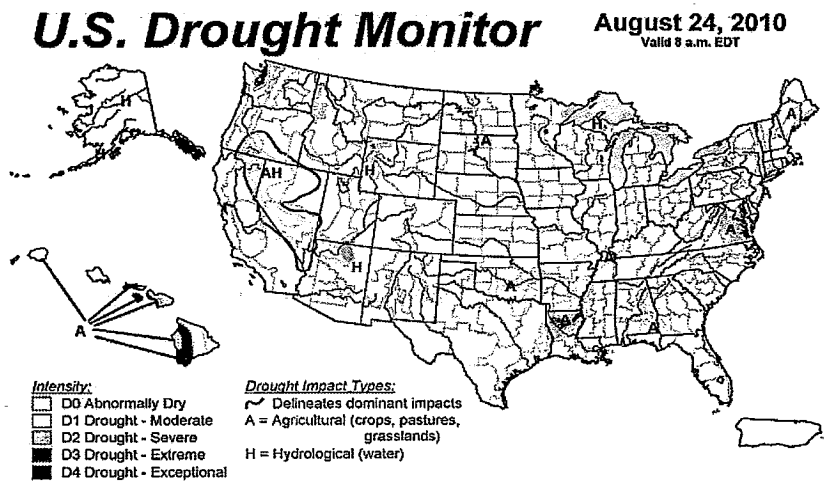


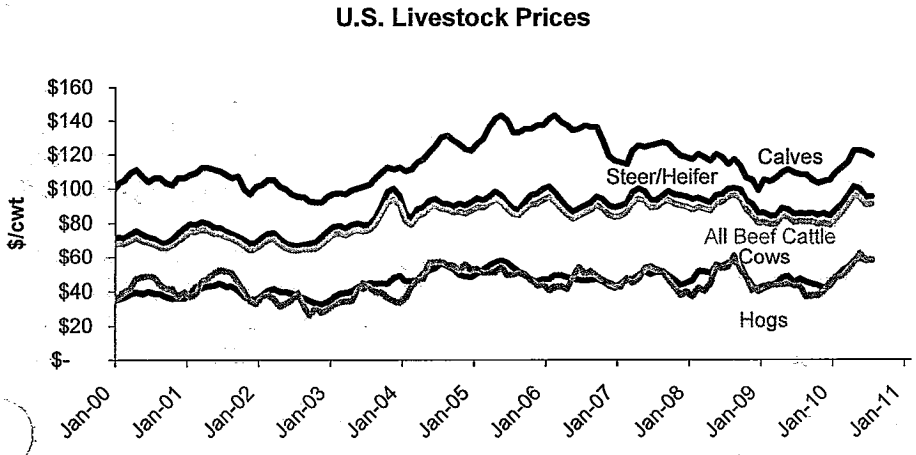
Source: *2009 annual data*
U.S. Department of Labor - Bureau of Labor Statistics http://www.bls.gov/bls/employment.htm
Kansas Department of Labor - Labor Market Information *http://laborstats.dol.ks.gov/*

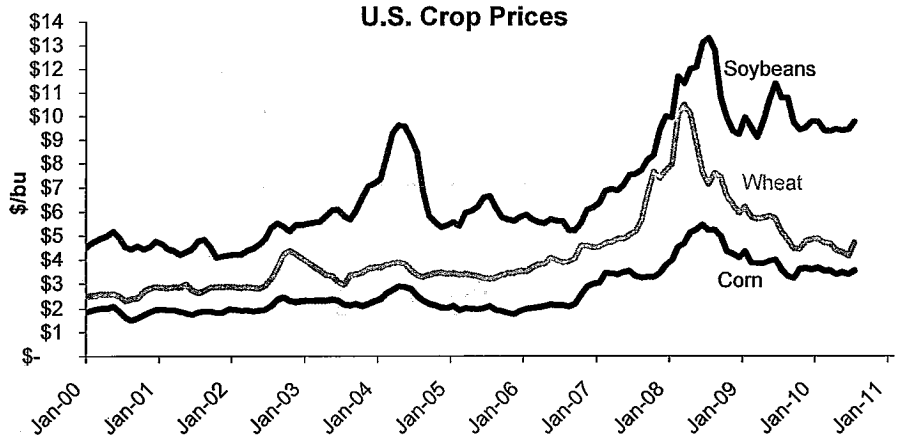
(8/2/2010 USDA Agricultural Prices) KANSAS: The July **All Farm Products Index** of Prices Received by Kansas farmers, at 137 percent of the 1990-92 base, is up 13 points from June but down 1 point from July 2009. The **All Crops Index** in July, at 164 percent of the 1990-92 base, is up 20 points from June but down 20 points from 2009. The **Meat Animals Index**, at 121 percent of the 1990-92 base, is unchanged from June but 11 points above last year.

Wheat prices in mid-July, at $4.60 per bushel, are up 64 cents from June but 69 cents below last July. **Corn** prices in mid-July, at $3.45 per bushel, are up 24 cents from June and 15 cents above last July. Farmers received an average of $5.65 per cwt. for **grain sorghum** in mid-July, up 63 cents from June and $1.00 above last July. **Soybean** prices, at $9.80 per bushel in mid-July, are up 52 cents from June but $1.00 below last July. **All hay** prices averaged $107 per ton in mid-July, up $1 from June and $5 higher than last year. **Alfalfa hay** averaged $115 per ton, up $5 from June and $3 higher than last July. **Other hay**, at $75 per ton, is up $5 from June but $1 below last July.

All beef cattle were bringing an average of $92.30 per cwt. in mid-July, unchanged from June but $7.50 above the price last July. **Cow** prices, at $58.00 per cwt., are up $2.00 from June and $9.20 above the price last July. **Steers and heifers** averaged $93.00 per cwt., unchanged from June but $7.50 above July 2009. **Calf** prices in mid-July were $128.00 per cwt., up $2.00 from June and up $14.00 from July 2009. The **all hog** price of $53.30 per cwt. for mid-July is down 60 cents from June but up $15.60 from last July. **Sow** prices averaged $52.00, down $1.50 from June but $22.30 higher than July 2009. **Barrow and gilt** prices averaged $53.50 per cwt. in mid-July, down 50 cents from June but $14.60 above last July.







Source: *2010 monthly data*
United States Department of Agriculture - NASS http://www.nass.usda.gov
National Drought Mitigation Center http://www.drought.unl.edu

Short-Term (2009)

- 1,477 farms reported farm operation data to KFMA
- KFMA farms averaged $463,742 in value of farm production
- KFMA farms averaged $358,961 in total farm expense
- KFMA average net farm income was $104,781
- SE region had the highest net farm income at $119,381
- SW region had the lowest net farm income at $84,462

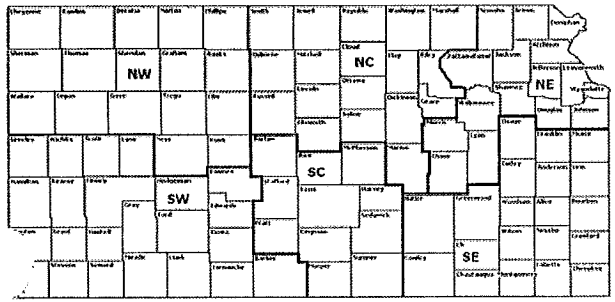
Long-Term (1999 to 2009)

- KFMA average net farm income varies widely from year to year
- 5-yr average net farm income was $89,554
- 10-yr average net farm income was $64,772

About the data and graphs

The Kansas Farm Management Association (KFMA) program is one of the largest publicly funded farm management programs in the U.S. Membership in the KFMA program includes nearly 2,500 farms and over 3,200 families.

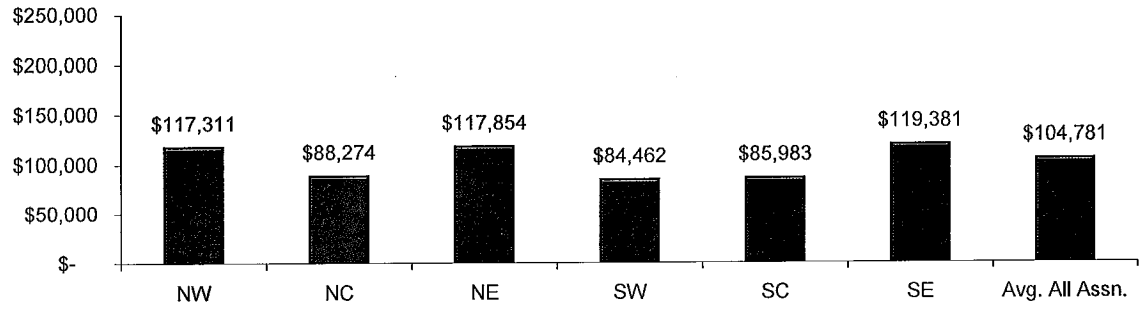
The goals of the KFMA program are to provide each member with information about business and family costs to improve farm business organization, farm business decisions, and farm profitability; and minimize risk. Through on-farm visits, whole-farm analysis, and other educational programs, Association Economists assist producers in developing sound farm accounting systems; improving decision making; comparing performance with similar farms; and integrating tax planning, marketing, and asset investment strategies. The KFMA program is organized into six regional associations.



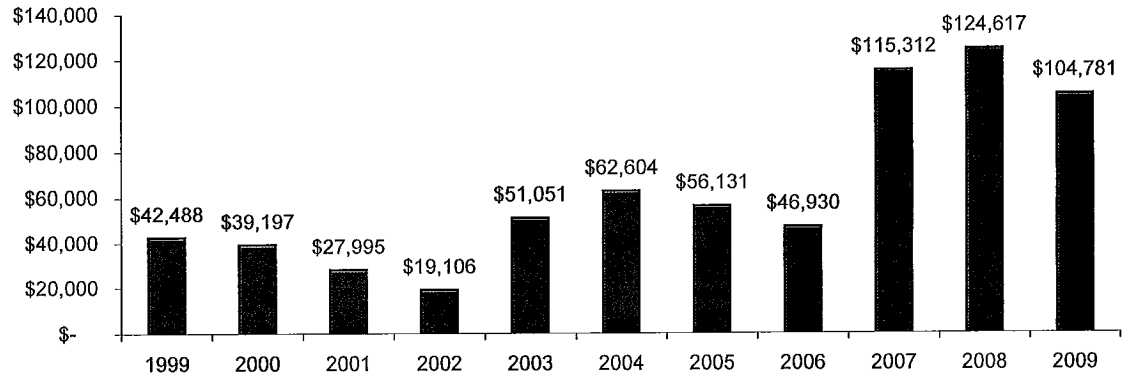
KFMA Average Net Farm Income by Region

Region	NW	NC	NE	SW	SC	SE	Avg. All Assn.
2008	$ 144,839	$ 104,516	$ 121,891	$ 82,605	$ 132,575	$ 133,820	$ 124,617
2009	$ 117,311	$ 88,274	$ 117,854	$ 84,462	$ 85,983	$ 119,381	$ 104,781
5-yr avg	$ 125,176	$ 73,098	$ 95,502	$ 65,258	$ 81,284	$ 94,246	$ 89,554
10-yr avg	$ 79,677	$ 54,393	$ 66,585	$ 45,922	$ 57,753	$ 74,425	$ 64,772

2008 Kansas Farm Management Association
Average Net Farm Income by Region



Kansas Farm Management Association
Average Net Farm Income
1999 - 2009



Source: 2009 annual data
Kansas State University - Kansas Farm Management Association

www.agmanager.info/kfma

Kansas, Inc.

Indicators of the Kansas Economy
Oil Production and Price

Aug-10

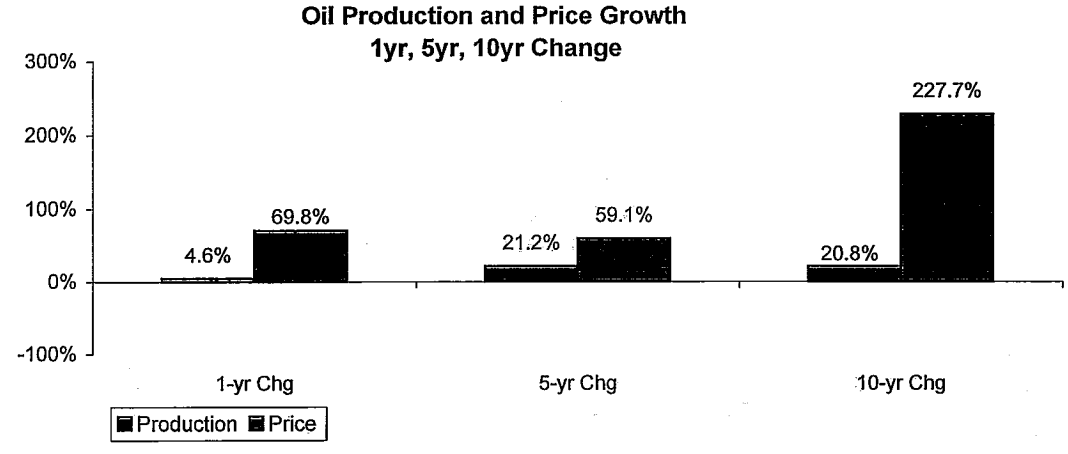
35-23

Short-Term (2009 to 2010)
- Kansas oil production up 150,535 bbl (4.6%)
- Oil price up $34.6 (69.8%)

Long-Term (2000 to 2010)
- Kansas oil production up 588,502 bbl (20.8%)
- Oil price up $58.6 (227.7%)

Oil Production* and Price
(most recent month of both production and price information)

	Apr-10	Apr-09	Apr-05	Apr-00	1-yr Chg	5-yr Chg	10-yr Chg
Production (bbl)	3,423,502	3,272,967	2,824,144	2,835,000	4.6%	21.2%	20.8%
Price ($/bbl)	$ 84.29	$ 49.65	$ 52.98	$ 25.72	69.8%	59.1%	227.7%



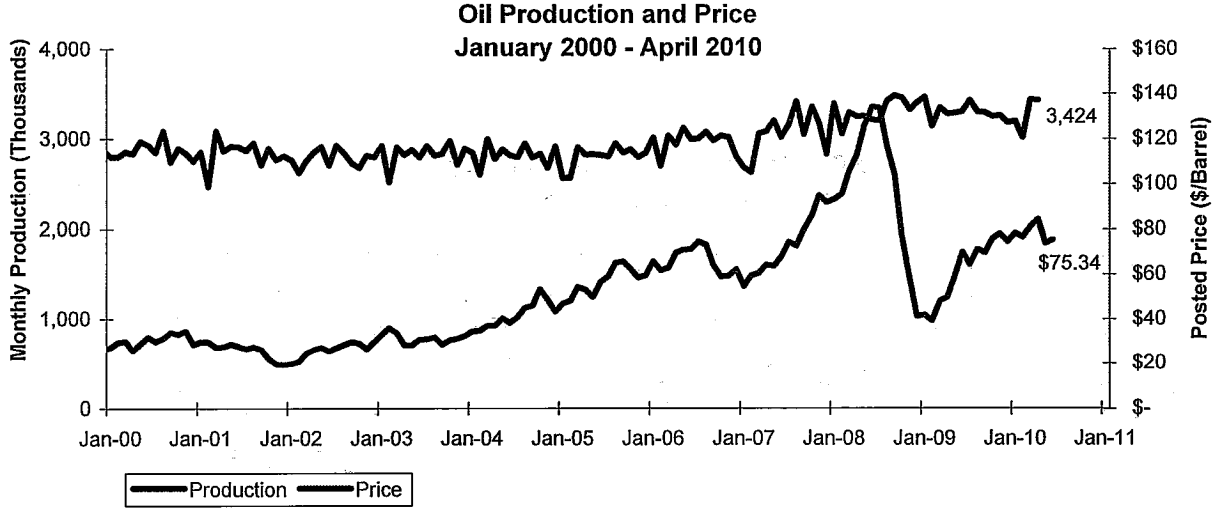
2009 Oil Production/Price

Month	Production*	Price	Month	Production*	Price
January	3,457,432	$ 41.71	July	3,422,120	$ 64.15
February	3,137,996	$ 39.09	August	3,293,572	$ 71.05
March	3,336,477	$ 47.94	September	3,286,941	$ 69.41
April	3,272,967	$ 49.65	October	3,244,421	$ 75.72
May	3,282,305	$ 59.03	November	3,256,399	$ 77.99
June	3,299,532	$ 69.64	December	3,175,332	$ 74.47

2010 Oil Production/Price

January	3,190,629	$ 78.33
February	3,012,735	$ 76.39
March	3,429,123	$ 81.20
April	3,423,502	$ 84.29
May		$ 73.74
June		$ 75.34

** Recent months production usually incomplete and revised upwards.*



About the data and graphs

Since the 1990's, monthly production of oil has steadily declined in Kansas. Kansas has experienced a natural decline in oil production as it becomes increasingly difficult to extract oil over time. CO_2 sequestration and other oil recovery techniques show great promise in recovering a larger share of the know oil reserves in Kansas. The higher prices received for oil along with new technology developments have helped to stabilize oil production levels since 1999.

These prices represent the Cushing, OK WTI Spot Price FOB ($/Barrel). The amount of oil produced is measured in bbl (barrels of oil).

Source: 2010 monthly data
Kansas Geological Survey http://www.kgs.ku.edu/PRS/petro/interactive.html
Energy Information Administration http://www.eia.doe.gov/

Kansas, Inc.

Indicators of the Kansas Economy
Natural Gas Production and Price

Aug-10

35-24

Short-Term (2009 to 2010)
- Kansas natural gas production down 2,501,892 mcf (-8.4%)
- Natural gas price up $0.5 (14.3%)

Long-Term (2000 to 2010)
- Kansas natural gas production down 23,641,788 mcf (-46.4%)
- Natural gas price up $1.1 (37.1%)

Natural Gas Production* and Price
(most recent month of both production and price information)

	Apr-10	Apr-09	Apr-05	Apr-00	1-yr Chg	5-yr Chg	10-yr Chg
Production (mcf)	27,265,194	29,767,086	31,511,956	50,906,982	-8.4%	-13.5%	-46.4%
Price ($/mcf)	$ 3.92	$ 3.43	$ 6.44	$ 2.86	14.3%	-39.1%	37.1%

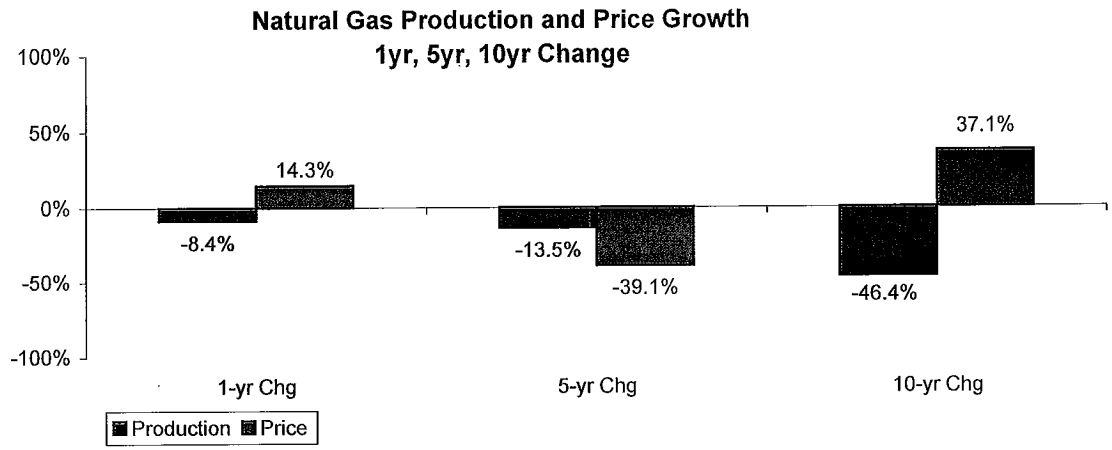
2009 Natural Gas Production/Price

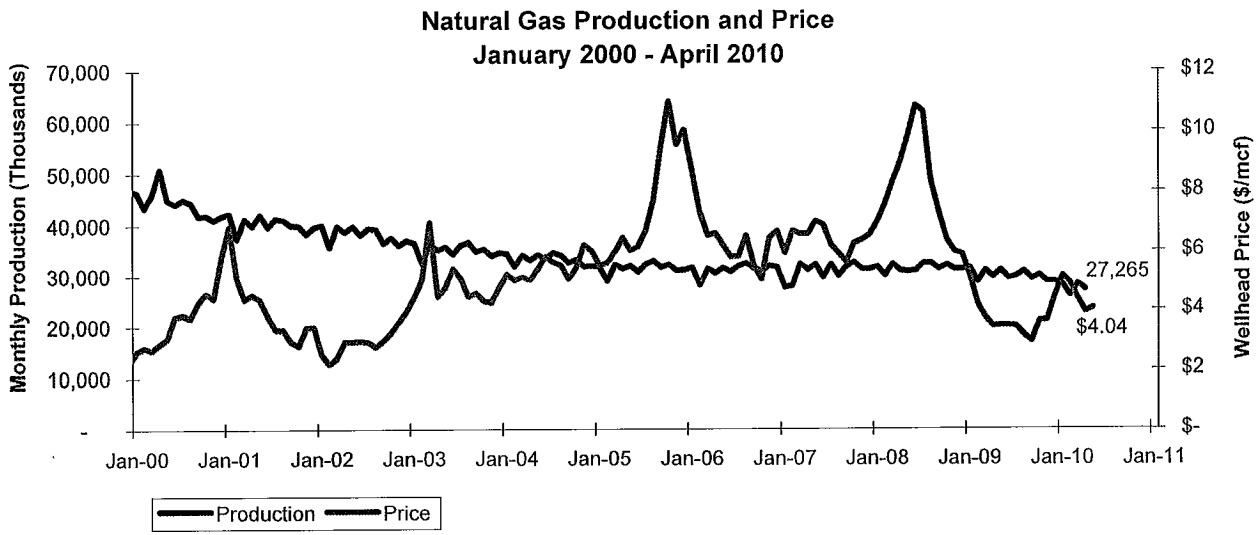
Month	Production*	Price	Month	Production*	Price
January	31,536,409	$ 5.15	July	29,907,774	$ 3.43
February	28,741,405	$ 4.19	August	30,831,766	$ 3.14
March	31,057,871	$ 3.72	September	29,404,290	$ 2.92
April	29,767,086	$ 3.43	October	30,089,582	$ 3.60
May	31,067,897	$ 3.45	November	28,811,916	$ 3.64
June	29,544,335	$ 3.45	December	28,857,190	$ 4.44

2010 Natural Gas Production/Price

January	28,257,779	$ 5.14
February	26,033,657	$ 4.89
March	28,343,109	$ 4.36
April	27,265,194	$ 3.92
May		$ 4.04
June		

** Recent months production usually incomplete and revised upwards.*





About the data and graphs

Since the 1990's, the monthly production of natural gas has declined in Kansas, as the Hugoton natural gas field has decreased in production. The Hugoton natural gas field is the state's largest natural gas field and extends into Oklahoma and Texas. As with Kansas oil production, natural gas production is experiencing a natural decline in production. Price for natural gas has remained fairly constant in the 1990's, and since March 1999 prices have rose considerably.

These prices represent wellhead price, the value at the th of the well. The amount of natural gas produced asured in Mcf's (thousand cubic feet).

Source: *2010 monthly data*
Kansas Geological Survey http://www.kgs.ku.edu/PRS/petro/interactive.html
Energy Information Administration http://www.eia.doe.gov/

July 28, 2010 - Tenth District - Kansas City - The Tenth District economy generally held steady in June and early July, despite weak real estate conditions. Consumer spending remained higher than year-ago levels and was expected to rise over the next three months. Manufacturing activity expanded slightly, but at a slower pace than in previous months. Transportation and high-tech firms reported increased activity. As expected, residential real estate activity contracted sharply in response to the expiration of tax credits. Commercial real estate conditions weakened, and activity was expected to slow in the months ahead. Bankers reported slightly increased loan demand and did not anticipate a change in loan quality over the next six months. Energy production expanded, raising expectations of increased employment and capital spending over the coming months. Agriculture conditions remained positive, and farmland values stayed above year-ago levels. Wage and retail price pressures remained subdued.

Consumer Spending - Consumer spending remained higher than a year ago, and contacts anticipated gains over the next three months. District retailers reported that sales in June and July were flat relative to the previous survey period but remained above year-ago levels. Retailers expected sales to rise over the next three months and a continued downward trend in prices. Auto sales increased in response to higher discounts, and dealers expected strong demand to persist in the coming months. Auto dealers reported continued declines in inventories. Restaurant sales were flat compared to the previous survey, but the average check amount fell. Tourism activity rose over the past month and was expected to remain strong during the summer months. Hotel occupancy rates increased more than anticipated, but contacts expected to give up some of these gains in the coming months.

Manufacturing and Other Business Activity - Growth in manufacturing activity eased slightly in June, while transportation and high-tech firms reported solid growth in sales and activity. Production at manufacturing firms continued to rise, but the pace of growth slowed for the second consecutive month. The volume of new orders, shipments, and finished goods inventories were flat compared to May, but the backlog of orders at manufacturing firms declined. Manufacturing activity continued to improve compared to a year ago, and firms remained optimistic about production and employment over the next six months. Capital spending continued to decrease compared to year-ago levels, and firms expected slightly less investment over the next six months. Transportation firms saw an increase in activity when compared to both the previous period and a year ago. Some firms continued to have difficulty finding qualified drivers.

Real Estate and Construction - Residential and commercial real estate activity declined since the last survey period. With the expiration of tax credits, residential sales dropped sharply resulting in higher inventories of unsold homes. Residential real estate contacts continued to report that lower-priced homes sold better than higher-priced homes. Over the next three months, real estate agents anticipated slower sales. However, builders reported higher traffic from potential buyers and expected starts to rise slightly the next three months. Despite flat construction supply sales since the previous survey, construction supply contacts also expected sales to increase during the coming months. Refinancing activity increased amid declining interest rates. Commercial real estate contacts reported that conditions weakened after improving slightly in the previous survey, including higher vacancy rates and declining sales, construction, prices and rents. Commercial real estate conditions were expected to worsen over the next three months. Developers reported easing difficulty accessing credit.

Banking - Bankers reported slightly increased loan demand, stable deposits, and an unchanged outlook for loan quality. Overall, loan demand edged up after holding steady in the previous survey. Demand for consumer installment loans increased. However, demand fell for commercial real estate loans and was little changed for commercial and industrial loans and residential real estate loans. Credit standards on residential real estate loans and consumer installment loans were unchanged, but a few banks tightened standards on their commercial and industrial loans and commercial real estate loans. About the same number of bankers reported an improvement in loan quality, compared to one year ago, as reported a deterioration. Also, for the second straight survey, respondents expected no change in loan quality over the next six months. Deposits were unchanged, consistent with their overall stability since late last year.

Energy - Energy production continued to expand, and firms expected activity to grow further in the coming months. Growth in the number of active drilling rigs slowed relative to strong gains earlier in the year. Crude oil prices were expected to remain unchanged due to a steadying of supply and demand conditions. Firms reported that they planned to increase the workforce the next three months, but some contacts noted difficulty finding qualified workers. However, they did not anticipate having to raise wages in order to attract workers. Capital spending was expected to increase over the next six to twelve months, and several firms mentioned the potential of developing the Niobrara oil shale in northeastern Colorado and eastern Wyoming.

Agriculture - Agricultural conditions remained positive since the last survey period. Ample moisture reduced the need for irrigation, and the corn and soybean crops were reported in generally good or better condition. Wet weather, however, delayed the winter wheat harvest. While many areas expected an abundant wheat crop, there were some reports of hail damage and poor quality yields, especially in Oklahoma. Corn and soybean prices held steady while wheat prices rallied slightly, mainly due to expectations of a smaller global wheat harvest. Livestock operations continued to be profitable with recovering demand for beef and pork. Farmland values remained above year-ago levels. Farm loan demand held steady, and ample funds were available at low interest rates for qualified borrowers.

Wages and Prices - Wage and retail price pressures remained low in June and July. District firms reported a slight uptick in the shortage of qualified labor, but wage pressures stayed at low levels. Retail prices continued to decline compared to both the last survey period and a year ago. Builders and construction supply firms expected prices to remain at current levels over the next three months. Raw material prices at District manufacturers grew during the survey period, but the pace of growth slowed considerably. Meanwhile, transportation companies continued to experience higher input prices. Overall, District contacts planned to keep prices at their current level the next three months.

About the data *The Summary of Commentary on Current Economic Conditions by Federal Reserve District, commonly known as the "Beige Book," is published eight times each year. Each Federal Reserve Bank gathers anecdotal information on current economic conditions in its District through reports from Bank and Branch directors and interviews with key business contacts, economists, market experts, and other sources. This document summarizes comments received from business and other contacts outside the Federal Reserve and is not a commentary on the views of Federal Reserve officials. The Federal Reserve Bank of Kansas City covers the 10th District of the Federal Reserve, which includes Colorado, Kansas, Nebraska, Oklahoma, Wyoming, and portions of western Missouri and northern New Mexico.*

Source: http://www.federalreserve.gov/FOMC/BeigeBook/2010/

35-29

Kansas, Inc.

Created by the Legislature in 1986, Kansas, Inc. is an independent, objective, and non-partisan organization designed to conduct economic development research and analysis with the goal of crafting policies and recommendations to ensure the state's ongoing competitiveness for economic growth. To attain our mission, Kansas, Inc. undertakes these primary activities: 1) Identifying, building, and promoting a Strategic Plan for economic development efforts in the State of Kansas; 2) To complement the Strategic Plan, Kansas, Inc. develops and implements a proactive and aggressive research agenda, which is used to identify and promote sound economic development strategies and policies; 3) Through collaboration and outreach with economic development entities and other potential partners, Kansas, Inc. conducts evaluation reviews and provides oversight of economic development programs to benchmark development efforts in the State of Kansas.

Co-Chaired by the Governor, Kansas, Inc. is governed by a 17-member Board of Directors. Board members, as mandated by legislation, include four members of Legislative leadership, a representative from the Board of Regents, the Secretary of Commerce, the Commanding General of the Kansas Cavalry, a representative from labor, and eight members from the private sector representing key Kansas industrial sectors. Private sector members are appointed by the Governor and confirmed by the Kansas Senate.

Board of Directors

Co-Chairs

Governor Mark Parkinson
Topeka

Don Landoll
Kansas Cavalry, Marysville

Members

Gene Argo
Mid-America Rodeo Company, Hays

Patti Bossert
Key Staffing, Topeka

Rep. Tom Burroughs
State Representative, Kansas City

Rep. Lana Gordon
State Representative, Topeka

Donna Johnson
Pinnacle Technology, Lawrence

Sen. Tom Holland
State Senator, Baldwin City

Lawrence McCants
First National Bank, Goodland

John Pilla
Spirit AeroSystems, Wichita

Don Schnacke
Donald P. Schnacke, P.A., Topeka

Secretary William Thornton
Kansas Department of Commerce, Topeka

Stephen Waite
Waiteco, El Dorado

Sen. Roger Reitz
State Senator, Manhattan

Staff

Debby Fitzhugh
Director of Operations

Stan R. Ahlerich
President

Dan Korber
Sr. Research Analyst