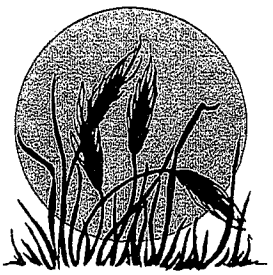

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House Committee on Aging and Long Term Care

CMHC System Over and Impact of Budget Cuts

January 18, 2011

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. I have included in your packet today a map of the CMHC system.

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. In Kansas, you first must be designated by your County to serve as the CMHC to the county residents, then you must secure a license from the Kansas Department of Social and Rehabilitation Services (SRS), to become the publicly funded CMHC and recognized as such by the State of Kansas. 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. Together, they employ 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, the CMHC system serves over 115,000 Kansans with mental illness. Some of the demographics of those we serve are listed below.

Characteristics

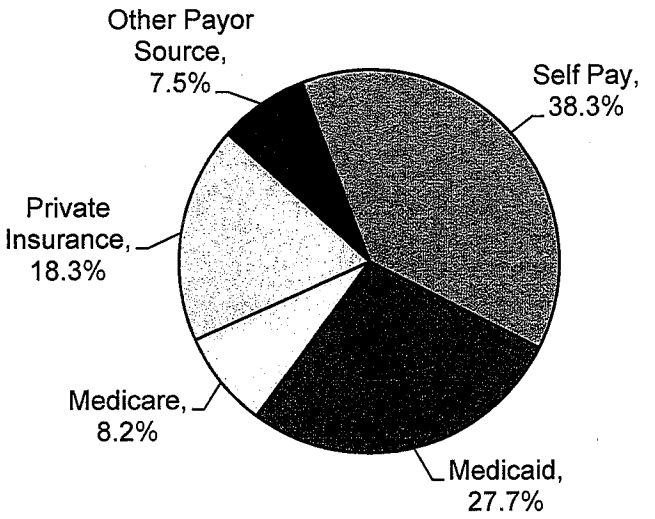
SPMI	18,764	16.40%
SED	19,682	17.21%
Non-SPMI	62,274	54.44%
Non-SED	13,660	11.94%

Age

0-17	33,342	26.80%
18-20	7,061	6.20%
21-64	69,152	60.20%
65+	4,825	4.20%

Gender

Male	53,954	47.00%
Female	60,426	53.00%



The federally mandated target population consists of adults who have a severe and persistent mental illness (SPMI) and children/adolescents who have a serious emotional disturbance (SED). The non-target population is basically everyone else served by the CMHC.

The pie chart reflects a payor mix of those served by the CMHC system (the groupings do overlap). For example, of the encounters, 18.3 percent of the time, a person presents with private insurance. Once the particular benefits run out or we determine coverage limits, if that particular source of payment is exhausted and the need is still there, the grants would then pick up the cost of care. Sliding fee scales and the grants are what make our services affordable to those who either have no resources or their ability to pay prohibits them paying 100% of the cost.

We are a system that is not self contained, but rather one that crosses boundaries. For example, the correctional system is one that if you haven't broken the law, you don't get in their system. For community mental health, there aren't any boundaries. Literally every other human service system recognizes the need for mental health services.

The CMHCs integrate and collaborate with systems such as education (regular education and special education), juvenile justice, developmental disabilities, corrections, aging, child welfare, general medicine, law enforcement, and many more.

As the local Mental Health Authorities for community-based mental health services in Kansas, CMHCs provide the primary linkages between and among service agencies as well as transitioning consumers from child to adult services. The CMHCs serve as the gatekeepers to state mental health hospital treatment by screening all referrals to state hospitals. Also, to ensure necessary linkages with community supports, mental health reform legislation mandates "that no patient shall be discharged from a state hospitals if there is a participating mental health center serving the area where the patient intends to reside, without receiving recommendations from such participating mental health center." Each CMHC has one or more liaisons who go to the state hospitals to assist with discharge and aftercare plans, as well as coordinating with private psychiatric facilities and nursing facilities for mental health (NFMHs).

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

As Legislators, I think it is important that you have a perspective of how Kansas "stacks up" to surrounding states as well as against available national data. While we know we don't have a perfect system, nor is there such a system anywhere in health care, we believe the system we have in Kansas is a good system. What we learned from this examination was that Kansas does stack up well against our surrounding states. It also shows where there are opportunities for continued improvement. I have included in your packet a copy of a report titled, How Kansas Stacks Up: A Regional and National Comparison." Highlights include: 2008 - data

- Kansas serves more individuals in its public mental health system than neighboring States.
- Kansas has a slightly lower hospital utilization rate than surrounding states and the national average.
- State Hospital readmission rates in Kansas are higher than all surrounding States other than Iowa.
- Kansas' child/youth consumer survey measures beat the national average in all four categories and report consumers are significantly more positive about outcomes. Only one neighboring State can boast such impressive results.
- Kansas is a high performer in comparison to surrounding States in relation to adult consumer survey measures.
- When looking at total mental health expenditures by State, Kansas is higher than most surrounding States. That can be attributed to our system serving more individuals. Kansas expenditures still lag behind the national average.

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. **$9.6 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.**

These cuts listed above have not been restored.

Further cuts are being proposed by Governor Brownback for FY 2012! To make matters worse, the new Administration is proposing to eliminate State Aid funding to CMHCs in FY 2012, which has been allocated at $10.2 million since the 1980s. Finally, the new Administration proposes to eliminate funding to the Family Centered System of Care, funded at $5 million from the Children's Initiate Fund.

Before presenting details of the Administration's proposed cuts for FY 2012, I would like to briefly go over the cuts this system has sustained since FY 2007, to put things in the best context for you.

Cuts in Mental Health Reform Funding

Mental Health Reform grants allow CMHCs to serve the uninsured and underinsured who do not qualify for Medicaid and do not have resources to pay for their mental health treatment. It is this funding which essentially ensures every Kansan has universal access to mental health treatment. The CMHCs have a State mandate to serve everyone regardless of their ability to pay. If those living with mental illness do not receive timely treatment, they could easily end up being admitted into a State psychiatric hospital - the most costly level of care. It is the grant funding which has allowed Mental Health Reform to be a success.

Those served by the CMHCs who are not Medicaid eligible are the largest population segment served, yet the CMHCs have limited resources available to cover the cost of providing those services. For example, 28 percent of individuals served by the CMHCs (or 32,000) have Medicaid as their sole payor source. The remaining 72 percent (or 83,000) are non-Medicaid eligible and benefit in some way from state grant funding.[1] We also know that of those served by the CMHC system who are non-Medicaid, and reporting income information, 69% earn less than $20,000 a year.

Without treatment and care, many will end up in contact with law enforcement, jails, hospital emergency rooms or State psychiatric hospitals. Individuals who are able to be treated in the community will have improved quality of life for themselves and their families, and ultimately be more productive citizens.

Budget cuts are placing the public mental health system at a breaking point. Every Kansan who walks through the doors of a CMHC is impacted by these budget cuts. Our workforce is also impacted by these cuts. The response of the State is to impose deep cuts to the public mental health system, walking away from a longstanding commitment to ensuring Kansans have access to quality community-based treatment when they need it. The chart below details this trend.

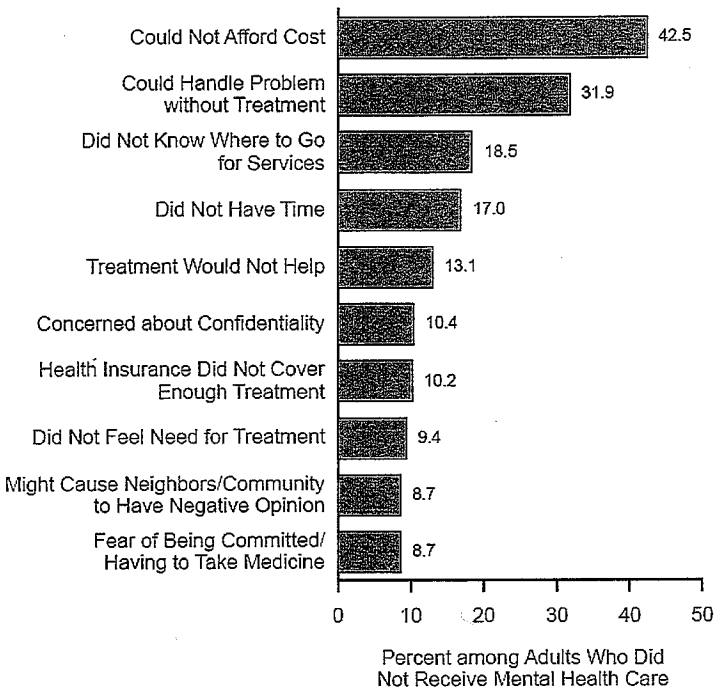
Mental Health Reform Funding

FY	Amount	Impact	Cumulative Impact	% Difference	Cumulative Difference
FY07	$31,066,330				
FY08	$21,874,340	-$9,191,990	-$9,191,990	-29.59%	-29.59%
FY09 (Base)	$21,874,340	-	-$9,191,990	-	-29.59%
FY09 (Revised - Governor's 3% cut to SRS)	$20,074,340	-$1,800,000	-$10,991,990	-8.23%	-35.38%
FY10 Budget Bill	$17,374,340	-$4,500,000	-$13,691,990	-20.57%	-44.07%
FY10 Omnibus Bill	$14,874,340	-$2,500,000	-$16,191,990	-14.39%	-52.12%
FY10 Governor's Allotments	$10,874,340	-$4,000,000	-$20,191,990	-26.89%	-65.00%
FY11	$10,874,340	-	-$20,191,990	-	-65.00%
FY12 Governor's Budget Recommendation	$10,874,340	-	**-$20,191,990**	-	**-65.00%**

The impact on those we serve and on the CMHC system is devastating and is already being felt throughout this State.

- **Increased admissions to hospitals - local emergency rooms and psychiatric hospitals.**
- **Increased suicide calls.**
- **Increased demand for services (90% of CMHCs are experiencing increased demand for services).**
- **Delayed access to services for the uninsured - outpatient, therapy limits, crisis services, reduced/capped benefits.**
- **Waiting lists for some services, longer wait times for appointments.**
- **Raising monthly fee payment arrangements.**
- **Elimination of programs and closing of local offices (75% of CMHCs have done so).**
- **Reduced staff hours.**
- **Reduced operating hours.**

According to the 2009 National Survey on Drug Use and Health (NSDUH), among the 6.1 million adults aged 18 or older who reported an unmet need for mental health care and did not receive mental health services in the past year, several barriers to care were reported, which are outlined in the bar chart below. **The top reason (43%) was they could not afford the cost of treatment.**



In these distressing economic times, mental health needs are on the rise and individuals negatively impacted by the economy turn to our public mental health system for help. With these difficult times come increased drinking, domestic violence and marital problems linked to financial stress, as well as children trying to cope with extreme anxiety within the home. Research shows rates of depression and suicide tend to climb during times of economic tumult.[2]

Mental Health Reform funding helped our system close state hospital beds and helps support services that are essential in keeping individuals out of inpatient settings. Reducing these funds puts at risk an already overstretched state hospital capacity. Without Mental Health Reform funding, there would be no universal

system; no safety net; no 24 hour emergency care; increasing demands for mental health care in emergency rooms and in-patient setting; and a growing number of persons in our jails.

MediKan

The Governor's FY 2010 November Allotment reduced the time limit for MediKan benefits from 18 months to 12 month; FY 2011 continues that policy. MediKan is a State-funded program that provides medical benefits to people awaiting determination for federal disability benefits (SSI/SSDI), approximately 3,000 adults in total. MediKan provides limited medical services and is generally considered interim coverage. MediKan is funded by State General Fund (SGF) dollars with no federal matching funds. The chart below highlights the cuts imposed on the MediKan (mental health) program.

MediKan – Mental Health

FY	Amount	Impact	Cumulative Impact	% Difference	Cumulative Difference
FY09 (24 months)	$6,836,999				
FY10 Reduction (reduction from 24 months to 18 months)	$4,176,257	-$2,660,742	-$2,660,742	-38.92%	-38.92%
FY10 Allotment (reduction from 18 months to 12 months)	$3,710,705	-$465,552	-$3,126,294	-11.15%	-45.73%
FY11	$3,710,705	-	-$3,126,294	-	-45.73%
FY12 Governor's Budget Recommendation	$3,710,705	-	**-$3,126,294**	-	**-45.73%**

For FY 2010, the MediKan time limit was reduced from 24 months with a hardship provision (allows the most ill to continue receiving benefits beyond the limit) to 18 months, placing a firm lifetime limit on the recipient of MediKan benefits (no hardship provision). This resulted in a reduction of $2.6 million SGF. For FY 2011, the MediKan time limit is being reduced from 18 months to 12 months. This results in an additional reduction of $465,000.

At the beginning of FY 2009, there were 3,155 individuals on MediKan. At the end of December 2009, that number was reduced to 1,928. We can clearly see the impact of the time limit by the number of individuals served by MediKan.

Many of the individuals who don't qualify for SSI/SSDI have a mental health diagnosis. **Without MediKan as a payor source or without additional funding provided to meet the needs of those previously served on MediKan who will not become eligible for SSI or Medicaid, the burden falls on existing resources within the public mental health system to meet their mental health needs. Those existing resources are the Mental Health Reform funds which have been significantly reduced since FY 2008.** While we understand the necessity in making this policy decision, we are concerned about accessibility of physical and mental health care for those individuals who are ultimately unsuccessful in pursuing SSI/SSDI benefits, regardless of what the time limit is set at. Again, these individuals will turn to safety net clinics and CMHCs to access the necessary care.

Community Support Medication Program

The Community Support Medication Program (CSMP) is for the purchase of atypical anti-psychotics, antidepressants, and other medications for the treatment of mental illness for those who are at risk of hospitalization and who meet income requirements. The CSMP is legislatively mandated as the "payment of last resort." For FY 09, the CSMP was appropriated at a little over $1 million. In FY 2010, that amount was reduced by 54 percent, or by almost $500,000. Based on expenditures through December 2009, over $325,000 has already been spent. If spending continues at this rate, we will run out of funding before the next fiscal year begins. This clearly shows the great need for this program.

FY	Amount	Impact	Cumulative Impact	% Difference	Cumulative Difference
FY09	$1,050,000				
FY10 Omnibus Bill	$489,715	-$560,285	-$560,285	-53.36%	-53.36%
FY11	$489,715	-	-$560,285	-	-53.36%
FY12 Governor's Budget Recommendation	$489,715	-	**-$560,285**	-	**-53.36%**

This, coupled with Mental Health Reform cuts and cuts to MediKan, only further exacerbates the challenges faced by those we serve who have no resources to pay for their care.

Cuts Proposed by the new Administration for FY 2012

State Aid

The Governor's proposed budget for FY 2012 eliminates State Aid funding allocated to CMHCs, a total of $10.2 million. That amount has remained the same since the 1980s. State Aid allows CMHCs to serve as the mental health safety net for all Kansans (similar role as primary care safety net clinics). **It ensures all Kansans have access to crisis and emergency services 24 hours a day, every day of the year.** As one of my Directors explains, "we are the fire department for mental health!" **The beneficiaries of these services are the uninsured and underinsured, over 70,000 Kansans.**

Examples of services paid with this funding stream include:

- physician and nurse intervention during crises (including psychiatric evaluation, medication monitoring)
- acute treatment services for those in crises
- overnight crisis stabilization (prevents admissions to state hospitals)
- mobile community crisis response (including responding to law enforcement requests for assistance)
- after-hours call center with on-site staff
- attendant care

If this proposed cut were to be approved by the Legislature, it would mean we would mean guaranteed access to crisis and emergency services for all would no longer be in place. What will happen to those in need of crisis services that we cannot provide service to? They will show up at hospital emergency rooms, jails, end up in inpatient care, and quite possibly even worse. This will simply drive up expenditures to the State of Kansas, expenditures that will be much greater as these entry points are more costly. Continuing to fund State Aid is the best value.

Family Centered System of Care

The Governor's proposed budget for FY 2012 eliminates funding for the Family Centered System of Care (FCSC). These funds come from the Children's Initiative Fund The FCSC is a statewide program that is blended into the community based services programs for youth with SED. It is one component of an overall movement to incorporate research based best practices into the Children's mental health service system in Kansas.

The FCSC program has three guiding principles: building community collaboration on behalf of service delivery; providing parent support services to families of children with SED; and increasing or expanding the array of community-based mental health services for children with SED and their families. Each CMHC developed a strategic plan in collaboration with key community stakeholders and parents to identify existing gaps in services and to build programs to meet the needs of this population. Those plans are unique to each community. Every CMHC has added

Parent Support Services to their service array. All other aspects of their plans vary according to local need. Every CMHC utilizes Interagency Community Teams for CMHC service development, planning purposes, and to coordinate care across systems for this population.

Eliminating this program means children with a severe mental illness and their families will lose critical services such as psychiatric medication, therapy, rehab services, support to families and parent support. Almost 500 kids and families benefit from this program in any given month.

It is very troublesome to us that the Administration is targeting mental health for budget reductions considering the state of our system which I have outlined here today. Sitting down with us ahead of time and asking tough questions and finding some solutions together would have been most helpful and could have contained the damage to our system. We now must turn to the Legislature to remedy this. Realizing that there is no new money to be found, the Association is developing some suggestions as to how the budget committees might remedy this without spending additional SGF.

Community Based Mental Health Services are the Best Value for the State

In the face of budget shortfalls, severe cuts have been imposed on CMHCs that will impact the public mental health system and individuals with mental illness and their families. Policy makers must understand that paying for the costs of treating mental illness is unavoidable. Our only decision is how we as a State pay for it. The State can either invest in the public mental health system or pay a greater price through increased psychiatric hospitalization and primary care costs, greater reliance correctional facilities, homelessness, and other costs to society including lost productivity and suicide.

We know it costs on average, $428 per day for treatment at one of our State psychiatric hospitals; $80 per day on average to be incarcerated at Larned Correctional Mental Health Facility; $10 per day on average for Medicaid expenditures for community-based mental health treatment; and $22 per day on average for Medicaid expenditures for the most chronic mental health conditions. This is consistent with other data which confirms community-based treatment for mental illness is the best value.

It is also important to note that investing in community-based mental health services directly lowers healthcare costs. Treatment for mental disorders is associated with a 20 percent reduction in the overall use of health care services.[3] Budget gains from reducing access to pharmaceuticals are more than offset by increases in spending on services elsewhere in the system (such as increased hospitalization and emergency room care).[4] At a time when the State is struggling with containing the costs of health care, paying for the cost of community-based mental health treatment is part of the solution to our State's budget crisis.

Why Investing in Mental Health is Important

- Good mental health enhances the workplace; a high percentage of lost productivity, staff absences and errors on the job is due to emotional problems, alcohol and/or drug abuse.
- Children learn better in a school environment where early intervention of mental health services is available.
- Effective community-based mental health treatment and support services, as well as newer medications, promote economic stability by permitting thousands of persons with serious mental illness to hold meaningful jobs and maintain productive lives in their own communities.
- Families stay healthier and grow stronger when affordable access to mental health services is readily available.
- The treatment success rates for such disorders as depression (more than 80%), panic disorder (70-90 percent) and schizophrenia (60 percent), surpass those of other medical conditions such as heart disease (45-50 percent).

- 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.
- 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.

Psychiatric Inpatient Capacity

Our 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.

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.

<u>The Importance of Inpatient Resources</u>

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.

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

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.

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.
- Proposed cuts by the current Administration total an additional $15.2 million.

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.

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.

- 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).

<u>State Hospitals as Critical and Necessary Public Safety Net</u>

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.

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.

Conclusion

The most pressing needs of the Kansas public mental health system are to prevent further devastating cuts in funding for community-based mental health treatment and adequate inpatient capacity so that inpatient care is available timely. If we are unable to prevent further cuts to community-based programs, we believe it is likely the State will continue to see even greater increases in reliance on inpatient services, hospital emergency rooms, jails, and terrible personal tragedies – all of which can be avoided.

Mr. Chairman, I thank you and the Committee for allowing me this opportunity to present an overview of our system and its most pressing issues.

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[1] Automated Information Management System (AIMS); Kansas Department of Social and Rehabilitation Services; FY 2009.
[2] National Alliance on Mental Illness; National Survey with MHA and Depression is Real. October 2009. http://www.nami.org/Content/NavigationMenu/Top_Story/Economys_Toll_on_Mental_Health.htm .
[3] Lave J. The cost offset effect. In FogelBS, Furino A, Gottlieb GL, *Mental health policy for older Americans: Protecting minds at risk.* Washington, DC: American Psychiatric Press. 1990.
[4] The Lewin Group. *Health Plan Benefit Barriers to Access to Pharmaceutical Therapies for Behavioral Health.* 1998.

FY 2012 Governor's Budget Recommendations for State Aid and FCSC

January 14, 2011

CMHC	State Aid	FCSC	TOTAL GRANT ADJUSTMENT
Area Mental Health Center	($448,740)	($233,815)	($682,555)
Bert Nash Community Mental Health Center	($248,077)	($124,508)	($372,585)
Center for Counseling & Consultation	($255,708)	($102,996)	($358,704)
Central Kansas Mental Health Center	($299,404)	($157,392)	($456,796)
Comcare of Sedgwick County	($1,395,560)	($687,664)	($2,083,224)
Cowley County Mental Health Center	($129,623)	($74,555)	($204,178)
Crawford County Mental Health Center	($131,421)	($136,723)	($268,144)
Family Life Center	($77,530)	($128,114)	($205,644)
Four County Mental Health Center	($214,777)	($179,968)	($394,745)
Elizabeth Layton Center	($155,208)	($92,390)	($247,598)
High Plains Mental Health Center	($736,306)	($189,063)	($925,369)
Horizons Mental Health Center	($535,403)	($176,527)	($711,930)
Iroquois Center for Human Development	($82,365)	($18,820)	($101,185)
Johnson County Mental Health Center	($1,067,488)	($521,581)	($1,589,069)
Kanza Mental Health & Guidance Center	($149,923)	($86,550)	($236,473)
Labette Center for Mental Health Services	($89,259)	($128,114)	($217,373)
Mental Health Center of East Central Kansas	($299,664)	($156,360)	($456,024)
The Guidance Center	($323,826)	($183,103)	($506,929)
Pawnee Mental Health	($601,057)	($301,011)	($902,068)
Prairie View Mental Health Center	($800,128)	($114,906)	($915,034)
South Central MHC	($165,566)	($99,773)	($265,339)
Southeast Kansas Mental Health Center	($251,423)	($188,070)	($439,493)
Southwest Guidance Center	($111,614)	($80,583)	($192,197)
Sumner Mental Health Center	($87,530)	($49,539)	($137,069)
Valeo Behavioral Health Care inc. FSGC	($976,028)	($322,588)	($1,298,616)
Wyandot Center for Community Behavioral Health Inc	($599,669)	($465,287)	($1,064,956)
Total	($10,233,297)	($5,000,000)	($15,233,297)

FY 2012 Governor's Budget Recommendation

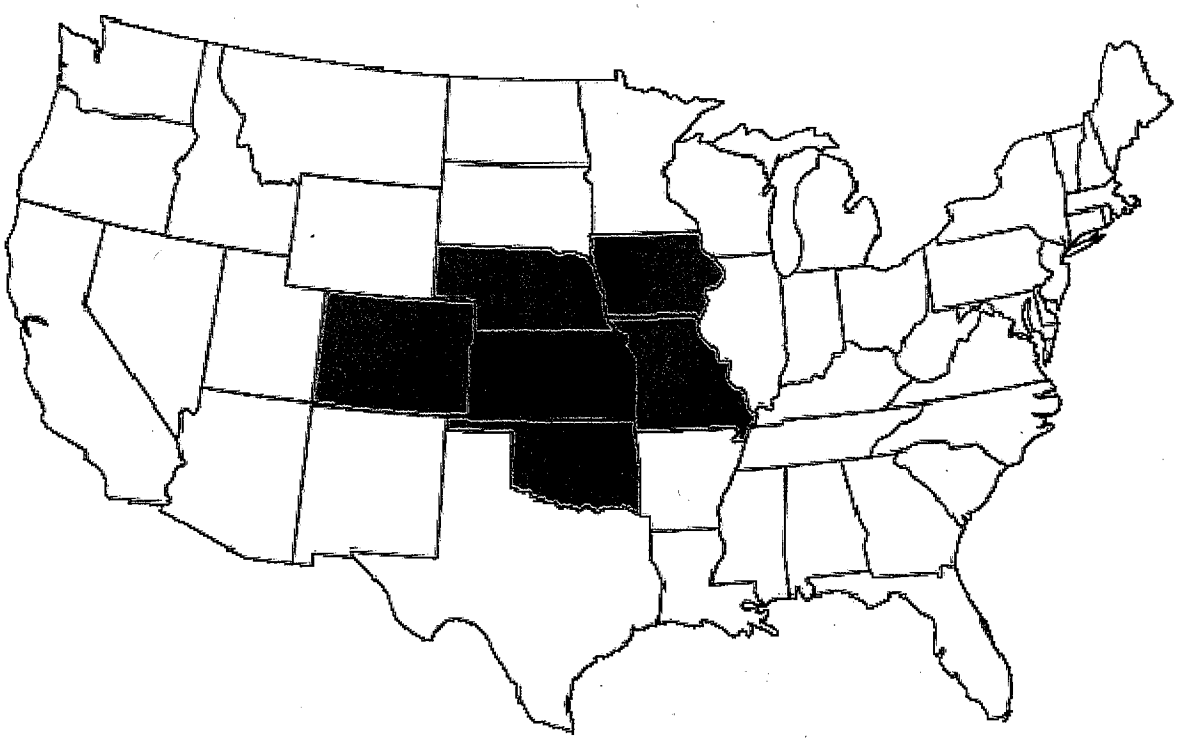
Impact to Community Mental Health Centers
House Committee on Aging and Long Term Care

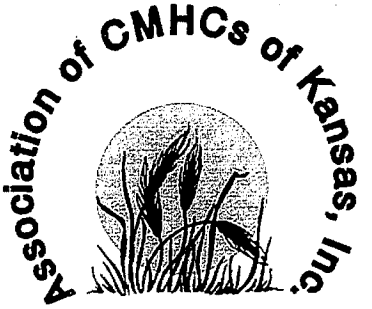
Rep Bob Bethell		
The Center for Counseling and Consultation		($358,704)
Horizons Mental Health Center		($711,930)
	Total	($1,070,634)
Rep Ron Worley		
Johnson County Mental Health Center		($1,589,069)
Rep Broderick Henderson		
Wyandot Center for Community Behavioral Health		($1,064,956)
Rep Don Hill		
Mental Health Center of East Central Kansas		($456,024)
Rep Bill Otto		
Southeast Kansas Mental Health Center		($439,493)
Elizabeth Layton Center		($247,598)
Mental Health Center of East Central Kansas		($456,024)
	Total	($1,143,115)
Rep Scott Schwab		
Johnson County Mental Health Center		($1,589,069)
Rep Jene Vickrey		
Elizabeth Layton Center		($247,598)
Rep Brian Weber		
Area Mental Health Center		($682,555)
Rep Kay Wolf		
Johnson County Mental Health Center		($1,589,069)
Rep Geraldine Flaharty		
COMCARE of Sedgwick County		($2,083,224)
Rep Kathy Wolfe Moore		
Wyandot Center for Community Behavioral Health		($1,064,956)

How Kansas Stacks Up

A Regional and National Comparison of Mental Health Care Services

November 2009





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How Kansas Stacks Up: A Regional and National Comparison

Executive Summary

In recent years, a strong interest has been expressed in the mental health field regarding the capability to identify and adequately measure the effectiveness of mental health services. Efforts to support this interest within the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services (HHS) have resulted in the Uniform Reporting System (URS) output tables. This report will use the most current available set, which is FY2008.

Additionally, the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI), which is under federal contract to study mental health, has been collecting data on revenues and expenditures of mental health. The most current report titled *Funding Sources and Expenditures of State Mental Health Agencies: FY2006* will be referenced in this report.

Additional information used for this report was secured from the following sources:

- Automated Information Management System (data warehouse for the Kansas public mental health system);
- Kansas Client Status Reports; and
- US Census Bureau 2007 Population Estimates

These national and state reports, for the first time, enable regional and national comparative analyses. In this second installment of the report, we have included Iowa with the other neighboring states. This was done to provide a more similarly matched population demographic to that of Kansas.

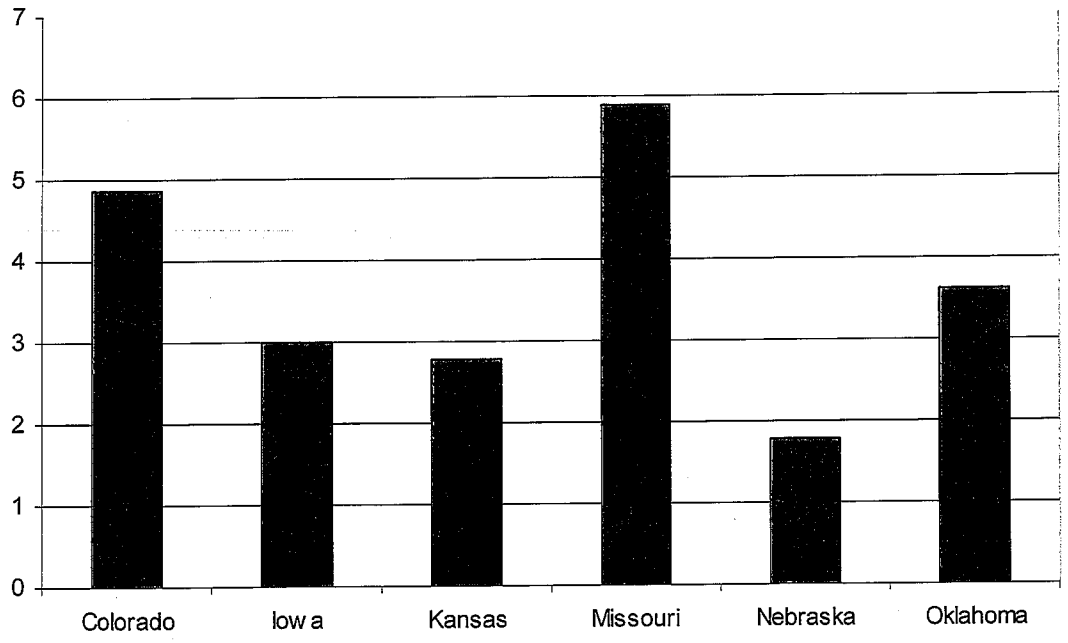
We recognize that there exists a multiplicity of variables that impact the way in which individual States report on each data element, therefore, the reader must exercise caution in reaching conclusions based on State or national comparisons alone. Nevertheless, useful conclusions may be developed to improve the public mental health system. With these caveats firmly in mind, we offer the following key points that flow from this initial analysis:

- Kansas serves more individuals in its public mental health system than neighboring States.
- Kansas has a slightly lower hospital utilization rate than surrounding states and the national average. This takes into account State Hospitals and other inpatient facilities.
- Readmission rates in Kansas are higher than all surrounding states other than Iowa.
- Kansas' child/youth consumer surveys measures beat the national average in all four categories and report consumers are significantly more positive about outcomes. Only one other neighboring state can boast such impressive results.
- Kansas is a high performer in comparison to surrounding states in relation to consumer survey measures.
- Kansas is third among the surrounding States in State Hospital expenditures as a percent of SMHA expenditures and is above the national average.
- Among surrounding states, only Iowa spends more per capita than Kansas on mental health. However, both states are lower than the national average.
- Among the surrounding States, Kansas is second to Iowa in Community Mental Health expenditures as a percent of SMHA expenditures. Again, Kansas by far exceeds the other comparison States in the number of individuals served and the penetration rate.
- Kansas has been maintaining or steadily improving outcomes for SED children/adolescents receiving case management.

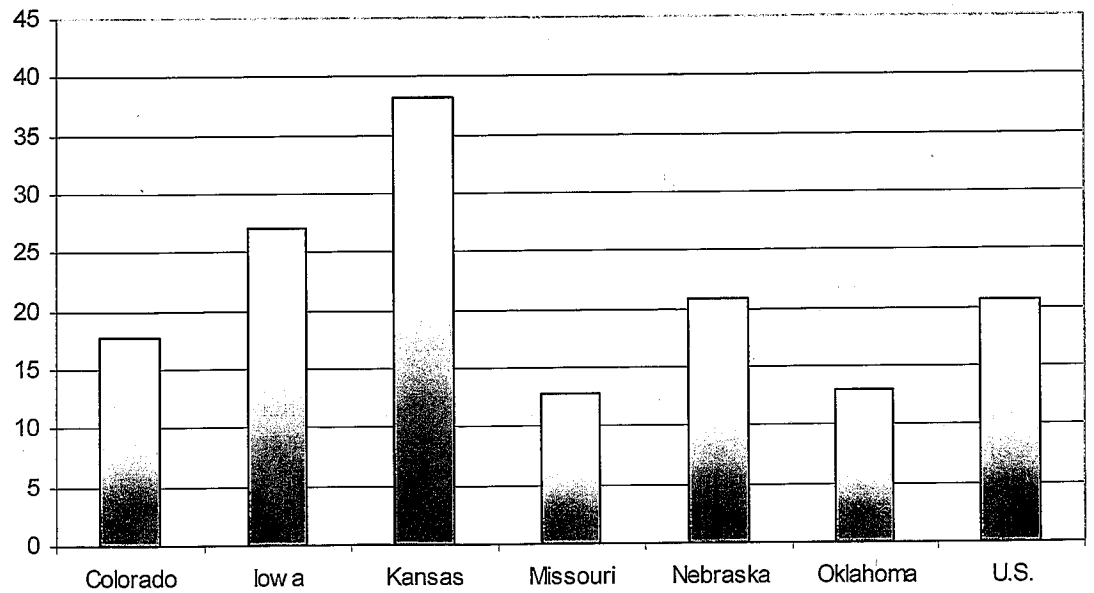
Populations and Numbers Served

Kansas presents a unique situation in the Midwest. Among other regional states, the population is lower than all but Nebraska. Yet, when looking at the ratio of persons served per thousand, Kansas far outpaces any regional neighbor. In fact, Kansas serves 34% more clients than the next closest state, Iowa.

2007 US Census Bureau Population Estimates
(in millions)



Total Number of Consumers per 1,000 Population

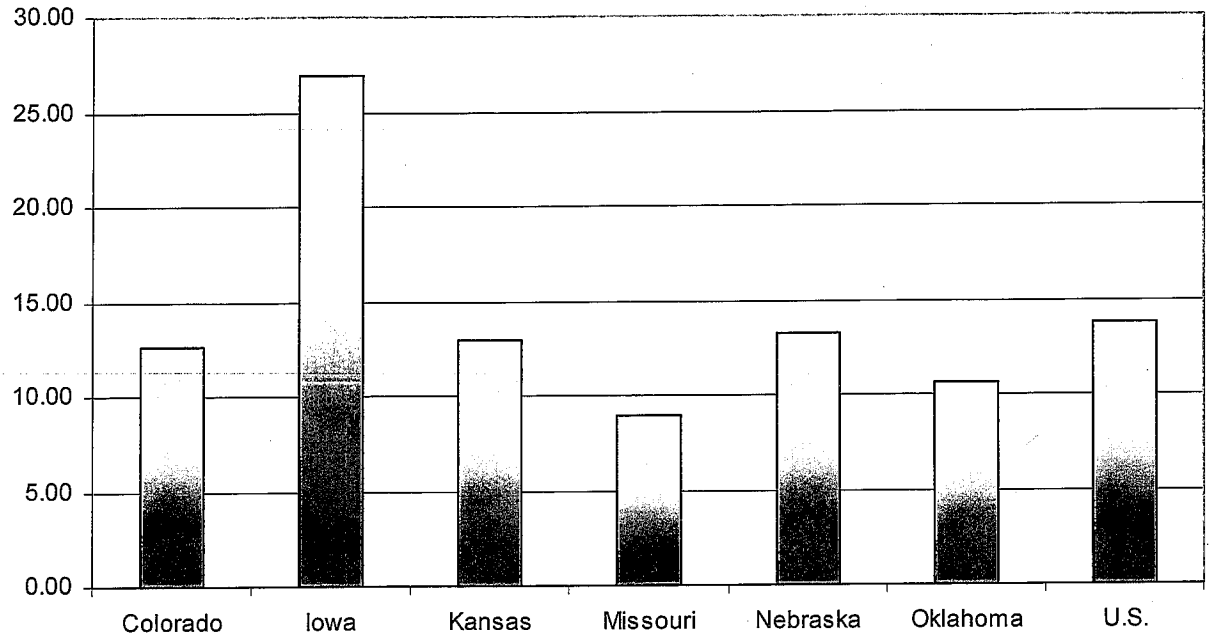


2-20

SED/SPMI Penetration Rates and Hospitalizations

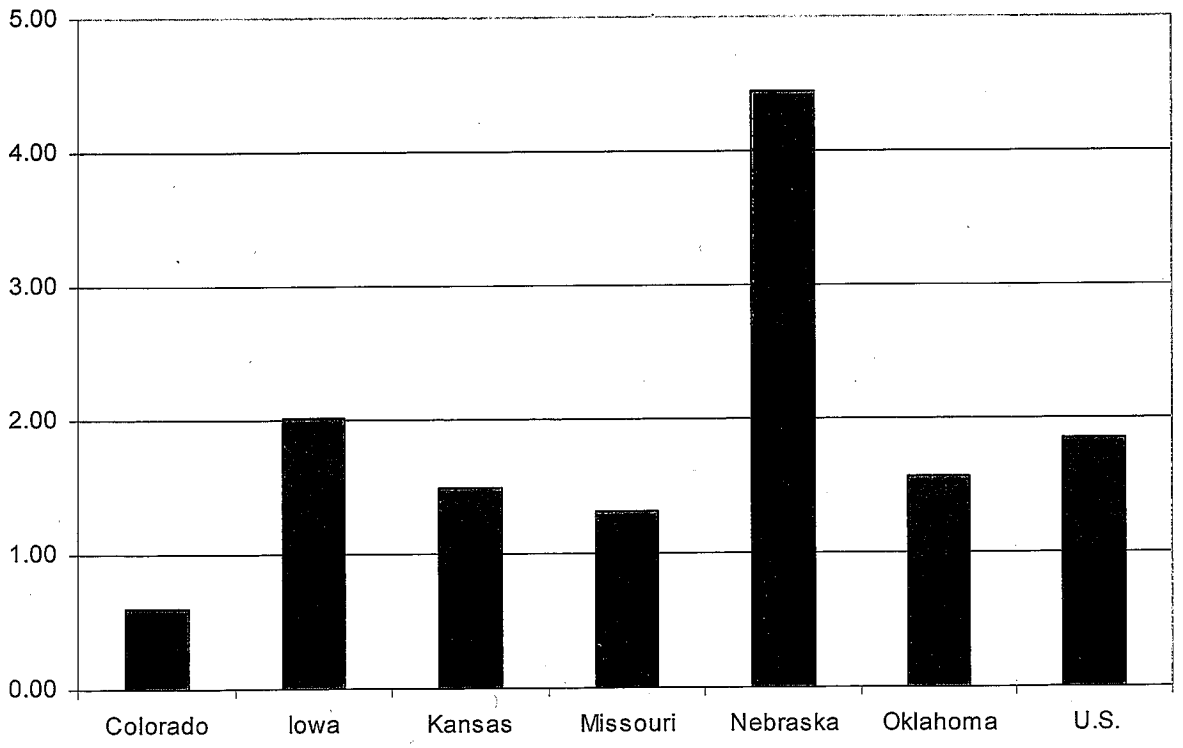
Kansas comes in middle of the pack when looking at the SED/SPMI penetration rate, just shy of the national average.

SED/SMI Penetration Rate Per 1,000 Population



Hospitalizations in Kansas are slightly lower than the surrounding states and national average.

State Psychiatric Hospital and Other Inpatient Utilization Rate per 1,000

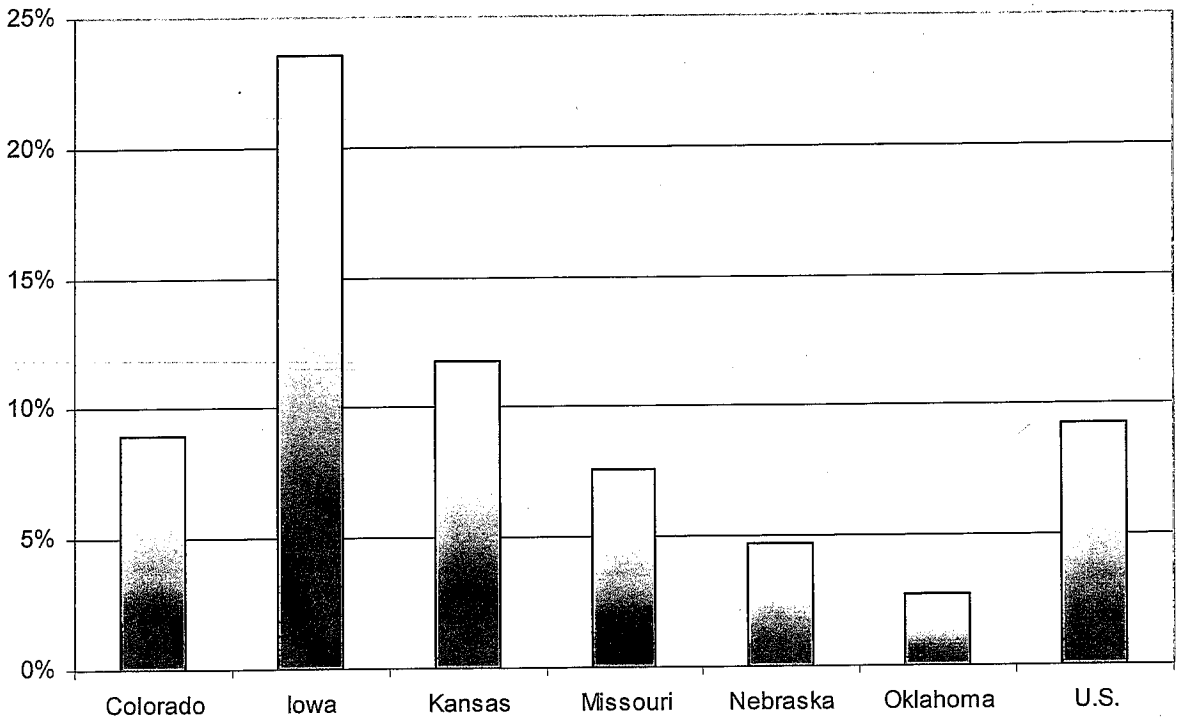


2-21

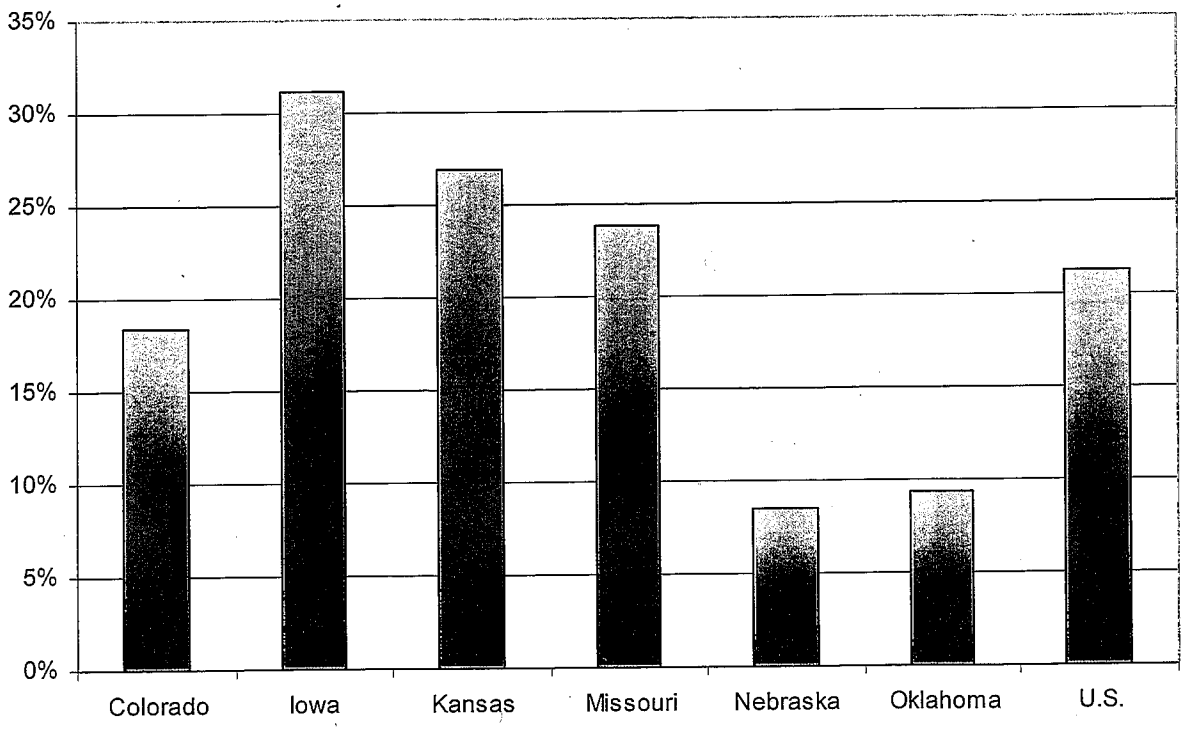
Hospital Readmission Rates

Kansas has higher readmission rates at both 30 and 180 days than all states but Iowa. Kansas also has higher rates than the national average.

State Hospital Readmission Rate: 30 Days



State Hospital Readmission Rate: 180 Days

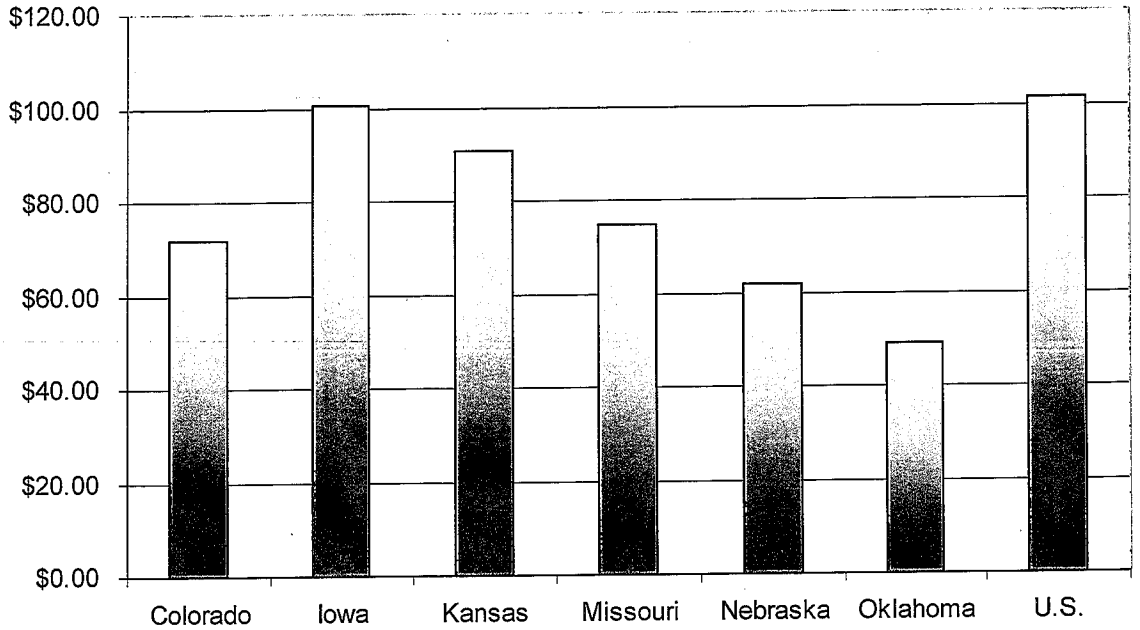


2-22

Expenditures

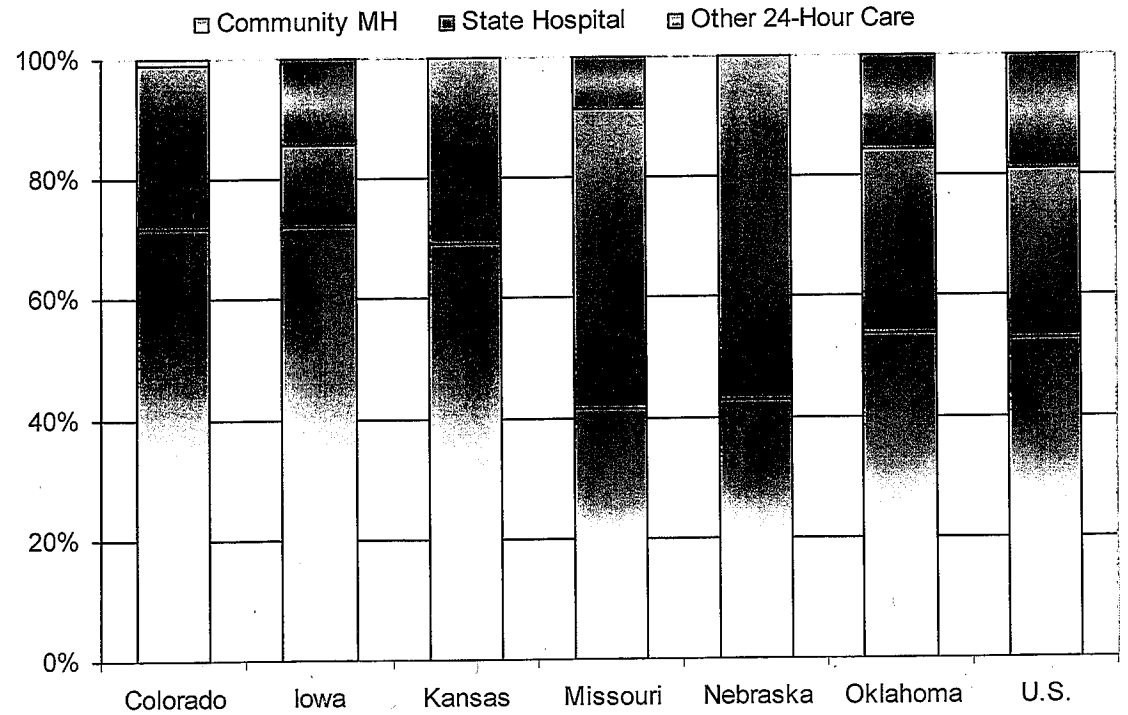
When looking at total mental health expenditures by state, Kansas is higher than most surrounding states but still lags the national average by approximately 11%.

Per Capita Total SMHA Mental Health Expenditures



If we take a look at how the dollars are allocated, we can see that only Missouri and Nebraska spend a greater percentage of their budget on State Hospitals.

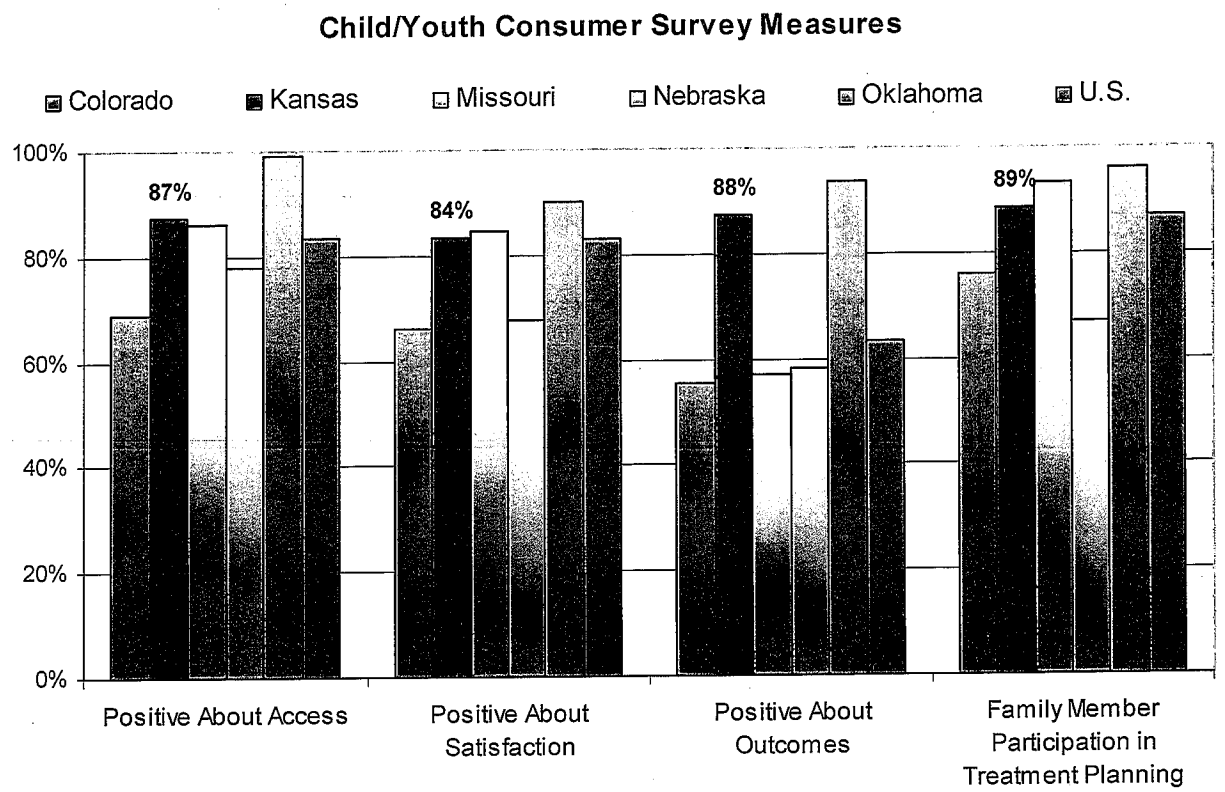
Expenditure Source as a % of Total SMHA Controlled Expenditures



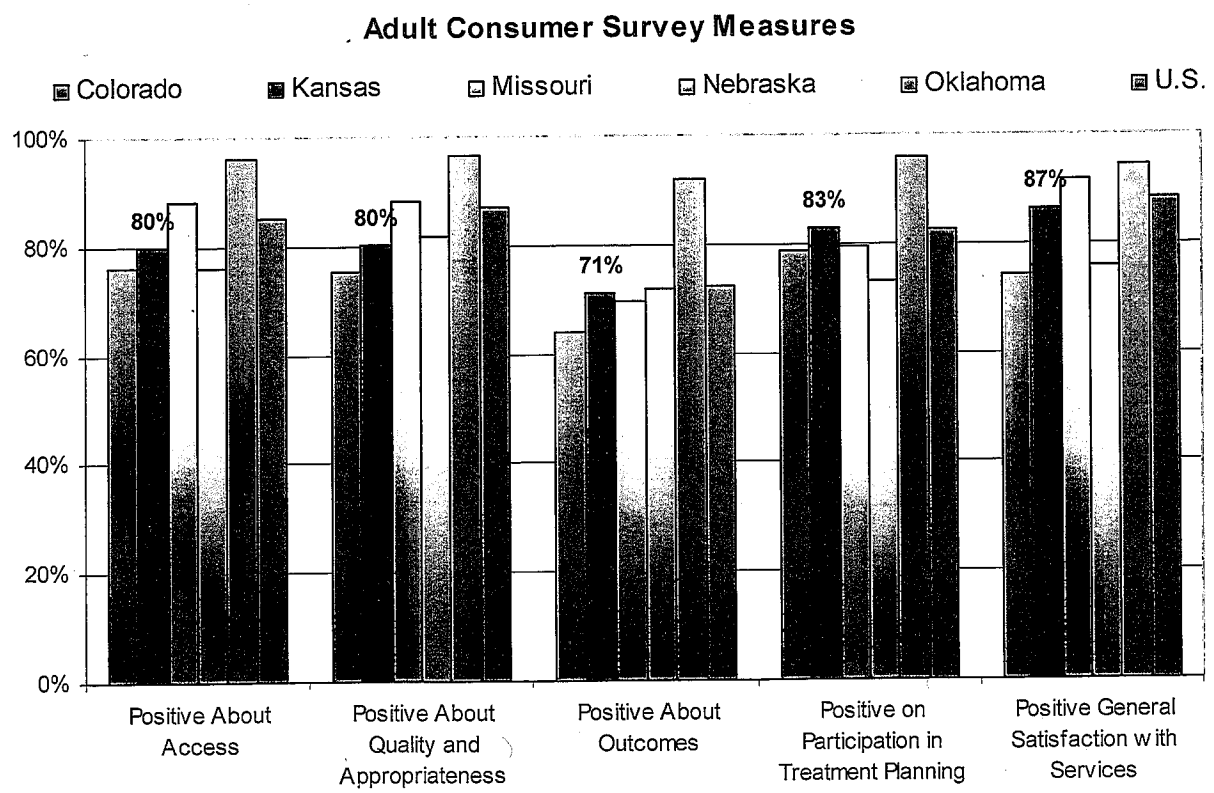
2-23

Consumer Survey Measures

Kansas performs at or above the national average on all Child/Youth Consumer Survey Measures. The highest score involves outcomes and is 24% higher than the national average.



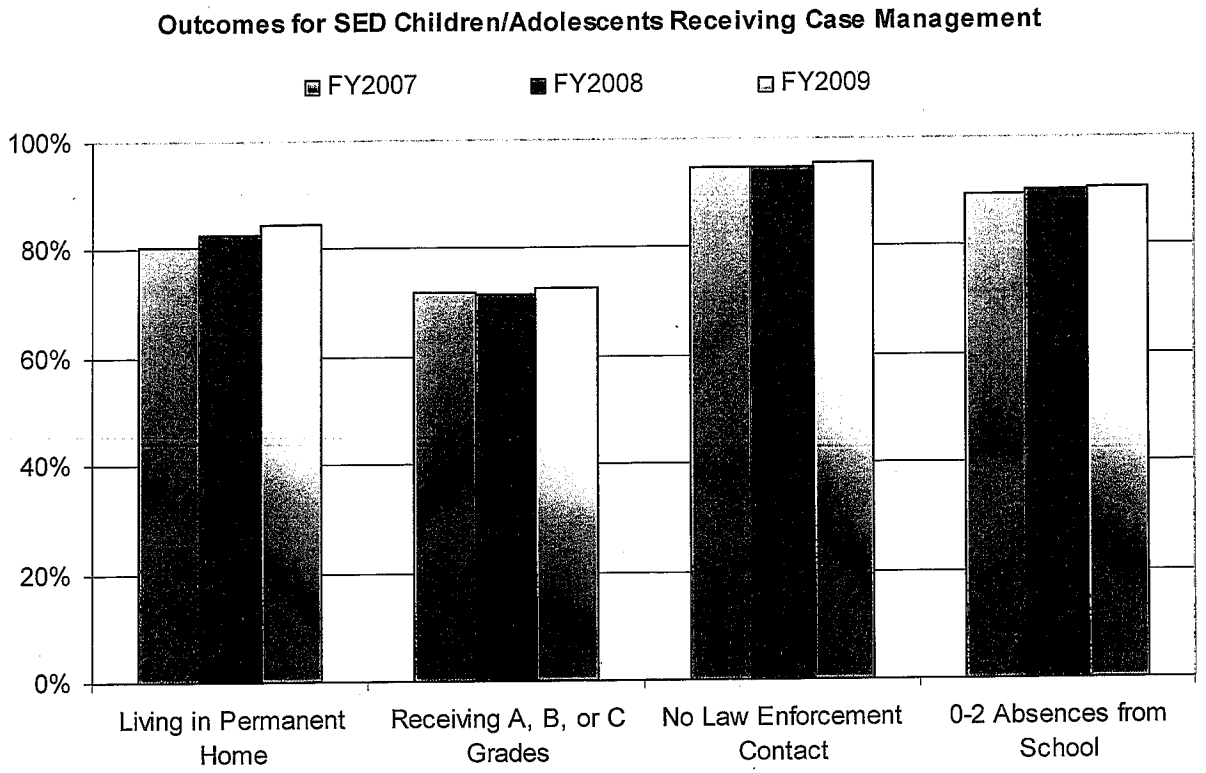
Kansas also scores highly among the Adult Consumer Survey measures.



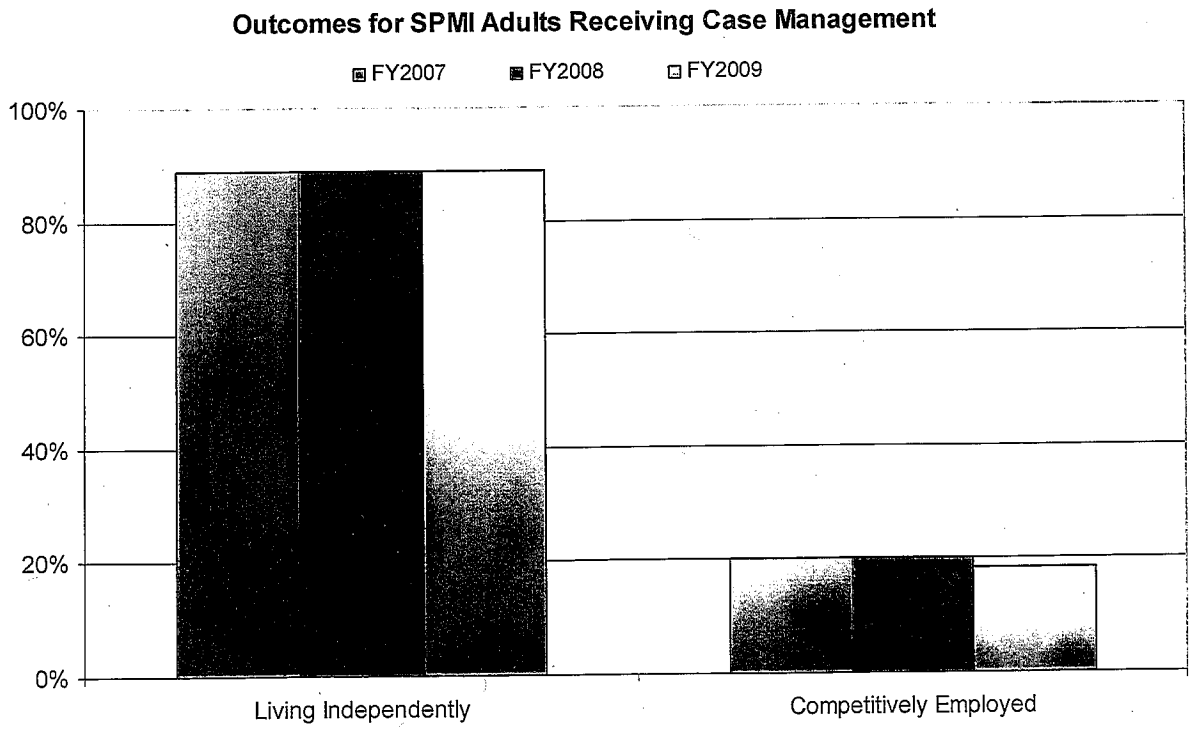
2-24

Kansas Outcomes

Kansas has also maintained or improved outcomes for SED children/adolescents receiving case management over the last three years.

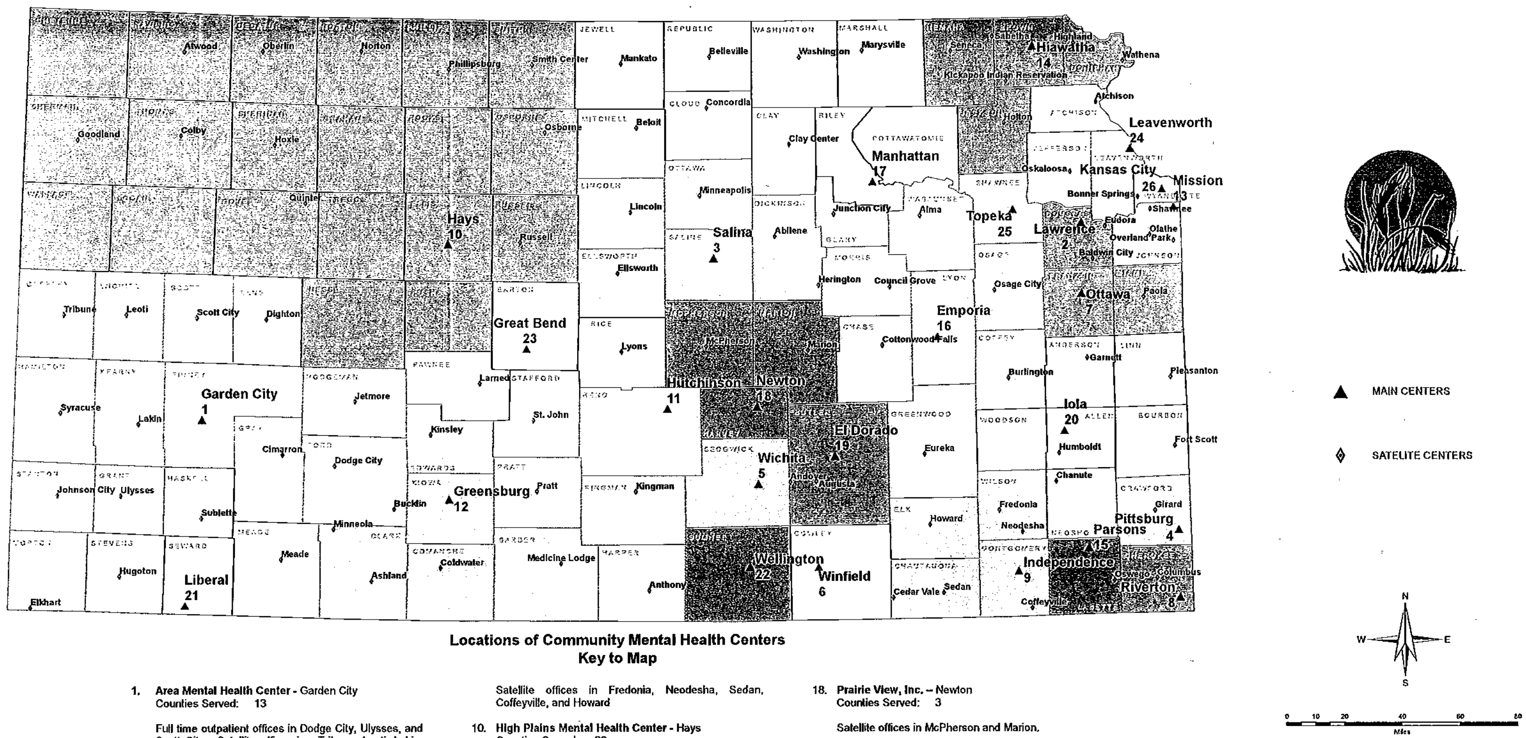


Outcomes for SPMI adults have remained flat over the last three years, sustaining an already high level of care. Only Competitive Employment fell over the last three years, most likely due to the financial crisis of 2007–2009 and ensuing recession.



2-25

Community Mental Health Centers of Kansas



Locations of Community Mental Health Centers
Key to Map

1. **Area Mental Health Center** - Garden City
Counties Served: 13

Full time outpatient offices in Dodge City, Ulysses, and Scott City. Satellite offices in: Tribune, Leoti, Lakin, Dighton, Syracuse, Cimarron, Jetmore, Johnson City, and Elkhart

2. **Bert Nash Community Mental Health Center**
Lawrence
Counties Served: 1

Satellite offices in Eudora and Baldwin.

3. **Central Kansas Mental Health Center** - Salina
Counties Served: 5

Satellite offices in Lincoln, Minneapolis, Abilene, Ellsworth, and Herington.

4. **Community Mental Health Center of Crawford County** - Pittsburg
Counties Served: 1

Satellite office in Girard

5. **COMCARE of Sedgwick County** - Wichita
Counties Served: 1

Family Consultation Service - Wichita
(Licensed Affiliate of COMCARE)
Counties Served: 1

6. **Cowley Community Mental Health Center**
Winfield
Counties Served: 1

7. **Elizabeth Layton Center, Inc.**
Ottawa
Counties Served: 2

Satellite office in Paola

8. **Family Life Center, Inc.** - Riverton
Counties Served: 1

Satellite office in Columbus.

9. **Four County Mental Health Center**
Independence
Counties Served: 4

Satellite offices in Fredonia, Neodesha, Sedan, Coffeyville, and Howard

10. **High Plains Mental Health Center** - Hays
Counties Served: 20

Branch offices in Norton, Phillipsburg, Goodland, Colby, Russell, and Osborne. Outpatient counseling is also provided in Atwood, Hoxie, Oberlin, and Smith Center.

11. **Horizons Mental Health Center** - Hutchinson
Counties Served: 5

Satellite offices in Pratt, Kingman, Medicine Lodge, and Anthony.

12. **Iroquois Center for Human Development**-Greensburg
Counties Served: 4

Satellite offices in Kinsley, Ashland, Coldwater, and Minneola.

13. **Johnson County Mental Health Center** - Mission
Counties Served: 1

Satellite offices in Olathe, Overland Park and Shawnee.

14. **Kanza Mental Health & Guidance Center** - Hiawatha
Counties Served: 4

Satellite offices in Sabetha, Seneca, Holton, Highland, Wathena, and Kickapoo Indian Reservation.

15. **Labette Center for Mental Health Services** - Parsons
Counties Served: 1

Satellite office in Oswego

16. **Mental Health Center of East Central Kansas**
Emporia
Counties Served: 7

Satellite offices in Council Grove, Alma, Osage City, Cottonwood Falls, Eureka, and Burlington.

17. **Pawnee Mental Health Services** - Manhattan
Counties Served: 10
Satellite offices in Jewell, Marshall, Washington, Mitchell, Republic, Pottawatomie, Concordia, Clay Center, and Junction City

18. **Prairie View, Inc.** – Newton
Counties Served: 3

Satellite offices in McPherson and Marion.

19. **South Central Mental Health Counseling Center**
El Dorado
Counties Served: 1

Satellite offices in Andover, August, and Rose Hill

20. **Southeast Kansas Mental Health Center** - Iola
Counties Served: 6

Satellite offices in Chanute, Ft. Scott, Garnett and Pleasanton

21. **Southwest Guidance Center** - Liberal
Counties Served: 4

Satellite offices in Sublette, Hugoton, and Meade

22. **Sumner County Mental Health Center** - Wellington
Counties Served: 1

23. **The Center for Counseling and Consultation**
Great Bend
Counties Served: 4

Satellite offices in Larned, St. John, and Lyons.

24. **The Guidance Center** - Leavenworth
Counties Served: 3

Satellite offices in Atchison and Oskaloosa.

25. **Valeo Behavioral Health Care** -Topeka
Counties Served: 1

Family Service & Guidance Center – Topeka
(Licensed Affiliate of Valeo BHC)
Counties Served: 1

26. **Wyandot Center for Community Behavioral Health**
Kansas City
Counties Served: 1

Satellite office in Bonner Springs.

AIMS
AUTOMATED INFORMATION MAPPING SYSTEM

MAP/DATA DISCLAIMER

December 21, 2006