



STUCK IN INSTITUTIONS: THE CRISIS OF MENTAL HEALTH SUPPORTS AND SERVICES IN KANSAS

An Investigative Report by the Disability Rights Center of Kansas

www.drckansas.org
info@drckansas.org
(877) 776-1541 toll free voice

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Table of Contents

Executive Summary and Public Policy Recommendations of DRC’s Mental Health System Investigation	i
Statute and Case Law Background	iv
Mental Health Funding History	iv
The Community Mental Health Centers	v
The NFMH System	v
Daily NFMH Rate/Average Monthly Cost	vi
NFMH Residents Want to Live in the Community	vii
Conclusions and Recommendations	viii
Stuck in Institutions: Full Investigative Report by DRC	
Introduction	1
Statutory and Case Law Background	6
The Decline in State Funding for Community Mental Health Services Places Kansans at Risk for Institutionalization.....	9
The Current State of the Mental Health System in Kansas Further Justifies the Need for Change.....	10
State Mental Health Hospitals	10
Community Mental Health Centers.....	12
Nursing Facilities for Mental Health	21
Daily NFMH Rate/Average Monthly Cost.....	25
Examples of Common Barriers to Discharge from Interviews	30
Conclusions	35
Attachment A – History of Mental Health Funding	A1 – A7

The Disability Rights Center of Kansas (DRC) has completed an extensive investigation of the Mental Health System in Kansas and issued a detailed investigative report finding that the State of Kansas has violated federal and state law by unlawfully institutionalizing Kansans.

This Executive Summary details many of DRC's key findings as well as provides public policy recommendations based on these findings to address Kansas' mental health crisis. The full results of DRC's extensive investigation report of the Kansas mental health system are detailed after the Executive Summary.

DRC is designated by the State of Kansas to be the Protection and Advocacy (P&A) system in Kansas, as mandated by federal and state law. DRC has special authority under federal law to advise and educate policymakers and decision makers, such as the recommendations in this report. DRC is an independent, private non-profit 501(c)(3) organization, providing legally-based services to Kansans with all types of disabilities.

EXECUTIVE SUMMARY OF DRC'S MENTAL HEALTH SYSTEM INVESTIGATION AND PUBLIC POLICY RECOMMENDATIONS

Kansas is discriminating against individuals with mental health needs who reside in Nursing Facilities for Mental Health (NFMH) by unnecessarily keeping them in these institutions. This discrimination is in violation of the Americans with Disabilities Act's (ADA) integration mandate and Kansas anti-discrimination laws. Kansans are unlawfully stuck in these NFMH institutions with little hope of getting out.

This report details how the Kansas mental health system is in crisis and broken for residents who are stuck in these NFMH institutions and prevented from discharging back to the community. Chronic underfunding of the community mental health system coupled with the lack of effective and aggressive discharge planning has resulted in NFMHs becoming *de facto* warehouses for Kansans with serious mental health needs. Our citizens languish in these institutions without active treatment or proper mental health support.

The staff at DRC have been concerned for some time that the state of Kansas has not dedicated sufficient resources or attention to provide adults with significant mental health issues adequate community based mental health services and supports. DRC's investigation confirms the state's lack of commitment on multiple fronts:

- 1) State government has forgotten its obligation under federal and state law to ensure its citizens who are stuck in NFMHs receive the advocacy, discharge planning and services to transition out of these institutions to the most integrated setting in the community.
- 2) State government is not doing nearly enough to prevent people from ending up in NFMHs in the first place.
- 3) State government has greatly reduced funding for its community mental health system at the same time it has called upon it to serve more Kansans.

The culmination of these issues has created a serious mental health crisis in Kansas. This report makes several recommendations to address and finally remedy this crisis, which has been ignored for far too long.

The vast majority of residents in these NFMH institutions (69%) want to be discharged to the most integrated, community-based setting. They want to live in the community just like everyone else. They want proper community services and supports to get out of these institutions. They want to keep those services to prevent them from ever having to go back. They want their piece of the American dream. Instead, they are stuck in these NFMHs. Unfortunately, the state has turned its back on these forgotten Kansans. Residents in these institutions do not have access to needed advocacy, discharge planning and other services to get them out of these institutions because the state has failed them. As a result, these forgotten Kansans institutionalized unnecessarily, which the U.S. Supreme Court has consistently held as being unlawful under the ADA.

NFMHs have unfortunately become *de facto* institutional warehouses where residents have virtually no opportunity for a meaningful life. This problem has become something of an open secret within the portions of state government responsible for these issues. For decades, decision makers within state government have been aware of the problems with these NFMH warehouses. Far too many reports and study committees have

identified the serious, prevalent and systemic problems involving these institutions. The lack of action thus far by state government is stunning.

The state of Kansas funds mental health services for adults in community and institutional settings. The state provides funding for community services to 26 non-profit Community Mental Health Centers (CMHC). It also provides funds for institutional care at two state-operated mental health psychiatric institutions (Larned and Osawatomie State Hospitals) and 10 private Nursing Facilities for Mental Health (NFMH) institutions, which are all for-profit ventures.

The disparity in how Kansas supports institutions versus community-based services is downright shocking. Funding for CMHCs has been cut significantly (16%) from FY 2007 to 2020 while they have had to serve 30,000 more Kansans. Forcing CMHCs to do a lot more with so much less has in and of itself created a crisis in community mental health services. NFMHs have fared dramatically better in Kansas. Funding for NFMHs has actually increased dramatically by 47% over that same time period, while they served 45 fewer beds.

The community-based services and supports recommended in this report are not unique. They have been successfully implemented in many other states. Providing adequate resources for these services and supports and implementing the strategies recommended in this report will prevent unnecessary institutional warehousing of Kansans in NFMHs and will help them live in the most integrated community setting, as required by federal and state law.

As detailed in this report, Kansas is spending an exorbitant amount of money on NFMHs. This funding can be better spent on more integrated and effective community mental health services so residents can leave NFMHs for a better life.

Kansas is the only state in the nation that operates NFMH institutions, which under federal law are not eligible for Medicaid match and must be entirely funded through state dollars. If Kansas were to take the entire \$20 million of state dollars it spends on 635 NFMH institutional beds and instead put it toward Medicaid-eligible community mental health services, it would leverage an additional \$30 million in new federal Medicaid match, for a total of approximately \$50 million.

Kansas enjoys a very favorable federal Medicaid match (the federal government picks up nearly 59% of every \$1 in Medicaid Kansas spends). Kansas should maximize that match by rightsizing the number of NFMH beds and rebalancing dollars away from NFMHs and towards community mental health, which will leverage significantly more money and preserve Kansas' precious taxpayer dollars. Doing this will also ensure the cost is not borne solely on the backs of Kansas taxpayers.

STATUTORY AND CASE LAW BACKGROUND

Federal and state laws prohibit discrimination against people with disabilities in having access to community supports and services.¹ Under Title II of the ADA, “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”² The State of Kansas is a “public entity.” The seminal United States Supreme Court case interpreting the ADA is *Olmstead v. L.C.*:

...we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.³

MENTAL HEALTH FUNDING HISTORY

Since Fiscal Year (FY) 2007, the state’s funding for community based mental health supports and services has significantly declined while funding for the state hospitals and the NFMHs has substantially increased.

¹ The Americans with Disabilities Act (ADA), 42 U.S.C. 12101, et seq. and The Kansas Act Against Discrimination (KAAD), 44 K.S.A. 1001, et seq.

² 42 U.S.C. 12132.

³ 527 U.S. 581, 607 (1999).

FISCAL YEAR	CMHC	NFMH	STATE HOSPITALS
2007	\$41.3 M*	\$13.6 M	\$83.3 M
2008	\$32.1 M	\$14.5 M	\$89.7 M
2009	\$30.3 M	\$15.6 M	\$87.2 M
2010	\$24.7 M	\$15.8 M	\$94.1 M
2011	\$23.4 M	\$18.4 M	\$94.9 M
2012	\$21.1 M	\$19.1 M	\$97.4 M
2013	\$26.1 M	\$16.6 M	\$97.1 M
2014	\$21.1 M	\$21.8 M	\$89.8 M
2015	\$21.1 M	\$22.8 M	\$89.8 M
2016	\$21.1 M	\$18.0 M	\$89.4 M
2017	\$21.1 M	\$19.2 M	\$103.5 M
2018	\$29.6 M	\$19.4 M	\$108.1 M
2019	\$29.6 M	\$19.6 M	\$111.0 M
2020 Approved	\$34.6 M	\$20.0 M	\$112.3 M
Change in Funding	-16%	+ 47%	+ 35%**

*All amounts are in millions

**Includes funding for the State Security Program and SPTP program at Larned State Hospital.

THE COMMUNITY MENTAL HEALTH CENTERS

Between FY 2007 and FY 2017, the state's funding for Community Mental Health Centers (CMHCs) declined nearly 50% before finally being increased the past three fiscal years. This funding has been too little, too late. Even with this funding, the CMHC budget still has declined 16% overall since FY 2007 at the same time they are providing services to approximately 30,000 more consumers than they did in FY 2007. The combination of this decline in funding with such a dramatic increase in new consumers being served has resulted in a crisis caused by financially stressed community mental health system.

THE NFMH SYSTEM

Unlike community-based services, funding for the ten NFMHs has increased by more than 47% from FY 2007 to 2020, even though four NFMHs are now in state receivership and collectively NFMHs are serving 45 fewer beds. Statewide NFMHs serve 635 residents. Whereas CMHCs are doing a lot more with far less funding, NFMHs are doing less with dramatically more funding.

Remember also that NFMHs are basically inferior places to live. They are cold, impersonal, congregate setting institutions. NFMHs provide little more than room and board. Active treatment and rehabilitation are practically non-existent. NFMHs are also extremely expensive to fund for Kansas taxpayers when compared to other far more affordable housing options. The average day rate for all ten facilities is \$129.56 (\$3,940.75 per month and \$47,289 per year on average). The most expensive NFMH receives more than \$62,000 per year for each resident for board and care and virtually no rehabilitation services.⁴

Daily NFMH Rate/Average Monthly Cost

Facility	FY 2007	FY 2019
Brighton Place North–Topeka (34 beds)	\$74.11/\$2,254.18	\$99.01/\$3,011.55
Providence Living Center–Topeka (78 beds)*	\$79.26/\$2,410.83	\$106.12/\$3,227.82
Countryside Health Center–Topeka (88 beds)	\$90.56/\$2,754.53	\$111.35/\$3,386.90
Franklin Healthcare of Peabody, LLC* (45 beds)	\$82.04/\$2,495.38	\$116.36/\$3,539.28
Haviland Operator, LLC–Haviland (45 beds)	\$74.72/\$2,272.73	\$123.58/\$3,758.89
Medicalodges–Paola (93 beds)	\$103.93/\$3,160.9	\$124.69/\$3,792.65
Brighton Place West–Topeka (50 beds)	\$89.08/\$2,709.52	\$132.41/\$4,027.47
Valley Health Care Center–Valley Falls (40 beds)	\$91.86/\$2,794.08	\$147.84/\$4,496.80
Eskridge Care and Rehabilitation Center, LLC (60 beds)*	\$88.28/\$2,685.18	\$163.26/\$4,965.52
Edwardsville Care and Rehabilitation Center, LLC (102 beds)*	\$90.53/\$2,753.62	\$170.97/\$5,200.34

*Facilities that are in state receivership

⁴ The daily rates are published prior to the beginning of the new fiscal year in the Kansas Register. The FY 2007 rates are at Vol. 25, No. 26, pp. 902-904 (June 25, 2006). The FY 2019 rates are at Vol. 37, No. 25, pp. 689 - 691 (June 21, 2018).

NFMH RESIDENTS WANT TO LIVE IN THE COMMUNITY

DRC's December 2018 survey of almost one-half of the 635 NFMH residents demonstrates Kansans are stuck in these institutions and, by and large, are prevented from transitioning to more appropriate integrated settings in the community, as mandated by federal and state law. The vast majority, 69%, of NFMH residents want to discharge back into the community while only 9% said they actually have a discharge plan. These Kansans' rights under the ADA to live in the most integrated community setting are being denied or thwarted either by state policy or by simple lack of action. Both reasons are unacceptable and not allowed under the ADA.

Question: Do you want to discharge back to the community?

Length of residence	Yes	No	Unsure	Total
Under 1 year	45	6	2	53
1–2 years	40	14	3	57
3–5 years	41	14	2	57
6–10 years	30	17	2	49
10+ years	36	22	6	64
Totals	192	73	15	280
% of 280 surveyed	69%	26%	5%	100%

Question: Do you have a discharge plan?

Length of residence	Yes	No	Unsure	Total
Under 1 year	4	37	12	53
1–2 years	7	42	8	57
3–5 years	5	36	16	57
6–10 years	8	32	9	49
10+ years	2	47	15	64
Totals	26	194	60	280
% of 280 surveyed	9%	69%	21%	100%

CONCLUSION AND POLICY RECOMMENDATIONS

Kansas is discriminating against individuals with mental health needs who reside in NFMH institutions in violation of the ADA's integration mandate and the state's anti-discrimination statutes. Kansans are unlawfully stuck in these NFMH institutions with little hope of getting out. Kansas must take swift and significant action to remedy this discrimination.

DRC makes the following recommendations to the State of Kansas to address its ongoing ADA violations and to solve this crisis:

- **Rebalancing:** Prioritize and rebalance funding of the mental health system towards funding comprehensive community mental health services and away from NFMH beds.
- **Focus on Discharging NFMH Residents to the Community and Rightsizing NFMH Bed Capacity:** Kansas needs to entirely change its focus to instead be on discharging those who want out of NFMHs and rightsizing/downsizing the number of NFMH institutional beds. Kansas must create and implement a comprehensive process that refocuses the mental health system on transitioning those who want out of NFMHs to discharge them to the most integrated, community-based settings with necessary supports and services. With proper discharge planning, the state can divert money from the NFMHs to community-based mental health and receive an enhanced federal match (every \$1 in state dollars becomes \$2.50 after the federal Medicaid match). Focusing on community mental health services will enable the rightsizing/downsizing of NFMHs, as fewer beds will be necessary for long-term institutional board and care at NFMHs. The state must work hand-in-hand with stakeholders to create measurable targets, accountability mechanisms and track outcomes to ensure discharge and rightsizing is the priority going forward. Several ideas below further detail this comprehensive process to refocus on discharge planning and rightsizing.
 - **Opportunity Created by the Four NFMHs in Receivership:** The fact that Kansas has four NFMHs in receivership should be a wakeup-call to state officials that they cannot wait any longer to dramatically change its focus towards discharging residents and rightsizing/downsizing the NFMH bed capacity. The fact that Kansas has four NFMHs in receivership, and thus they may not

survive financially, creates an opportunity for the state to be even swifter in rightsizing the number of NFMH beds statewide and focus on moving people out of NFMHs and into the community.

- **Independent “Olmstead Advocates” to Enable Discharges:** Contract for and fund independent “Olmstead advocates” embedded in each NFMH to provide effective navigation, support, discharge planning and advocacy for residents who want to discharge into the community. They are specifically called “Olmstead Advocates” because they provide services to advocate for the Olmstead rights of NFMH residents to get them out of these institutions and into the community. The current system is failing NFMH residents and the people of Kansas. Each CMHC is technically responsible for discharge planning for its consumers in all ten NFMH institutions. However, NFMHs are spread out across Kansas, often several windshield hours away from the CMHC. This is highly ineffective and creates significant barriers to discharge. The current system perpetuates institutionalization. Having Olmstead advocates at each NFMH institution who are organizationally separate from both CMHCs and NFMHs would remedy this problem. Without these advocates, NFMH residents will continue to be “out of sight, out of mind.” Additional reasons for having advocates include:
 - **Financial Incentive Against Discharge:** The current system encourages NFMHs to drag their feet and thwart residents who want to discharge because the NFMH has a financial incentive to keep their bed occupied, so they get paid.
 - **Combating Conflicts of Interest:** The inherent conflict of interest with discharge planning is another reason why there must be strong state-funded Olmstead advocates independent of both the CMHC and NFMH systems in order to ensure those who want out of these institutions have access to robust navigation, support, advocacy and discharge planning in order to get out. These independent advocates are greatly needed to help residents navigate the complexities of discharge planning, stand up for the resident’s rights, hold the system accountable and ensure the person is not being institutionalized when a more integrated setting is available.

- **Boots on the Ground:** Having these “boots on the ground,” independent Olmstead advocates coupled with better funding for CMHCs (see below) would ensure effective discharges into the most integrated, community-based setting.
- **Divert New Admissions Away from NFMHs through Enhanced CMHC rates:** Create effective safeguards so that Kansans who do not need or want to be in an NFMH institution are instead diverted to community-based services. Mental Health Reform was successful in diverting people from state-run psychiatric institutions and reducing the reliance on beds with enhanced rates for CMHCs. Kansas needs a similar system to divert people from unnecessarily ending up in NFMH institutions. Having this incentive on the front end through enhanced CMHC rates would greatly divert such admissions.
- **Change the purpose of the NFMH system; Quickly Develop a Comprehensive Plan for Supports:** Kansas lacks fiscal or public policy justification to continue operating NFMHs as board and care institutions. Instead, Kansas must quickly develop and execute a comprehensive transformation process to change the purpose of NFMHs fundamentally. The emphasis must be on providing rehabilitation services from the first day of admission and better ensuring residents can successfully discharge back to the community quickly.
- **Review Past Recommendations:** Consider implementing the recommendations of the Adult Continuum of Care Committee regarding NFMHs, including peer support specialists to talk with residents about recovery, shared living experiences, coping skills, better decision making and other supports to deliver on the hope for a better future beyond living for the rest of their life in an institution (see pages 12, 14, 17 and 29 of the Committee’s report).
- **Report Measurable Progress to Stakeholders:** Create a committee of key mental health stakeholders to report measurable progress as the state addresses this mental health crisis. Work with this stakeholder committee to identify goals, objectives and other outcomes measurements to ensure successful and measurable progress takes place to address this systemic mental health crisis.

- **Increase Community Mental Health Funding to Necessary Services and Draw Down Additional Federal Match Dollars:** Increase funding for supported housing as well as numerous necessary community mental health services (see full list below). These services listed below are absolutely needed, but are unfortunately nonexistent, terminated or seriously deficient throughout Kansas. The vast majority of these listed services can draw down additional federal Medicaid match. Additionally, the state must: 1) increase core funding to CMHCs to restore the past cuts and 2) provide “catch-up funding” to make up for the lack of funding for the 30,000 more consumers CMHCs are serving since FY 2007 while they sustained deep cuts. The listing of necessary community mental health services includes:
 - a. Mobile 24/7 crisis intervention teams;
 - b. Assertive Community Treatment (ACT) programs which provide an evidence-based, multidisciplinary team approach with assertive outreach in the community;
 - c. Improved peer support programs to assist individuals in the community and those who want to discharge from NFMHs and the state hospitals;
 - d. Sufficient home-based medical services, including personal care assistance, home health, and nursing for those in the community now and those who want to leave an institution;
 - e. Health home programs which provide effective integrated, coordinated physical and mental health programs;
 - f. An effective system to identify and provide all necessary behavioral, rehabilitation, and primary healthcare services for each individual who is admitted to an NFMH beginning the day of admission;
 - g. A program to pay CMHC staff to provide the necessary behavioral and rehabilitation services to NFMH residents throughout their stay instead of just 120 days prior to discharge;
 - h. Sufficient crisis housing services and short and long term supported housing programs; and
 - i. Sufficient supported employment programs working in close coordination with the state’s Vocational Rehabilitation services.

The state has failed to meet its legal obligation under the ADA and the U.S. Supreme Court's *Olmstead* decision.

The state of Kansas must reverse course and rebalance its mental health portfolio towards community-based investments. Through effective and aggressive discharge planning, the number of NFMH institutional beds must be rightsized and funding must be rebalanced and reprioritized towards community-based services, including new initiatives that enable transition to the most integrated setting. Kansas must stop warehousing people with mental health issues in NFMH institutions and significantly increase its investment in community based mental health services.

All ten NFMHs are for-profit ventures. The distressing conclusion from the funding history is that the state has prioritized maintaining the viability of the private, for-profit, institutional NFMH system instead of dedicating adequate funding for the public, non-profit community mental health system.

We understand that current Governor Laura Kelly inherited this problem. We appreciate that there were already multiple challenges facing the state when Governor Kelly was inaugurated in January of 2019. We agree that the fewer numbers of state employees has created capacity challenges for state government. We appreciate all of those issues. However, Kansas' mental health system for the over 600 residents in NFMHs is in crisis. This problem demands swift and significant action by the State of Kansas. This crisis deserves the full attention and power of state government to address this on-going problem.

STUCK IN INSTITUTIONS: THE CRISIS OF MENTAL HEALTH SUPPORTS AND SERVICES IN KANSAS

An Investigative Report by the Disability Rights Center of Kansas

Report Released May 2019

INTRODUCTION

The Disability Rights Center of Kansas, Inc. (DRC) is designated by the State of Kansas to be the Protection and Advocacy (P & A) system in Kansas as mandated by federal and state law (www.drckansas.org). DRC is an independent, private non-profit 501(c)(3) organization which provides legal and advocacy disability rights services to Kansans with disabilities. DRC also has federal statutory authority to monitor facilities that provide services to individuals with disabilities. DRC is provided special authority under federal law to advise and educate policymakers and decision makers. These facilities include Nursing Facilities for Mental Health (NFMH), state psychiatric institutions, and other facilities for those with intellectual and developmental disabilities.

During our monitoring of these facilities, DRC staff have authority to meet with patients and residents privately at their request, obtain records with their consent, and investigate allegations of abuse and neglect. A core priority for DRC is to advocate for Kansans with disabilities to live in the most integrated setting which is able to meet their needs. For individuals in institutions, DRC staff will advocate for them to be discharged and provided the opportunity to live outside the institution if they are willing and able to benefit from community programs.

SUMMARY OF DRC'S MENTAL HEALTH SYSTEM INVESTIGATION

The state of Kansas funds mental health services for adults in community and institutional settings. The state provides funding for community services to 26 non-profit Community Mental Health Centers (CMHC). It provides funds for institutional care at 2 state-operated mental health hospitals and 10 private Nursing Facilities for Mental Health (NFMH). The staff at DRC have

been concerned for some time that the state of Kansas has not been dedicating sufficient resources to provide adult Kansans with significant mental health issues adequate community based mental health services and supports.

From FY 2007⁵ to FY 2012 state and consolidated grant funding for core services provided by the CMHC system declined by \$20.2 million from approximately \$41.3 million to \$21.1 million, a 49% reduction. The budget for CMHCs increased to \$26.1 million in FY 2013, but it was cut again to \$21.1 million the next year and remained the same through FY 2017. The state restored approximately \$8.5 million of the \$20.2 million in CMHC budget cuts beginning in FY 2018; however, the amount restored is only 42% of the total cuts, and the CMHCs are now serving 30,000 additional consumers.⁶ Even with the partial restoration of \$8.5 million in FY 2018, CMHCs still experienced a devastating 28% cut in funding from FY 2007 to FY 2019. The CMHC approved budget for FY 2019 is the same as in FY 2018. The approved FY 2020 budget added \$5 million to equal \$34.6 million, but it is still 16% less than the FY 2007 budget.⁷

The state hospital at Larned receives funding for three programs: a 90-bed Psychiatric Services Program for voluntary and court committed individuals; the State Security Program for forensic evaluations and inpatient treatment; and the Sexual Predator Treatment Program (SPTP) for individuals determined to be sexual predators. The state hospital at Osawatomie receives funding mainly for treatment of court committed individuals. Some of the patients are voluntary admissions, but only individuals who have been court committed are accepted now.



⁵ The fiscal year began July 1, 2006 and ended June 30, 2007.

⁶ The information on the increased number of consumers was provided by the Association of Community Mental Health Centers in spring 2018.

⁷ DRC obtained the budget information for the CMHCs, NFMHs, and state hospitals from the Kansas Legislative Research Department and the Association of Community Mental Health Centers.

From FY 2007 through FY 2016, the budget for the state hospitals increased \$6.1 million from \$83.3 million to \$89.4 million. The budget spiked dramatically in FY 2017 to \$103.5 million after the federal Center on Medicare and Medicaid (CMS) decertified Osawatomie State Hospital from the Medicare program due to safety, building, and staffing issues in December 2015. The state reported it would lose approximately \$1 million per month due to the decertification.⁸ The hospital budgets rose again to \$108.1 million for FY 2018 and \$111.0 million for FY 2019. The Governor's recommended budget for FY 2020 is also higher at \$112.3 million.⁹



CMS restored Medicare certification in December 2017 for a 60-bed acute care unit after the state extensively renovated it and improved staffing issues, including salaries. The state is continuing to renovate other buildings and has reduced the bed capacity for commitments by almost 20%. CMS cited Larned State Hospital for deficiencies in October 2017 due to staffing and safety issues, including parts of the facility, such as doors that were possible ligature points. Larned's facility is much newer than the buildings at Osawatomie, so physical repairs were much less costly. They were substantially completed in early 2018. Some of the increased funding was also dedicated to higher staff salaries and the expanding SPTP population.

⁸ <https://www.khi.org/news/article/lack-of-security-checks-patient-violence-create-a-perfect-storm-at-osawatomie>

⁹ The history of mental health funding from FY 2002 through the budget proposed for FY 2020 is included at the end of this report as Attachment A.

Between FY 2007 and FY 2019, the budget for the NFMHs increased 44% (\$6 million) from \$13.6 million to \$19.6 million. Eleven facilities were operating in FY 2007, but a 45-bed facility in Chanute closed in 2015.¹⁰ The other ten remain open today. The recommended NFMH budget for FY 2020 increases another \$400,000 to \$20 million.

The chart below summarizes the year-to-year funding for the CMHCs, NFMHs, and state hospitals between FY 2007 and FY 2019. The budget for the state hospitals has increased modestly for civil commitment mental health services, but fewer beds for treatment are available. The state hospital budget includes other unrelated services. The NFMH budget has significantly increased even though they have 45 fewer beds to fill. The CMHCs, however, have lost significant funding despite serving tens of thousands of more consumers now than in FY 2007.

FISCAL YEAR	CMHC	NFMH	STATE HOSPITALS
2007	\$41.3 M*	\$13.6 M	\$83.3 M
2008	\$32.1 M	\$14.5 M	\$89.7 M
2009	\$30.3 M	\$15.6 M	\$87.2 M
2010	\$24.7 M	\$15.8 M	\$94.1 M
2011	\$23.4 M	\$18.4 M	\$94.9 M
2012	\$21.1 M	\$19.1 M	\$97.4 M
2013	\$26.1 M	\$16.6 M	\$97.1 M
2014	\$21.1 M	\$21.8 M	\$89.8 M
2015	\$21.1 M	\$22.8 M	\$89.8 M
2016	\$21.1 M	\$18.0 M	\$89.4 M
2017	\$21.1 M	\$19.2 M	\$103.5 M
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2020 Approved	\$34.6 M	\$20.0 M	\$112.3 M
Change in Funding	-16%	+47%	+ 35%**

*All amounts are in millions

**Includes funding for the State Security Program and SPTP program at Larned State Hospital.

¹⁰ Applewood Rehabilitation in Chanute closed due to a daily bed rate reduction. For further details, see the KHI July 2, 2015 article at <https://www.khi.org/news/article/funding-woes-to-close-chanute-facility-for-mentally-ill>.

In 2015, DRC staff began a lengthy investigation into the impact of the CMHC budget cuts on services to Kansans with mental health issues. Staff compiled financial data, met with administrators at many of the 26 CMHCs, and met with residents, patients, and administrators at the 12 public and private institutions for adults with mental health issues. The investigation also included research into whether the state of Kansas and its private contractors were meeting the statutory and regulatory requirements for developing effective treatment and rehabilitative plans for individuals who have been admitted into long term mental health institutions. In particular, DRC staff wanted to determine whether the treatment and rehabilitation plans provide a reasonable opportunity for residents to discharge to a more integrated community setting with adequate supports and services.

SUMMARY CONCLUSION

From the information, data and interviews, DRC concludes that the state of Kansas has failed to meet its legal obligation under federal and state law to dedicate the necessary financial support for comprehensive community mental health services in order to allow adult Kansans with mental health issues a reasonable opportunity to live independently in the community and avoid unnecessary institutionalization. In particular, DRC concludes that the state's system for admission into and continued stay at long term mental health board and care institutions (NFMHs) impedes the ability of their residents to reintegrate into the community to the extent that it violates federal and state laws.

Although the state hospital budget has not increased significantly, and its patient bed capacity has been reduced since FY 2007, the state has substantially increased the budget for NFMH residents. In the meantime, the CMHC budget was cut in half for years before being only partially restored by less than 50% 11 years later. The CMHCs also are now trying to serve tens of thousands more consumers with less state dollars. As a result, the CMHCs must prioritize who receives services. When considering the NFMH residents—who are not visibly present day-to-day to the CMHCs—many are left behind with little or no help to reintegrate into their home communities.

Such a lack of meaningful access to community services violates state and federal anti-discrimination laws.

STATUTORY AND CASE LAW BACKGROUND



Federal and state laws prohibit discrimination against people with disabilities in having access to community supports and services.¹¹

Under Title II of the ADA, “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”¹² The State of Kansas is a “public entity.” The seminal United States Supreme Court case interpreting the ADA is *Olmstead v. L.C.*¹³

The plaintiffs in *Olmstead* were residents of an institution for people with mental health disabilities in Georgia. The cost for their care was paid by the state. They were willing and able to live in the community instead of an institution if they could receive community-based programs to help them address their mental health issues. The state funded community-based programs, but it claimed that all available funding was being used for those programs. As a result, the plaintiffs remained involuntarily institutionalized. The Supreme Court rejected the state’s claim that it can deny community programs to some individuals but not others based on how much it decides to budget for the programs when it also dedicates funds for institutionalization:

“...we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.”¹⁴

¹¹ The Americans with Disabilities Act (ADA), 42 U.S.C. 12101, et seq. and The Kansas Act Against Discrimination (KAAD), 44 K.S.A. 1001, et seq.

¹² 42 U.S.C. 12132.

¹³ 527 U.S. 581 (1999).

¹⁴ 527 U.S. at 607.

The state Mental Health Reform Act of 1990 prioritized the provision of services to Kansans with mental health issues in the community instead of institutions.¹⁵ The Act's mandate follows the ADA and *Olmstead* by requiring the state to assist in the provision of mental health services in community settings “whenever possible.”¹⁶ It gave the secretary of the Kansas Department on Aging and Disability Services (KDADS) the power and obligation to oversee the provision of mental health services throughout the state, including (to quote from the Act):

- to function as the sole state agency to develop a comprehensive plan to meet the needs of persons who have mental illness;
- to evaluate and coordinate all programs, services and facilities for persons who have mental illness presently provided by agencies receiving state and federal funds and to make appropriate recommendations regarding such services, programs and facilities to the governor and the legislature;
- to assist in the provision of services for persons who are mentally ill in local communities whenever possible, with primary control and responsibility for the provision of services with mental health centers, and to assure that such services are provided in the least restrictive environment;
- to adopt rules and regulations for targeted population members which provide that, within the limits of appropriations therefor, no person shall be inappropriately denied necessary mental health services from any mental health center or state psychiatric hospital and that each targeted population member shall be provided such services in the least restrictive manner;
- to establish and implement policies and procedures within the programs and activities of the Kansas department for aging and disability Services so that funds from the state shall follow persons who are mentally ill from state facilities into community programs;

¹⁵ K.S.A. 39-1601, et seq.

¹⁶ K.S.A 39-1603(f).

- **to provide the least restrictive treatment and most appropriate community based care as well as rehabilitation for Kansas residents who are mentally ill persons through coordinated utilization of the existing network of mental health centers and state psychiatric hospitals** (emphasis added);
- to assure the establishment of specialized programs within each mental health center throughout the state in order to provide appropriate care for designated targeted population members;
- to establish service requirements for programs within mental health centers which will ensure that targeted population members receive the most effective community treatment possible; and
- to ensure the development and continuation of high quality, community-based mental health services, including programs for targeted population members, in each mental health center service delivery area through the provision of technical assistance, consultation and funding.¹⁷

The KDADS Secretary is required to “develop and adopt a state assessment of needs and a plan to develop and operate a state system to provide mental health services for persons who are residents of Kansas, including all targeted population members...” The plan is to be reviewed annually and must “include coordinating and assisting in the provision of community-based mental health services in the service delivery areas of mental health centers, including the services provided by state psychiatric hospitals and the provision of state financial assistance.”¹⁸

The Mental Health Reform Act also specifically mandated the state to reduce the inpatient bed capacities by 60 to 90 beds over various three year periods at each of the three state hospitals operating at the time: Osawatomie State Hospital; Topeka State Hospital; and Larned State Hospital.¹⁹ This requirement clearly signaled that the state government had concluded that Kansans with mental health issues are better served by comprehensive

¹⁷ K.S.A 39-1603.

¹⁸ K.S.A. 39-1604(a).

¹⁹ K.S.A. 39-1610(c).

community mental health services as opposed to institutional inpatient treatment. Topeka State Hospital eventually closed in 1997 due to the mandate to reduce institutionalization.

THE DECLINE IN STATE FUNDING FOR COMMUNITY MENTAL HEALTH SERVICES PLACES KANSANS AT RISK FOR INSTITUTIONALIZATION

The state's financial commitment to the CMHC system reached a peak in FY 2006 and FY 2007 with consolidated grants totaling more than \$31 million each year. The CMHCs used much of the money to fund the provision of mental health services to consumers who were uninsured or underinsured. The state also committed more than \$10.2 million for provision of round-the-clock crisis and emergency services. The total for these core services was \$41.3 million.

The state's commitment to community mental health began a precipitous and troubling decline in FY 2008 with the Great Recession when the consolidated grant funding was slashed to \$21.9 million. State funding continued to be cut almost yearly until it hit \$10.9 million in FY 2014, where it remained until the legislature increased the budget to \$19.4 million in FY 2018, still well short of the \$31 million provided 11 years earlier.

Although the state aid for crisis services stayed at \$10.2 million, it has never been increased despite the obvious need for more. The state created annual grants for \$10 million beginning FY 2014 which are dedicated for at-risk persons in the community. It also added \$1 million to the budget starting in FY 2016 (increased to \$2 million in FY 2017) specifically for mental health screens which the CMHCs are required to provide to individuals who may be facing involuntary civil commitment to one of the state hospitals due to their behavior and/or decision making issues.

Even with these recent additions, total state funding for the uninsured and underinsured has declined by almost 30%. Yet by all accounts, the need for comprehensive community mental health services has only increased in the last 10 years. CMHCs are now serving over 30,000 more Kansans while their funding has been cut by 16%. Instead of fully restoring the budget cuts and dedicating more funding to address the increased need, the state instead

has left the community mental health system struggling to provide services to more people with less money. The lack of funding has caused the CMHCs to shrink the overall availability of necessary services instead of maintaining or expanding them to meet the needs of their consumers. The funding crisis has negatively impacted Kansans with mental health issues who live in the community and receive services from the CMHCs and those who reside in the NFMHs. The two state hospitals, Osawatomie State Hospital (OSH) and Larned State Hospital (LSH), have their own unique problems which adversely impact individuals aside from the decline in community mental health funding. Considering these barriers created by the state, the end result is that Kansans with serious mental health issues are unnecessarily institutionalized. When institutionalized in NFMHs, these individuals also face significant barriers to being discharged with adequate mental health services and supports.

THE CURRENT STATE OF THE MENTAL HEALTH SYSTEM IN KANSAS FURTHER JUSTIFIES THE NEED FOR CHANGE

1. State Mental Health Hospitals

The majority of the patients at the state mental health hospitals have been admitted through the state statutory procedure for involuntary civil commitment. Typically, staff at a CMHC will certify through a screening process that an individual is a danger to him or herself or to others and does not have the current ability to make decisions in his or her best interest. A court can then order the individual to be admitted, and the hospital staff provides treatment until the court determines that the patient no longer meets the statutory criteria for involuntary commitment. The hospital staff can also discharge the patient without court order whenever they determine the patient is no longer in need of treatment. In that case, the court is notified, and the court proceeding is dismissed. The hospital staff must contact the CMHC where the patient plans to live in order to receive and consider their recommendations. The care and treatment statutes require no discharge planning other than “receiving and considering recommendations from the participating mental health center serving the area where the patient intends to reside.”²⁰

²⁰ K.S.A. 59-2973(a).

Osawatomie State Hospital (OSH) is the larger of the two state hospitals. Until 2015, its patient capacity was 206. But as noted above, well documented and chronic staffing shortages, overcrowding, safety problems, and poor facility conditions led to the federal Center for Medicaid and Medicare Services (CMS) revoking the hospital's Medicare certification. CMS required the state to develop a corrective action plan to come into compliance. Part of the plan included reducing the total number of patient beds to 146 and limiting new admissions to involuntary commitments. CMS recertified a 60-bed unit at the hospital in December 2017. This unit, Adair Adult Care Unit (AAC), operates separately from the rest of the facility. Since then the state has increased the total number of beds, including AAC, to 166 which is 19% fewer beds than in 2015.

Reducing bed capacity and capping admissions left numerous individuals on a waiting list to be admitted. Wait times in Wichita were reported in June 2016 to range from 20 to 96 hours. Some waited in hospital emergency rooms, others in jails.²¹ The longest reported wait times in Johnson County increased significantly from 23 hours in the first 4 months of 2015 to 128 hours for one individual in early 2016. The local mental health center reported in an August 23, 2016 news report that 4 people were in jails waiting for admission.²² Reports of extended wait times have decreased since then, in part perhaps due to the creation of crisis stabilization centers in Kansas City and Wichita (explained further in the following section).

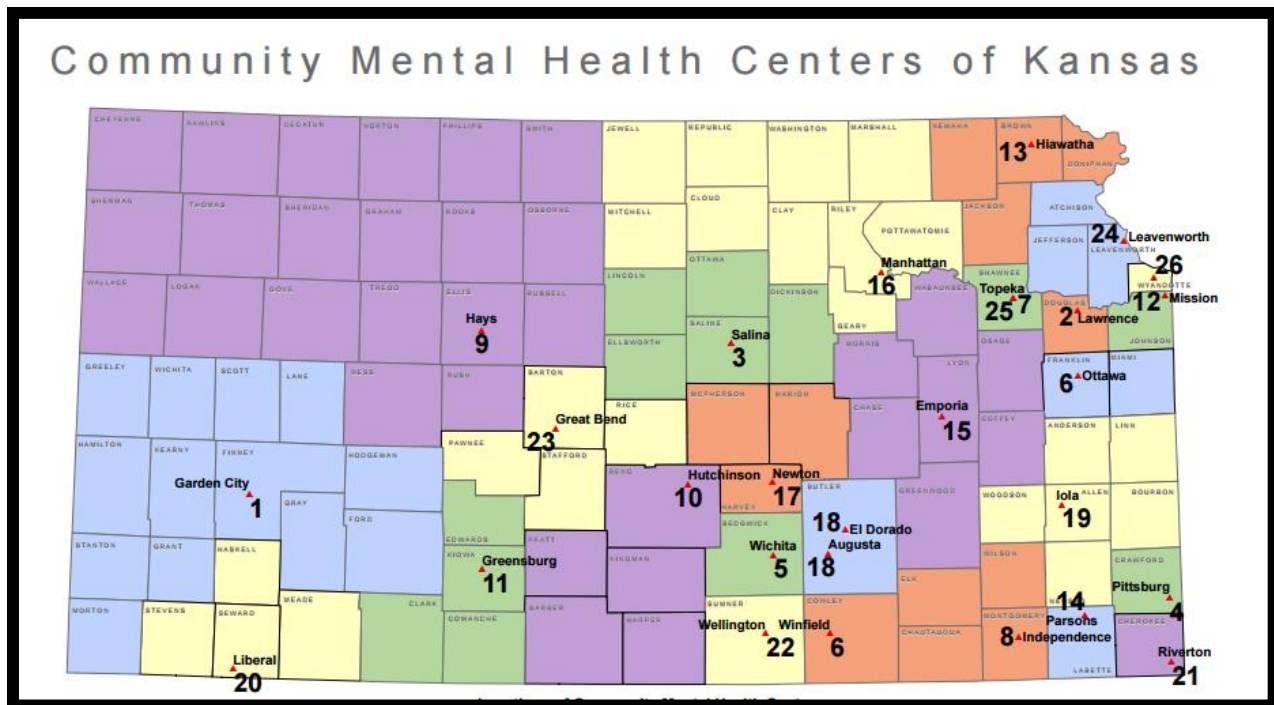
Larned State Hospital (LSH) has a patient capacity of 90 beds. CMS threatened to terminate Medicare certification in 2017, primarily due to facility issues. LSH also has had chronically high staff vacancy rates forcing staff to work up to double shifts which threaten patient safety. For a time, LSH would not admit anyone unless its census dropped below 85 patients. The state addressed the facility issues quickly enough to avoid losing its certification, but the staff vacancy dilemma persists, although to a lesser degree now.

Many patients in both institutions who are ready for discharge will need significant community supports and services to give them a reasonable opportunity to avoid cycling back into the hospital. As explained below, these necessary supports and services are lacking.

²¹ KHI news service report, June 24, 2016, found at <http://www.khi.org/news/article/kansas-hospitals-report-long-patient-waits-for-osawatomie-beds>.

²² KCUR news service report, August 23, 2016, found at <https://www.kcur.org/post/kansas-mental-health-official-hopeful-about-progress-osawatomie-state-hospital#stream/0>.

2. Community Mental Health Centers



The state has 26 Community Mental Health Centers (CMHCs). All 105 counties are served by a designated CMHC. The service areas range from 1 county (8 CMHCs) to 19 counties (the CMHC in Hays). Many of them have satellite offices for easier access. CMHCs provide an array of treatment services with the goal of helping their consumers stay in the community. The types of services include case management, medication management, counseling, peer support, crisis stabilization, supported employment, transition housing, and longer-term supported housing. Each CMHC sets priorities for the services it will emphasize with funding limitations being a primary consideration.

The CMHC system was created by statute in 1961.²³ Individual CMHCs were created by single or multiple local county governing bodies and largely funded at the local level until the Mental Health Reform Act in 1990 created the statewide funding and oversight scheme. “Community based mental health services” in the Act includes, but is not limited to:

evaluation and diagnosis, case management services, mental health inpatient and outpatient services, prescription and management of psychotropic medication, prevention, education,

²³ K.S.A 19-4001, et seq.

consultation, treatment and rehabilitation services, twenty-four-hour emergency services, and any facilities required therefor, which are provided within one or more local communities in order to provide a continuum of care and support services to enable mentally ill persons, including targeted population members, to function outside of inpatient institutions to the extent of their capabilities. Community-based mental health services also include assistance in securing employment services, housing services, medical and dental care, and other support services.²⁴

DRC staff met with 15 of the 26 CMHC directors throughout the state. Despite the decline in state funding since 2007, the CMHCs continue to provide core services as required by law, however, many have laid off staff²⁵ making it difficult to provide effective services.²⁶

Medicaid and private insurance generally cover more than 50% of the treatment costs, however, all CMHCs still have a significant percentage of uninsured consumers receiving services, some more than 50%. Many CMHCs must write off unpaid bills as bad debts. For example, Compass Behavioral Health in Garden City noted in its 2017 Annual Report that it wrote off \$393,000 in 2016 alone. The reduced state consolidated grants since 2007 fall far short of covering the remainder of the cost. All of the CMHCs have some form of local funding and other non-state grants to help in varying degrees cover uninsured care.

Lack of funding prevents CMHCs from providing effective services. The CMHCs that DRC staff visited said they provide some transitional and longer-term supported housing, however, some of these services are minimal at best. Supported employment services are provided sporadically due to funding limitations. Most no longer provide peer support services due to lack of funding.

The CMHCs provide some form of crisis stabilization services, but they are not sufficient to meet demand. Some CMHCs do not have a facility with

²⁴ K.S.A. 39-1602(b).

²⁵ For example, 9 of the CMHCs were operating at a loss by 2010, resulting in significant layoffs. See, <https://www.khi.org/news/article/centers-cut-staff-and-services>.

²⁶ Information on the impact of the budget cuts can be found in an article on the Kansas Health Institute's (KHI) website on July 7, 2016 found at <https://www.khi.org/news/article/budget-cuts-devastating-mental-health-system-providers-say>. See also the KHI article on July 11, 2016 at <https://www.khi.org/news/article/loss-of-ku-contract-will-diminish-quality-of-mental-health-care-providers-s> concerning the termination of the contract between the University of Kansas Center for Mental Health Research and KDADS to provide training to the CMHCs on evidence based practice.

sobering beds and staff to help individuals cope with a crisis. In the past 2 years, the state has provided some additional financial support to a few CMHCs for new crisis services. Legislation passed in 2017 established specialized crisis intervention centers which meet certain criteria which, if implemented correctly and effectively, may help some individuals in crisis avoid commitment to OSH or LSH.

KDADS and local governments have provided some funding, however, it is nowhere near what is actually needed. In the past 2 years, the state has provided some additional financial support to a few CMHCs for new crisis services. KDADS awarded a \$500,000 grant to Valeo Behavioral Health Care in Topeka to help fund its existing crisis stabilization services. KDADS also awarded \$85,000 and \$725,000 to help fund crisis stabilization services in Salina and Manhattan respectively. Legislation passed in 2017 established specialized crisis intervention centers which meet certain criteria which are structured to help individuals in crisis avoid possible commitment to OSH or LSH. The Crisis Intervention Act allows the centers to hold an individual involuntarily for up to 72 hours in most cases before either having to discharge the individual or filing a court petition seeking involuntary civil commitment to one of the state hospitals.²⁷ KDADS awarded grants to operate facilities in Kansas City and in south central Kansas to provide crisis stabilization services under the act.²⁸ They will provide 24/7 assessment and triage for individuals experiencing a mental health crisis, crisis observation, short-term crisis stabilization, and sobering beds.

The majority of CMHCs received no additional state funds to support crisis stabilization services. In two counties, local governments have provided additional funding to CMHCs to help provide these services. Residents in Douglas County approved a quarter-cent sales tax increase in November 2018 to help finance and operate a behavioral health recovery campus operated by Bert Nash Community Mental Health Center. The campus will include a crisis center, supportive housing programs, and crisis prevention programs. In Johnson County, the Board of County Commissioners increased the budget for the Johnson County Mental Health Center by \$4.2

²⁷ K.S.A. 59-29c01, et seq.

²⁸ RSI, Inc. and the South Central Mental Health Counseling Center/Regional Recovery Support Center. For the announcement by KDADS, see file <https://www.kdads.ks.gov/media-center/news-releases/2017/11/06/kdads-announces-award-of-two-contracts-for-behavioral-health-crisis-services>.

million to add staff in order to try to maintain its current level of services.²⁹ These two local initiatives are the exception, not the norm.

Most of the CMHCs no longer provide comprehensive discharge planning and community integration assistance to those who want to discharge out of an NFMH. Other than conducting the preadmission and periodic assessments, only two of the CMHCs³⁰ provide any rehabilitative services to consumers who reside in their service area (known as catchment area).

The other CMHCs typically only provide other assistance to residents 120 days prior to discharge when they can bill Medicaid for some limited rehabilitation services; otherwise, they receive no dedicated funding from the state for helping the resident discharge from the NFMH.³¹ With no funding, the CMHCs prioritize their scarce resources for residents in the community, and those in the NFMHs are neglected. The two CMHCs that emphasize community integration use local funds or obtain grants for the services. The state funding simply doesn't exist to conduct effective discharge planning and community integration.

KDADS asked a group of stakeholders in 2015 “to review and make recommendations for transforming the behavioral health system to ensure an effective array of behavioral health services were available to promote recovery and community integration.”³² The stakeholders formed the Adult Continuum of Care Committee (later referred to as the ACC Task Force) which produced a report in 2015 and a follow-up report in 2017. Both reports confirm our findings and conclusion that the state has been chronically underfunding necessary comprehensive community mental health services and support for years to the detriment of those who need them most in order to remain in the least restrictive setting possible. The Committee recognized the decrepit state of affairs in the mental health system in its Executive Summary on page 6 of the 2015 report:

Kansas has identified the need to move beyond a mental health system that is stretched beyond its ability to provide the right care at the right time in the right place for Kansas citizens since 2006.

²⁹ https://www.jocogov.org/sites/default/files/pio-publications/JoCo_Mag%20Oct2018_10-23_Web.pdf, p. 2.

³⁰ COMCARE in Wichita and Iroquois Mental Health Center in Greensburg.

³¹ Adult Continuum of Care Final Report, p. 16. The report is found online at <http://cdm16884.contentdm.oclc.org/cdm/ref/collection/p16884coll24/id/119>.

³² Adult Continuum of Care Final Report, p. 3.

The health and safety of our citizens, families and communities are at risk in a system where we must desperately seek alternative placements in order to avoid unacceptable hospital census numbers.

The Committee found the following gaps and barriers in the provision of services by the CMHCs:

Due to underfunding, the capacity of any given community or region to provide an array of services for their citizens' behavioral health needs at a local level is less than it has been, creating more pressure on the state hospital system to be the final safety net for many people.

Inpatient psychiatric units in local community hospitals are becoming far scarcer than once was the case. There are many reasons for this. Two that were mentioned in our small groups are the shortage of psychiatrists and financial constraints; they lose a lot of money.

People with a primary mental illness or substance use disorder are burdening local emergency departments, leaving them with less capacity to serve people with medical emergencies.

Uninsured people may utilize a large amount [of] community behavioral health services that go unreimbursed, causing local hospitals to lose money, particularly on psych services, CMHCs to have to do more with less, and the availability of SUD treatment continues to diminish.

When funds are tight, some CMHCs perceive disincentives to provide evidence based care and treatment.

Caseload sizes at many CMHCs are too high to provide adequate services and support to the people who need more intensive care and/or crisis intervention.

Not enough resources exist in communities at present that might serve to divert people in crisis from state hospitals. These could include CMHC provided case management, attendant care or

peer support services that are available outside regular office hours, peer support services offered by consumer run organizations, peer run respite homes, RSI type crisis facilities, sobering beds or “social detox” being more widely available, and local inpatient psych units.³³

Individuals wanting to discharge from the state hospitals or NFMHs have a critical need for adequate, affordable, housing, including supported housing; otherwise, they face a greater likelihood of homeless and re-institutionalization. As the Committee stated:

While some housing resources exist for people with severe mental illness, communities lack affordable housing, and too many are homeless or precariously housed. As a result, the mental health needs of consumers are exacerbated by the chronic stress of homelessness and inadequate housing. People who are homeless are at greater risk of law enforcement contact leading to an increase in the jail census of people experiencing mental illness. As a result, there are a greater number of people ordered for involuntary inpatient and outpatient treatment. But, because they are homeless, they are harder to treat and often harder to find. Some people with severe mental illness have difficulty living independently and meeting their own daily living activities, abuse alcohol or drugs, and need frequent support. Too often, the result is an admission to the state hospital.³⁴

The Committee surveyed the CMHCs to determine the availability of different types of housing programs. The results confirmed DRC’s finding that such housing today is woefully inadequate and in some cases nonexistent. For example, 16 CMHCs responded they had no interim housing or transitional beds available. Nineteen had no structured care housing which provides onsite support. Fifteen reported they use the local homeless shelter as a transition option, and of those, 10 reported they had employed that option more than 15 times. Seven had no housing specialist to help individuals find adequate housing.³⁵

³³ Adult Continuum of Care Final Report, pp. 19-20.

³⁴ Adult Continuum of Care Final Report, p. 18.

³⁵ Adult Continuum of Care Final Report, pp. 36–38.

The Committee met twice in 2016 and issued an updated report on January 5, 2017. They found a distressing lack of progress in addressing the deficiencies in community mental health services that its initial report highlighted:

The members of the ACC Task Force are discouraged at the continued erosion of the Kansas behavioral health continuum of care since the last report. While there have been positive developments, including Rainbow Services, Inc., and the creation of new crisis services in Wichita and Topeka, the overall system has degraded and cannot meet the statewide need...

Kansans who need treatment through the behavioral health system are currently all too often unable to get the help they need. Community resources are strained, affecting both mental health treatment and substance use disorders treatment...

The lack of capacity in community based mental health services and in the state hospital system exacerbates the mental health crisis of the individual through increased use of criminal charges for minor offenses to resolve immediate problems of the disorder. This results in citizens being incarcerated that could be better served by mental health services. Incarceration in these situations needlessly compounds the person's ability to function in the community and places them in a setting where they are, at best, receiving minimal mental health services with diminished probability of stabilization...

Kansas must, in the immediate future, implement regulations and funding strategies to incentivize the treatment and services necessary to fill the gaps of our continuum of care. Without access to the services necessary, people will continue to suffer the life-threatening trauma of serious mental illness and addictions without the services that might prevent unnecessary incarceration or hospitalization. Without the resources for treatment at the right time and in the right setting, which includes

housing and employment support, we will continue to overuse more restrictive and expensive resources.³⁶

The Committee once again urged the state to step up and provide the necessary resources to give Kansans with significant mental health issues a better opportunity to avoid institutionalization, in particular to establish supported housing programs in underserved areas:

The State and payor systems should be committed to ensuring needed resources to support recovery in the community are available. A cycle of repeat hospitalizations and /or multiple incarcerations is a reality for far too many Kansans. This devastating cycle hurts individuals, families, and our communities. It goes without saying that it is absolutely a poor use of public resources...

Supported Housing is a fundamental stabilizing component for individuals “at risk” of hospitalization or incarceration or moving out of secured settings to community-based services. A plan should be created to provide supported housing programs where individuals do not have access to such programs. (Appendix E of the 2015 Report for the Transitional Care Services Needs Assessment.)³⁷

Finally, the Committee’s Update identified the shortage of qualified behavioral health providers in many communities and the inability to pay a competitive salary to work in some fields.³⁸

The state restored some of the budget cuts later in 2017, but a year earlier it ended dedicated funding for the Health Home Program which provided beneficial wrap around medical and behavioral health care services. The end of the program resulted in staff layoffs.³⁹ KDADS also cancelled contracts with the University of Kansas and Wichita State University which “played a pivotal role in the training of community-based services staff.”⁴⁰

³⁶ Adult Continuum of Care Task Force Update to the Final ACC Report of July 2015, pp. 2-3. The Update can be found at https://www.kdads.ks.gov/docs/default-source/CSP/bhs-documents/Reports/adult-continuum-of-care-task-force-update-to-the-2015-report-january-2017000360a0172e66d690a7ff00009edf98.pdf?sfvrsn=e82d06ee_0.

³⁷ ACC Task Force Update, p. 5.

³⁸ ACC Task Force Update, p. 6.

³⁹ ACC Task Force Update, p. 4. <https://www.khi.org/news/article/budget-cuts-devastating-mental-health-system-providers-say>.

⁴⁰ ACC Task Force Update, p. 4.

The Kansas Legislature passed a budget provision in June 2017 directing KDADS to establish another group, the Mental Health Task Force, “to assess the strengths and weaknesses of state’s current mental health system and make recommendations for improvements in a report to the Kansas Legislature before January 8, 2018...”⁴¹ The recommendations in the task force’s report confirm the existing deficiencies highlighted in the previous Committee reports. In particular concerning housing as a key factor to assist in crisis stabilization:

The Task Force believes that lack of access to safe, affordable, and stable housing is often a barrier to individuals and families seeking behavioral health treatment, particularly for those who have experienced long-term or repeated homelessness, which can increase the risk of mental health crises. This sentiment was echoed in another report released this year.

The Governor’s Behavioral Health Services Planning Council Subcommittee on Housing and Homelessness 2017 Annual Report indicated that the expansion of housing will lead to decreased admissions to state psychiatric hospitals, reduced incarceration rates, and reduced rates of individuals becoming homeless due to disability. This, in turn, will save tax dollars and help Kansans achieve recovery. If housing is not expanded, the report suggests that this may possibly force Kansans with behavioral health needs into environments not favorable to their needs and desires.⁴²

The task force recommended expanding housing options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership.⁴³

The results of DRC’s investigation echo the findings of the Committee’s two reports and the recommendations of the Mental Health Task Force. Some new programs in urban areas have been added to provide crisis stabilization

⁴¹ Mental Health Task Force Report to the Legislature, p. iii. The report can be found at https://www.kdads.ks.gov/docs/default-source/CSP/bhs-documents/governor's-mental-health-task-force/mental-health-task-force-report.pdf?sfvrsn=462106ee_2.

⁴² Mental Health Task Force Report, p. 19.

⁴³ Mental Health Task Force Report, p. 18.

services and temporary supported housing, but the majority of the state has no system for addressing these critical needs. Even with the restoration of some budget cuts starting in FY 2018, the CMHC system still has 16% less for its core services than in FY 2007, and it is serving 30,000 more consumers. Long term supported housing continues to be essentially nonexistent in most communities.

Lastly, the state's refusal to expand Medicaid eligibility and the inability of many mental health consumers to pay for private health insurance results in millions of dollars of uncompensated care being provided by the CMHCs. To compensate, the CMHCs must use outside funds to pay for the core services, prioritize which services it will provide and make cuts in the lower priority services. Without a significant change in commitment at the state level, the deterioration of community mental health services will continue.

3. Nursing Facilities for Mental Health (NFMH)

The NFMH system began in the early 1980s as an alternative to placing individuals with severe and persistent mental illness (SPMI) in traditional nursing facilities. In 1988, the Medicaid Act was amended to exclude federal payment for care or treatment of any resident or patient between ages 21 and 65 who is in a facility that has "more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."⁴⁴ The Act identifies any such facility as an "Institution for Mental Disease" or IMDs; the prohibition on payments is known as "the IMD exclusion rule." Consequently, the stays of NFMH residents ages 21-65 have been financed solely with State General Funds. As in other traditional nursing facilities, a resident receiving federal disability benefits (SSI or Social Security Disability Insurance) is obligated to pay the facility all but \$62.00 of the individual's monthly benefit.

As explained in the previous section, an individual cannot be admitted to an NFMH unless she meets specific mental health criteria identified in the PASRR Level II.⁴⁵ After the CMHC completes the PASRR, the NFMH is

⁴⁴ 42 U.S.C. 1396d(a)(30)(B); 42 CFR 435.1009(a)(2).

⁴⁵ 42 C.F.R 483.100, et seq. As explained in fn 24, the state follows these federal PASRR regulations for NFMH admissions even though they do not receive Medicaid funding. State regulations K.A.R. 28-39-226 and 227 also adopt by reference 42 C.F.R 483.1 - .75 and 42 C.F.R. 483.400 - .480.

required to develop a comprehensive resident assessment within 14 days after admission.⁴⁶



Brighton Place North, Topeka

The assessor must observe and communicate with the individual and must include information related to discharge planning.⁴⁷ The facility must then develop a comprehensive person-centered care plan within 7 days and also develop and implement a timely and effective discharge planning process. The process must:

- Involve the resident;
- Ensure that the resident's discharge needs are identified;
- Develop a discharge plan which identifies what placement opportunities are available and what resources, skills and behaviors are needed to facilitate the placement.
- Include regular re-evaluations to identify changes that may require modification of the plan;
- Consider what the resident may need when discharged such as caregivers and other supports;
- Tell the resident about the final plan.⁴⁸

⁴⁶ 42 C.F.R. 483.20(b)(2)(i), K.A.R. 30-10-2(a)(11)(A).

⁴⁷ 42 C.F.R. 483.20(b).

⁴⁸ 42 C.F.R. 483.21(b)(c).

The NFMH must then review and update the plan quarterly after admission to determine the appropriate level of care.⁴⁹ As part of the person centered planning process the NFMH “must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.”⁵⁰ The care plan must include what “structured mental health rehabilitative services” the resident needs to help meet the discharge planning goals.⁵¹ The discharge planning process must also “[i]nclude regular re-evaluation of the residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.”⁵²



Brighton Place West, Topeka

Ten facilities currently operate as an NFMH. Historically, all have been private, for-profit facilities; however, in the last year, KDADS took receivership of four NFMHs because of significant financial difficulties. The four are located in Edwardsville, Eskridge, Peabody, and Topeka. Nine of the ten are located in eastern Kansas. Four of these are located in Topeka. The westernmost facility is in Haviland which is 120 miles west of Wichita.

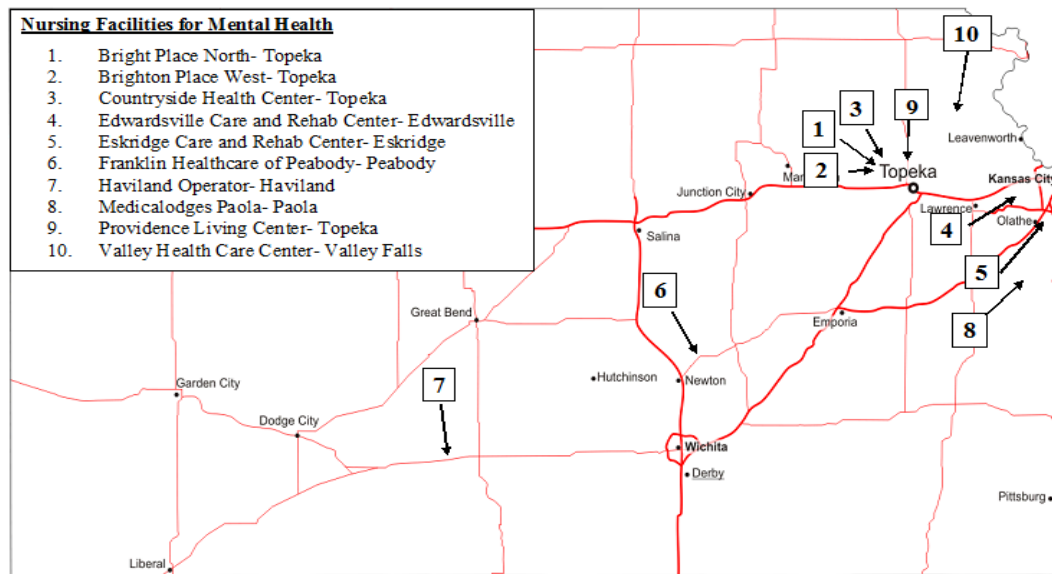
⁴⁹ C.F.R. 483.20(c); C.F.R. 483.21(b)(2)(iii); K.A.R. 30-10-2(a)(11)(A); K.A.R. 30-10-7(c).

⁵⁰ C.F.R. 483.21(c)(1).

⁵¹ K.A.R. 30-10-1a(26)(B).

⁵² 42 C.F.R. 483.21(c)(1)(ii).

The total capacity for all ten is 635. The largest is in Edwardsville with 102 beds; the smallest is one of the four in Topeka with 34 beds.



The NFMHs are licensed, regulated and paid set daily rates by KDADS as adult care homes, the same as traditional nursing facilities. The published daily rates for FY 2019 range from \$99.01 at Brighton Place North in Topeka (34 beds) to \$170.97 per day at Edwardsville Care and Rehabilitation Center, LLC (102 beds). The average day rate for all 10 facilities is \$129.56; the average monthly cost per resident to the state is \$3,940.75. In comparison, the average day rate for FY 2007 was \$86.44, and the average monthly cost was \$2,629.13.⁵³ The chart below summarizes the daily rates and monthly costs for the 10 facilities.

⁵³ The daily rates are published prior to the beginning of the new fiscal year in the Kansas Register. The FY 2007 rates are at Vol. 25, No. 26, pp. 902-904 (June 25, 2006). The FY 2019 rates are at Vol. 37, No. 25, pp. 689 - 691 (June 21, 2018).

Daily NFMH Rate/Average Monthly Cost

Facility	FY 2007	FY 2019
Brighton Place North–Topeka (34 beds)	\$74.11/\$2,254.18	\$99.01/\$3,011.55
Providence Living Center–Topeka (78 beds)*	\$79.26/\$2,410.83	\$106.12/\$3,227.82
Countryside Health Center–Topeka (88 beds)	\$90.56/\$2,754.53	\$111.35/\$3,386.90
Franklin Healthcare of Peabody, LLC* (45 beds)	\$82.04/\$2,495.38	\$116.36/\$3,539.28
Haviland Operator, LLC–Haviland (45 beds)	\$74.72/\$2,272.73	\$123.58/\$3,758.89
Medicalodges–Paola (93 beds)	\$103.93/\$3,160.9	\$124.69/\$3,792.65
Brighton Place West–Topeka (50 beds)	\$89.08/\$2,709.52	\$132.41/\$4,027.47
Valley Health Care Center–Valley Falls (40 beds)	\$91.86/\$2,794.08	\$147.84/\$4,496.80
Eskridge Care and Rehabilitation Center, LLC (60 beds)*	\$88.28/\$2,685.18	\$163.26/\$4,965.52
Edwardsville Care and Rehabilitation Center, LLC (102 beds)*	\$90.53/\$2,753.62	\$170.97/\$5,200.34

*Facilities that are in state receivership

The NFMHs are licensed to provide “skilled nursing care and special mental health services to compensate for activities of daily living limitations.”⁵⁴ **Most NFMHs provide virtually no rehabilitative services to help residents prepare to discharge to a community setting.** All arrange periodic group trips for personal shopping and sometimes outdoor activities and all scheduled various activities in the facilities. Most are recreational involving limited to no physical or intellectual stimulation. Only one is unlocked. Residents can only leave the facility with permission and many have restrictions placed on them by the facility limiting when they can leave. Most residents share a room with at least one other person, but many share a room with up to three other people. The buildings generally look old and worn. Residents have little privacy. Most facilities have no space for residents to congregate and socialize except in large open areas where most of the other residents are sitting, such as the dining room. They

⁵⁴ K.S.A. 39-923(a)(3).

have congregate showers and bathing facilities. Most residents are put on a periodic schedule for bathing. Most have little to no landscaping to provide a less than stark institutional look and feel. **In every sense of the word, NFMHs are institutions where residents are admitted for permanent, not temporary, placement.**

The 2015 ACC report recognized the dire state of affairs for NFMH residents when it identified the following issues:

Due to the inadequate reimbursement rates paid the NFMHS, they are not able to provide adequate training and compensation for their staff.

Due to the institutional setting of the NFMHS, the individual has limited freedom and limited choices about basic life activities that others may take for granted such as what and when to eat, what to do for recreation, who to share living space with, who to spend time with, work, education, or other factors that might help a person feel motivated towards recovery. Over time, the environment in an NFMH fosters dependence and people become afraid to be discharged because they may be aware that they've lost skills and/or feel unable to make healthy choices for themselves.

There is a lack of ongoing, active behavioral health care treatment in these facilities. This results in very few residents being discharged to a lesser level of care and their recovery options limited. (emphasis in the original).⁵⁵

The report identified numerous barriers and proposed remedies to address them:

Barriers:

- Not rehabilitative
- Funding does not allow for transition plans
- People are “stuck” in NFMH due to lack of alternative housing
- Role of NFMH is not clear
- IMD Exclusion rule may be challenged

⁵⁵ Adult Continuum of Care Final Report, p. 16.

Remedies:

- Redefine the role of NFMHs
- Review data to see what type of residents are currently using NFMH
- Reach out to other states to see what they use instead of NFMH
- Open codes for CMHC services to be provided in the NFMH
- Increase supported housing options
- Coordinated mental health services
- Support rehab and transition planning⁵⁶

The Committee's 2017 update reiterated the lack of rehabilitative services and discharge planning for NFMH residents. It urged the state to implement a number of important strategies that had been recommended by the NFMH Work Group:⁵⁷

- Implement a strengths-based screening process;
- Collaboration between NFMHs and CMHCs;
- Begin discharge planning on the first day of admission to the NFMH;
- Encourage appropriate placement of residents based on criteria;
- Provide support for resident skill-building programs that were removed due to nursing home regulations;
- Update licensing structure to allow for necessary rehabilitative services and inclusion within the continuum of care;
- Incentivize moving individuals out of facilities, with discharge rates, job programs, medication management processes, and therapy appointments;
- Improve reimbursement for services, especially for collaborative programs with CMHCs;
- Enhance training for mental health screeners;
- Provide consistent training for NFMH staff providing mental health care; and
- Develop a process for the NFMHs and CMHCs to work together and share information for the benefit of the resident.⁵⁸

⁵⁶ Adult Continuum of Care Final Report, p. 29.

⁵⁷ The 2015 ACC report recommended that the NFMH Work Group be formed.

⁵⁸ ACC Task Force Update, p. 6.

The 2018 Mental Health Task Force report prioritized three recommendations for the NFMH system:

Licensing Structure: Update licensing structure to allow for necessary rehabilitative services in NFMHs and inclusion within the continuum of care.

Presumptive Approval of Medicaid: Coordinate with the Kansas Department of Health and Environment (KDHE) and determine if a policy could be developed that allows presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs.

Crisis Services in NFMHs: Develop a process for crisis services to be accessed/provided for individuals in NFMHs to include the creation of additional crisis stabilization units with medical and mental health abilities to help stabilize people up to 14 days.⁵⁹

The task force recommended changing the licensing structure in order to promote better residential and rehabilitative treatment. To pay for the better services, the task force recommended that the state seek a waiver to the federal IMD exclusion for Medicaid coverage.⁶⁰ Establishing a presumptive Medicaid approval process hopefully would improve interactions between KDADS and KDHE to pre-approve those residents who had Medicaid when they were admitted and likely would be eligible again upon discharge. Having a Medicaid card at discharge would allow the resident to refill medications and start community services without delay. For improved crisis services, the task force recommended forming contacts between the NFMHs and CMHCs and informal arrangements with multiple parties. To pay for services, the task force again recommended applying for a waiver of the Medicaid IMD exclusion.

DRC's investigation of the NFMH system confirms the findings of the reports cited above, particularly concerning the lack of emphasis and availability of adequate rehabilitative services at most of the NFMHs. The required structured mental health rehabilitative services are distant second priorities for the majority of the NFMHs compared to basic room and board and limited mental health care they claim to provide.

⁵⁹ Mental Health Task Force Report, pp. 38-41.

⁶⁰ Mental Health Task Force Report, p. 39.

In addition to the limited rehabilitation services that may be offered, residents rarely receive adequate reviews and comprehensive revisions of their plans of care and discharge planning services. The NFMH must review and update the initial resident assessment, at least annually.⁶¹ The comprehensive care plan must be reviewed and revised by the NFMH staff after each annual comprehensive assessment and the quarterly reviews.⁶²

A qualified mental health professional from the resident's CMHC must also conduct an annual assessment at the facility to determine whether it is appropriate for the individual to remain at the NFMH.⁶³ The assessment is called a Screen for Continued Stay:

The assessment of the level of care needs for an NFMH resident must include a comprehensive review of the individual's strengths and goals, as well as, their service, support, and financial needs, and the community's capacity to respond to those needs, prior to the determination that continued nursing facility placement is the best option ... Continuing NFMH care should only be recommended for individuals whose needs cannot be met in the community. Therefore, a review of the community's capacity to provide needed support is a critical piece of the assessment. Both formal and informal sources of support should be considered.⁶⁴

If the assessor decides discharge to the community is not feasible, the screen must document the reasons.⁶⁵

The Screens for Continued Stay that DRC staff reviewed often only recite general goals in the discharge plan section, such as "medication management" and other basic information. Federal regulations adopted by the state for the NFMHs, however, require "the facility to develop and implement an effective discharge planning process" that focuses on the resident's goals and determines how the resident will be an active partner in discharge planning. They also require that the plan: 1) identify the resident's

⁶¹ 42 C.F.R. 483.20(b)(2)(iii); K.A.R. 30-10-2(a)(11)(A). The NFMH must also review the resident assessment within 14 days after staff determine or should have determined that the resident has experienced a significant change in her physical or mental condition. The revised assessment must then be reviewed at least annually thereafter.

⁶² 42 C.F.R. 483.21(b)(iii).

⁶³ K.A.R. 30-10-7(d).

⁶⁴ The cited text is on p. 6 of the Screen for Continued Stay which can be found on the KDADS website at <https://www.kdads.ks.gov/provider-home/providers/screens-for-continued-stay>.

⁶⁵ 42 C.F.R. 483.21(c)(vii)(C).

discharge need and incorporate them into the plan; and 2) determine whether the resident will need a caregiver or support person after discharge and whether such supports are available.⁶⁶ If the resident is in an NFMH far from his home CMHC, that CMHC often asks another CMHC which is closer to the resident to conduct a “courtesy screen.” The courtesy screener may not be familiar with the resident and have little information other than what is in the NFMH file. That lack of familiarity results in a basic, generic recommendation. The lack of detailed discharge planning is further confirmation to many residents that they can expect little help from the NFMH staff and the state to move back to the community.

Examples of Common Barriers to Discharge from Interviews

Resident 1 was diagnosed with multiple mental health conditions before she was a teenager, but she was able to live independently for most of her life. Before being admitted to an NFMH, she lived in subsidized housing with assistance from family and the local CMHC. Services included medication management and individual and group therapies. She was admitted to an NFMH more than 10 years ago. Her main goal was to receive treatment in dealing with her stress and some physical health issues and then return to the community. While periodic reviews identify Resident 1’s goal, the care plans the facility has developed each year do not contribute to improving her physical health issues and helping her cope with her mental health issues. The NFMH only became more helpful after Resident 1 contacted DRC for assistance with discharge planning. Contacting her CMHC for long-range help is futile because the state’s budget for community mental health services allows for only limited services within 120 days of discharge.

Resident 2 has numerous mental health diagnoses and several physical limitations. Although his mental and physical issues impose limitations on his well-being, Resident 2 could still live in a community setting with supports and services such as supported housing, case management, and therapies. Almost 10 years ago, he was hospitalized due to physical health problems

⁶⁶ 42 C.F.R. 483.21(c).

and received in-patient treatment for substance abuse, after which he voluntarily admitted himself to an NFMH. He expected to stay just long enough to become stable and then move back into the community; however, he has been in NFMHs ever since. The CMHC has never come back to the NFMH to conduct an annual review of Resident 2's status, and the NFMH has never actively worked on an effective discharge plan for him.

Resident 3 has been in two different NFMHs over the past three years. He had been receiving CMHC services prior to his admission, but he decompensated into crisis and eventually admitted himself voluntarily. He has repeatedly said he wants to discharge and has asked for help from the NFMH and the CMHC to set up supported housing and other community services. But the CMHC has repeatedly recommended in the annual reviews that he continue to stay at the NFMH because of his past behaviors and failures in the community setting. The screens provide only generic recommendations for how he can overcome his past failures to persuade the CMHC screener to recommend discharge. The NFMH was also not helpful until DRC contacted them on behalf of Resident 3, but his local CMHC has refused to help with discharge planning. When DRC assisted Resident 3 in calling the CMHC along with NFMH staff to request help in discharging, the CMHC staff told Resident 3 that they would not help him locate housing or set up services until he discharged from the NFMH and was back in the community. At that time, he would be welcome to come in and complete an intake so they could get services set up for him. This leaves Resident 3 effectively stuck in an NFMH with no way to access community services.

Resident 4 has been at an NFMH for more than two years. He wants to return to the community and has identified the services he will need to help him have a better chance to live independently. He had a PASSR Level II review 12 months ago which found he meets the criteria to continue admission, but as is typical, it provides no details on what Resident 4 needs to work on for a discharge plan. Instead, it only generically states that the NFMH will work with him on medication management, activities such as personal hygiene and generally crafting a discharge plan. The NFMH does not have a detailed plan for him, and the CMHC has never met with him to develop a specific discharge plan.

In December 2018 DRC staff conducted a survey with residents at all 10 NFMHs asking whether they desired to live in the community and if so, whether they were getting help. One goal of the survey was to determine whether the stories staff heard during their earlier resident interviews about the desire for help to discharge were commonplace or isolated. DRC staff surveyed 280 out of 635 residents, or about 45%. Of those surveyed, 47 reported they had been at their facility for 6–10 years, and 64 reported they were admitted more than 10 years ago. One hundred ninety-two, or 69%, of the residents DRC staff interviewed, said they want to discharge back to the community. Only 26 of the 280 (9%) said they have a discharge plan. Sixty residents did not know whether they have a discharge plan, and 194 residents said they have no discharge plan. Although every resident may have something identified as a discharge plan in his or her file, the fact that 254 out of 280 residents who were surveyed could not say they have a plan indicates that the NFMHs do not provide effective, comprehensive, ongoing discharge planning services. Some of the residents may have poor memories, but it is unlikely that is the case for all 254. Instead, a more reasonable explanation is that the results confirm the findings of the state's reports that the NFMH model which emphasizes board and care over ongoing, active behavioral health care and discharge planning leave residents with limited hope to discharge back to their communities.

The charts on the below summarize DRC's findings and breaks them down by length of residence.

Question: Do you want to discharge back to the community?

Length of residence	Yes	No	Unsure	Total
Under 1 year	45	6	2	53
1–2 years	40	14	3	57
3–5 years	41	14	2	57
6–10 years	30	17	2	49
10+ years	36	22	6	64
Totals	192	73	15	280
% of 280 surveyed	69%	26%	5%	100%

Question: Do you have a discharge plan?

Length of residence	Yes	No	Unsure	Total
Under 1 year	4	37	12	53
1–2 years	7	42	8	57
3–5 years	5	36	16	57
6–10 years	8	32	9	49
10+ years	2	47	15	64
Totals	26	194	60	280
% of 280 surveyed	9%	69%	21%	100%

The reports commissioned by the state correctly conclude that NFMH residents who want to discharge need longer-term access to CMHC discharge planning services and better coordination between the CMHCs and NFMHs than currently exist. Instead, budget cuts have required the CMHCs to prioritize which consumers get services. For the most part, they have chosen to focus their state fund resources on consumers in the community and cut back on services to NFMH residents. In most cases, DRC staff found that these service reductions have resulted in the CMHCs becoming an additional barrier to successful discharge planning. With little to no available help with rehabilitation planning, NFMH residents are left stranded and on their own to identify and develop resources and services needed to get out.

As explained above (p.28), the Mental Health Task Force Report in 2018 recommended that the state seek a waiver of the IMD exclusion for psychiatric services in the NFMHs.⁶⁷ A second Mental Health Task Force Report submitted to the legislature in January 2019 also recommends seeking a waiver.⁶⁸ The 2019 Task Force Report further recommended the submission of the IMD exemption for mental health services be revisited at least annually.⁶⁹ With the waiver, the state could access federal Medicaid funds to pay approximately 57% of the costs of allowable Medicaid services. The Brownback and Coyler administrations supported the Task Force's recommendation and filed an application in 2018 with CMS for a waiver for psychiatric services and substance use disorder (SUD) treatment in the NFMHs and state hospitals. CMS approved only a waiver for SUD treatment for short-term residents in an IMD in January 2019.⁷⁰

If CMS approves a new waiver application by the state for long-term psychiatric services, DRC does not believe such a waiver on its own would be an effective remedy to the problem. The IMD exclusion exists to encourage the state to commit to improving access to integrated, community services instead of institutional care through the use of Medicaid dollars. Instead of improving access, however, the state has done just the opposite; it has significantly reduced access despite having to maintain the NFMH system with only state money. It is illogical to expect that the state will reverse course and improve access if the IMD exclusion were waived.

Assuming the state reversed course, it would have to dedicate any savings from the waiver to a variety of new rehabilitation programs in the NFMHs. This goal historically has been diametrically opposite of the NFMH business model. The NFMHs would have to change course from continuing as a long-term institutional board and care system to becoming a shorter-term rehabilitation system. Given their dismal track record, it is difficult to envision the NFMHs creating the necessary programs, hiring qualified staff to implement the programs, and assuming the risk of losing state payments for failing to meet meaningful benchmarks for progress in providing

⁶⁷ Mental Health Task Force Report - 2018, pp. 38-41.

⁶⁸ Mental Health Task Force Report to the Legislature, January 14, 2019, pp. 53-54. The report is on the KDADS website at https://www.kdads.ks.gov/docs/default-source/csp/bhs-documents/final-mental-health-task-force-report---january-2019.pdf?sfvrsn=4dac04ee_0.

⁶⁹ Mental Health Task Force Report - 2019, p. 35.

⁷⁰ CMS Waiver Authority approval letter dated January 15, 2019, p. 3 of the online document, found at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-ca.pdf>.

rehabilitation and discharge planning services. Without constant oversight from the state, the NFMHs likely would default to its current business model of institutional board and care with little to no emphasis on rehabilitation.

The state also would need to increase funding to the CMHCs to staff more comprehensive discharge planning with NFMH residents and enhance community-based services upon their discharge, including supported employment and housing. The new funding would need to be dedicated only for community integration services and supports. As with the NFMHs, the state would also have to maintain evidence-based oversight on the CMHCs.

DRC questions whether the savings from waiving the IMD exclusion would cover all these services and the necessary oversight by the state to monitor a robust community integration program which reduces the number of institutional residents. The share of the savings dedicated to the CMHCs likely would not resolve the problems created by the tens of millions of dollars in budget cuts the past ten years and tens of thousands of new consumers. The state likely will need to make a larger financial commitment to reverse its mindset toward institutional care and community integration. In the end, obtaining the waiver without significant additional funding is likely just a limited attempt to fix to a much bigger problem.

CONCLUSION

Kansas is discriminating against individuals with mental health issues in the NFMHs in violation of the ADA's integration mandate and the state's anti-discrimination statutes. Kansas must take immediate and significant action to remedy this discrimination.

DRC's investigation and the reports commissioned by the state clearly establish that the mental health system is broken for NFMH residents who want to discharge back to the community. The decline in state mental health funding since FY 2007 has substantially limited the ability of individuals with mental health issues to obtain necessary community mental health services in the community to avoid crisis. Those who are institutionalized at an NFMH have virtually no contact with their CMHCs to receive rehabilitation services to help them leave for a more independent life in the community.

Chronic underfunding leaves the CMHCs in the undesirable position of having to prioritize what services they will provide and where they will provide them. Most decide to concentrate on their consumers already in the

community. Those who dedicate funds for community integration services do so with funds other than those coming from the state. Most of the NFMHs give only lip service to helping their residents work on effective discharge plans. Residents who are lucky enough to have an NFMH and CMHC which are willing to help them discharge still have challenges accessing adequate support services in the community. Some residents successfully discharge in spite of systemic barriers but most residents languish in NFMHs for years with little or no expectation that they will ever leave. Having some successful discharge stories does not justify a conclusion that the state's budget commitment to the mental health system meets the community integration requirements of the ADA and the *Olmstead* decision, given how many others are left behind.

The chronic underfunding of the community mental health system has resulted in NFMHs becoming *de facto* warehouses for Kansans with serious mental health needs where they languish without active treatment or proper mental health support. DRC's survey of NFMH residents shows Kansans are stuck in these institutions and they are not being transitioned to more appropriate and more integrated settings in the community. Sixty-nine percent of the residents want to be discharged back into the community; 9% believed they have a discharge plan; and 5% were "unsure" if they wanted to be discharged back into the community.

In FY 2018 the state restored \$8.5 million of the \$20.2 million cut from the CMHC's funding since FY 2007. But the CMHCs now serve 30,000 more consumers than in FY 2007 and the cost of providing services has increased in the past 11 years. The state has failed to meet its legal obligation under *Olmstead*.

The list of vital community mental health programs and services which are nonexistent, terminated, or seriously deficient throughout the state, include but are not limited to:

- a. Mobile 24/7 crisis intervention teams;
- b. Assertive Community Treatment (ACT) programs which provide an evidence based, multidisciplinary team approach with assertive outreach in the community;
- c. Improved peer support programs to assist individuals in the community and those who want to discharge from NFMHs and the state hospitals;

- d. Sufficient home-based medical services, including personal care assistance, home health, and nursing for those in the community now and those who want to leave an institution;
- e. Health home programs which provide effective integrated, coordinated physical and mental health programs;
- f. An effective system to identify and provide all necessary behavioral, rehabilitation, and primary healthcare services for each individual who is admitted to an NFMH beginning the day of admission;
- g. A program to pay CMHC staff to provide the necessary behavioral and rehabilitation services to NFMH residents throughout their stay instead of just 120 days prior to discharge;
- h. Sufficient crisis housing services and short and long term supported housing programs; and
- i. Sufficient supported employment programs working in close coordination with the state's Vocational Rehabilitation services.

In stark contrast to the state's funding strategy for community mental health services is its decision to increase funding for the NFMHs by 47% from \$13.6 million to \$20 million between FY 2007 and FY 2020 even though the number of available beds declined by 45. With the increase in funding the average daily rate rose 50% during this time period from \$86.48 to \$129.56, and the average monthly rate rose from \$2,629.13 to \$3,940.75. Meanwhile, community mental health funding was slashed by 50% between FY2007 and FY2017 before restoring less than one-half of the cuts in FY2018. **The distressing conclusion from the funding history is that the state has prioritized maintaining the viability of the private, institutional NFMH system instead of dedicating adequate funding for the community mental health system.**

Kansas must stop warehousing people with mental health issues in NFMHs and significantly increase its investment in community based mental health services. **Kansas is the only state in the nation that operates NFMHs, which by federal law must be entirely funded through State General Fund dollars.** The current system discriminates against Kansans with mental health issues and is fiscally irresponsible. Instead of relying on NFMH institutions, Kansas must instead prioritize community-based services which can be paid for in part with federal Medicaid matching funds and will improve the lives of Kansans with mental health issues.

The state lacks fiscal or public policy justification to continue operating the NFMHs as board and care institutions. A plan must be developed and implemented to create transitional housing with rehabilitative services. Kansas must invest in supported housing, crisis stabilization, and community mental health services and other community-based services/supports which will improve quality of life and other mental health outcomes as well as generate millions of additional federal Medicaid match dollars. To ensure that the funds are used as intended, they must be specifically designated in the yearly budget for each of these services/supports.

The state's skewed budget priorities clearly fail to meet the community integration requirements of the ADA, state law, and Olmstead. The state of Kansas must reverse course and prioritize funding for necessary community based mental health services. Kansans with mental health issues deserve to have access to necessary services without burdensome barriers, so they have a reasonable opportunity to live in the community.

Attachment A

HISTORY OF MENTAL HEALTH FUNDING

HISTORY OF MENTAL HEALTH FUNDING

Community Mental Health Centers	FY 2002	FY 2003	FY 2004	FY 2005
<i>Funding for Uninsured and Infrastructure</i>				
State Aid	\$10,233,297	\$7,733,297	\$10,233,297	\$10,233,297
Consolidated Grants *	28,268,698	25,874,024	28,210,049	28,220,130
Mental Health Block Grant	2,728,707	2,728,707	2,851,707	2,748,707
Federal Social Services Block Grant	2,934,316	5,270,343	2,934,317	3,179,236
Family Centered System of Care (CIF)	4,937,000	5,937,000	5,937,000	5,937,000
Grants for At-Risk Persons	-	-	-	-
MH Screens for State Hospitals	-	-	-	-
Sub-TOTAL Grants	\$49,102,018	\$47,543,371	\$50,166,370	\$50,318,370
<i>Funding for Medicaid Recipients**</i>				
CMHS Direct Medicaid Payments	\$51,443,665	\$63,134,616	\$71,261,033	\$84,868,054
Medicaid Certified Match Grant ***	11,573,081	15,645,154	16,519,850	19,562,865
SED Waiver Federal Share***	8,545,009	10,072,990	12,477,254	15,043,814
SED Waiver Certified Match Grant ***	5,658,796	5,890,301	8,566,939	9,719,930
MediKan ***	4,598,820	5,168,140	4,296,419	5,445,956
Sub-TOTAL Medicaid	\$81,819,371	\$99,911,201	\$113,121,495	\$134,640,619
Number of Medicaid Recipients	28,669	31,984	34,977	42,247
Average per Member/per Year for CMHC	2,854	3,124	3,234	3,187
TOTAL CMHC Funding	\$130,921,389	\$147,454,572	\$163,287,865	\$184,958,989
Private Medicaid Practitioners				
Private Medicaid Practitioner Payments	NA	NA	NA	\$4,275,099
Number of Medicaid Recipients	NA	NA	NA	NA
TOTAL Private Practitioner Funding	-	-	-	\$4,275,099
Non Categorized				
Medicaid MH Payments (Non-Inpatient)	NA	NA	NA	NA
Mental Health Grants (Not CMHC specific)				
PATH & Interim Housing Grants	NA	NA	NA	NA
Grants/ Contracts for At-Risk Persons	NA	NA	NA	NA
MH Screens- uninsured	NA	NA	NA	NA
Facilitation Contracts Administration	NA	NA	NA	NA
Rainbow Services	NA	NA	NA	NA
Cooperative Agreement to Benefit Homeless	NA	NA	NA	NA
Supported Employment Grant	NA	NA	NA	NA
Intermediate & Transition Services	NA	NA	NA	NA
Systems of Care Grant	NA	NA	NA	NA
Total Mental Health Grants (Not CMHC specific)	-	-	-	-
Residential Treatment				
PRTFs	-	-	-	-
NFMHs	14,242,525	13,625,423	13,425,068	13,117,334
TOTAL Residential Treatment	\$14,242,525	\$13,625,423	\$13,425,068	\$13,117,334
State Mental Health Hospitals				
LSH	\$30,861,782	\$32,269,010	\$35,948,370	\$40,458,105
OSH	20,666,556	19,503,126	19,863,218	21,039,618
RMHF	6,608,776	6,591,998	7,071,519	7,212,977
TOTAL MH Hospitals	\$58,137,114	\$58,364,134	\$62,883,107	\$68,710,700
State Hospital Expenditures by KDADS				
Food Service Contract Expenditures	\$-	\$-	\$-	\$-
State Hospital Diversion Beds	-	-	-	-
Total State Hospital Expenditures by KDADS	\$-	\$-	\$-	\$-
TOTAL MENTAL HEALTH SERVICES	\$203,301,028	\$219,444,129	\$239,596,040	\$271,062,122

Note: Capital improvements are not reflected in the above chart

HISTORY OF MENTAL HEALTH FUNDING

Community Mental Health Centers	FY 2006	FY 2007	FY 2008	FY 2009
<i>Funding for Uninsured and Infrastructure</i>				
State Aid	\$10,233,297	\$10,233,297	\$10,233,297	\$10,233,297
Consolidated Grants *	31,082,431	31,066,300	21,874,340	20,074,340
Mental Health Block Grant	2,649,857	2,465,801	2,465,801	2,465,801
Federal Social Services Block Grant	-	-	-	-
Family Centered System of Care (CIF)	5,937,000	5,721,944	5,608,720	5,000,000
Grants for At-Risk Persons	-	-	-	-
MH Screens for State Hospitals	-	-	-	-
Sub-TOTAL Grants	\$49,902,585	\$49,487,342	\$40,182,158	\$37,773,438
<i>Funding for Medicaid Recipients**</i>				
CMHS Direct Medicaid Payments	\$65,816,299	\$72,857,974	\$159,143,233	\$168,988,567
Medicaid Certified Match Grant ***	19,678,394	18,508,435	-	-
SED Waiver Federal Share***	15,407,292	16,529,663	-	-
SED Waiver Certified Match Grant ***	10,034,075	10,954,764	-	-
MediKan ***	5,126,307	4,889,944	-	-
Sub-TOTAL Medicaid	\$116,062,367	\$123,740,780	\$159,143,233	\$168,988,567
Number of Medicaid Recipients	41,437	38,840	38,208	40,648
Average per Member/per Year for CMHC	2,801	3,186	4,165	4,157
TOTAL CMHC Funding	\$165,964,952	\$173,228,122	\$199,325,391	\$206,762,005
Private Medicaid Practitioners				
Private Medicaid Practitioner Payments	\$3,268,164	\$3,680,510	\$8,375,819	\$8,974,573
Number of Medicaid Recipients	NA	3,228	13,482	15,447
TOTAL Private Practitioner Funding	\$3,268,164	\$3,683,738	\$8,389,301	\$8,990,020
Non Categorized				
Medicaid MH Payments (Non-Inpatient)	NA	NA	NA	NA
Mental Health Grants (Not CMHC specific)				
PATH & Interim Housing Grants	NA	\$360,135	\$544,535	\$544,535
Grants/ Contracts for At-Risk Persons	NA	6,250,153	5,263,449	3,277,636
MH Screens- uninsured	NA	-	988,738	3,073,042
Facilitation Contracts Administration	NA	8,948,847	11,852,512	10,412,772
Rainbow Services	NA	-	-	-
Cooperative Agreement to Benefit Homeless	NA	-	-	-
Supported Employment Grant	NA	-	-	-
Intermediate & Transition Services	NA	-	-	-
Systems of Care Grant	NA	-	-	-
Total Mental Health Grants (Not CMHC specific)	\$-	\$15,559,135	\$18,649,234	\$17,307,985
Residential Treatment				
PRTFs	\$-	\$-	\$29,434,293	\$36,276,452
NFMHs	11,750,315	13,574,494	14,484,069	15,578,223
TOTAL Residential Treatment	\$11,750,315	\$13,574,494	\$43,918,362	\$51,854,675
State Mental Health Hospitals				
LSH	\$45,516,019	\$51,400,696	\$54,010,803	\$53,447,191
OSH	23,458,913	23,926,848	26,393,531	25,989,756
RMHF	7,864,088	8,010,786	8,250,004	7,811,108
TOTAL MH Hospitals	\$76,839,020	\$83,338,330	\$88,654,338	\$87,248,055
State Hospital Expenditures by KDADS				
Food Service Contract Expenditures	\$-	\$-	\$-	\$-
State Hospital Diversion Beds	-	-	-	-
Total State Hospital Expenditures by KDADS	\$-	\$-	\$-	\$-
TOTAL MENTAL HEALTH SERVICES	\$257,822,451	\$289,383,819	\$358,936,626	\$372,162,740

Note: Capital improvements are not reflected in the above chart

HISTORY OF MENTAL HEALTH FUNDING

Community Mental Health Centers	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual
<i>Funding for Uninsured and Infrastructure</i>				
State Aid	\$10,233,297	\$10,233,297	\$10,233,297	\$10,233,297
Consolidated Grants ¹	14,462,868	13,127,616	10,890,993	15,890,993
Mental Health Block Grant	2,465,801	2,465,801	3,039,992	2,465,801
Federal Social Services Block Grant	-	-	-	-
Family Centered System of Care (CIF)	5,000,000	4,850,000	5,006,703	5,006,703
Grants for At-Risk Persons	-	-	-	-
MH Screens for State Hospitals	-	-	-	-
Sub-TOTAL Grants	\$32,161,966	\$30,676,714	\$29,170,985	\$33,596,794
<i>Funding for Medicaid Recipients²</i>				
CMHS Direct Medicaid Payments	\$175,121,006	\$178,721,023	\$194,966,378	NA
Sub-TOTAL Medicaid	\$175,121,006	\$178,721,023	\$194,966,378	\$-
TOTAL CMHC Funding	\$207,282,972	\$209,397,737	\$224,137,363	\$33,596,794
Private Medicaid Practitioners				
Private Medicaid Practitioner Payments	\$11,322,641	\$13,946,458	\$13,953,658	NA
TOTAL Private Practitioner Funding	\$11,322,641	\$13,946,458	\$13,953,658	\$-
Non Categorized				
Medicaid MH Payments (Non-Inpatient)	NA	NA	NA	\$179,131,969
Mental Health Grants (Not CMHC specific)				
PATH & Interim Housing Grants	\$613,401	\$645,035	\$635,664	\$611,938
Clubhouse Model ³	-	-	-	-
Community Crisis Centers ^{4,5}	-	-	-	-
Grants/ Contracts for At-Risk Persons	1,803,565	3,543,649	2,554,691	3,510,436
MH Screens- uninsured	1,044,273	1,955,735	-	1,800,000
Facilitation Contracts Administration	8,986,833	10,650,750	10,073,609	13,772,634
Rainbow Services	-	-	-	-
Cooperative Agreement to Benefit Homeless	-	-	-	-
Supported Employment Grant	-	-	-	-
Intermediate & Transition Services	-	-	-	-
Systems of Care Grant	-	-	-	-
Total Mental Health Grants (Not CMHC specific)	\$12,448,072	\$16,795,169	\$13,263,964	\$19,695,008
Residential Treatment				
PRTFs	\$42,172,359	\$46,819,717	\$31,781,681	\$29,152,593
NFMHs	15,814,601	18,398,889	19,063,099	16,601,835
TOTAL Residential Treatment	\$57,986,960	\$65,218,606	\$50,844,780	\$45,754,428
State Mental Health Hospitals				
LSH	\$56,302,029	\$57,259,415	\$59,526,468	\$61,928,206
OSH	29,125,352	29,003,864	29,454,105	28,198,518
RMHF	8,753,096	8,592,205	8,436,211	6,993,578
TOTAL MH Hospitals	\$94,180,477	\$94,855,484	\$97,416,784	\$97,120,302
State Hospital Expenditures by KDADS				
Food Service Contract Expenditures ⁶	\$-	\$-	\$-	\$-
State Hospital Diversion Beds	-	-	-	-
Total State Hospital Expenditures by KDADS	\$-	\$-	\$-	\$-
Other Mental Health Funding				
Juvenile Crisis Centers ⁷	\$-	\$-	\$-	\$-
Health Homes ⁷	-	-	-	-
Medicaid Reinstatement Policy ⁷	-	-	-	-
Juvenile Transition Crisis Center Pilot ⁸	-	-	-	-
Mental Health Pilot Program ⁸	-	-	-	-
Total Other Mental Heal Funding	\$-	\$-	\$-	\$-
TOTAL MENTAL HEALTH SERVICES	\$383,221,122	\$400,213,454	\$399,616,549	\$375,298,501

Note: Capital improvements are not reflected in the above chart

HISTORY OF MENTAL HEALTH FUNDING

Community Mental Health Centers	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual
<i>Funding for Uninsured and Infrastructure</i>				
State Aid	\$10,233,297	\$10,233,297	\$10,233,297	\$10,233,297
Consolidated Grants ¹	10,890,993	10,890,993	10,890,995	10,890,993
Mental Health Block Grant	2,377,301	2,377,301	2,339,776	2,377,301
Federal Social Services Block Grant	-	-	-	-
Family Centered System of Care (CIF)	-	-	-	-
Grants for At-Risk Persons	10,006,703	10,006,703	10,006,700	10,006,703
MH Screens for State Hospitals	-	-	1,091,792	2,183,580
Sub-TOTAL Grants	\$33,508,294	\$33,508,294	\$34,562,560	\$35,691,874
<i>Funding for Medicaid Recipients²</i>				
CMHS Direct Medicaid Payments	NA	NA	NA	NA
Sub-TOTAL Medicaid	\$-	\$-	\$-	\$-
TOTAL CMHC Funding	\$33,508,294	\$33,508,294	\$34,562,560	\$35,691,874
Private Medicaid Practitioners				
Private Medicaid Practitioner Payments	NA	NA	NA	NA
TOTAL Private Practitioner Funding	\$-	\$-	\$-	\$-
Non Categorized				
Medicaid MH Payments (Non-Inpatient)	\$183,276,697	\$180,180,914	\$215,842,226	\$215,821,994
Mental Health Grants (Not CMHC specific)				
PATH & Interim Housing Grants	\$647,166	\$627,262	\$525,820	\$1,211,919
Clubhouse Model ³	-	-	-	-
Community Crisis Centers ^{4,5}	-	-	-	647,956
Grants/ Contracts for At-Risk Persons	3,346,087	5,707,445	3,058,838	1,910,112
MH Screens- uninsured	2,155,000	2,155,000	680,446	370,372
Facilitation Contracts Administration	11,120,847	9,031,384	6,194,248	2,283,341
Rainbow Services	-	3,211,061	3,576,100	3,576,100
Cooperative Agreement to Benefit Homeless	-	-	1,628,156	1,602,760
Supported Employment Grant	-	-	776,402	833,908
Intermediate & Transition Services	-	-	637,500	425,000
Systems of Care Grant	-	-	-	2,406,473
Total Mental Health Grants (Not CMHC specific)	\$17,269,100	\$20,732,152	\$17,077,510	\$15,267,941
Residential Treatment				
PRTFs	\$26,197,935	\$24,438,049	\$29,338,046	\$28,882,988
NFMHs	21,785,879	22,778,586	18,002,948	19,207,072
TOTAL Residential Treatment	\$47,983,814	\$47,216,635	\$47,340,994	\$48,090,060
State Mental Health Hospitals				
LSH	\$58,218,725	\$57,616,190	\$56,508,630	\$63,651,862
OSH	27,911,291	32,163,859	32,862,967	39,811,533
RMHF	3,656,270	-	-	-
TOTAL MH Hospitals	\$89,786,286	\$89,780,049	\$89,371,597	\$103,463,395
State Hospital Expenditures by KDADS				
Food Service Contract Expenditures ⁶	\$4,898,465	\$5,239,344	\$5,404,309	\$-
State Hospital Diversion Beds	-	700,000	4,011,629	3,000,000
Total State Hospital Expenditures by KDADS	\$4,898,465	\$5,939,344	\$9,415,938	\$3,000,000
Other Mental Health Funding				
Juvenile Crisis Centers ⁷	\$-	\$-	\$-	\$-
Health Homes ⁷	-	-	-	-
Medicaid Reinstatement Policy ⁷	-	-	-	-
Juvenile Transition Crisis Center Pilot ⁸	-	-	-	-
Mental Health Pilot Program ⁸	-	-	-	-
Total Other Mental Heal Funding	\$-	\$-	\$-	\$-
TOTAL MENTAL HEALTH SERVICES	\$376,722,656	\$377,357,388	\$413,610,825	\$421,335,264

Note: Capital improvements are not reflected in the above chart

HISTORY OF MENTAL HEALTH FUNDING

Community Mental Health Centers	FY 2018 Actual	FY 2019 Approved	FY 2019 Gov Rec	FY 2020 Gov Rec
<i>Funding for Uninsured and Infrastructure</i>				
State Aid	\$10,233,297	\$10,233,297	\$10,233,297	\$10,233,297
Consolidated Grants ¹	19,390,993	19,390,993	19,390,993	19,390,993
Mental Health Block Grant	2,038,342	2,038,342	2,038,342	2,038,342
Federal Social Services Block Grant	-	-	-	-
Family Centered System of Care (CIF)	-	-	-	-
Grants for At-Risk Persons	11,006,703	11,006,703	11,006,703	11,006,703
MH Screens for State Hospitals	2,183,580	2,183,580	2,183,580	2,183,580
Sub-TOTAL Grants	\$44,852,915	\$44,852,915	\$44,852,915	\$44,852,915
<i>Funding for Medicaid Recipients²</i>				
CMHS Direct Medicaid Payments	NA	NA	NA	NA
Sub-TOTAL Medicaid	\$-	\$-	\$-	\$-
TOTAL CMHC Funding	\$44,852,915	\$44,852,915	\$44,852,915	\$44,852,915
Private Medicaid Practitioners				
Private Medicaid Practitioner Payments	NA	NA	NA	NA
TOTAL Private Practitioner Funding	\$-	\$-	\$-	\$-
Non Categorized				
Medicaid MH Payments (Non-Inpatient)	\$217,980,214	\$220,160,016	\$226,699,422	\$228,966,417
Mental Health Grants (Not CMHC specific)				
PATH & Interim Housing Grants	\$1,091,140	\$1,036,947	\$1,258,034	\$1,258,034
Clubhouse Model ³	500,000	1,000,000	250,000	-
Community Crisis Centers ^{4,5}	1,885,000	4,885,000	2,610,000	1,885,000
Grants/ Contracts for At-Risk Persons	2,566,443	2,000,000	2,000,000	2,000,000
MH Screens- uninsured	370,372	370,372	370,372	370,372
Facilitation Contracts Administration	3,000,000	3,000,000	3,000,000	3,000,000
Rainbow Services	3,576,100	3,576,100	3,576,100	3,576,100
Cooperative Agreement to Benefit Homeless	1,694,298	1,706,673	925,694	-
Supported Employment Grant	813,414	857,226	161,550	-
Intermediate & Transition Services	1,000,000	3,355,000	3,355,000	3,355,000
Systems of Care Grant	2,449,350	2,618,040	1,865,034	1,812,759
Total Mental Health Grants (Not CMHC specific)	\$18,946,117	\$24,405,358	\$19,371,784	\$17,257,265
Residential Treatment				
PRTFs	\$29,171,818	\$29,463,536	\$30,338,691	\$30,642,078
NFMHs	19,399,143	19,593,134	19,789,065	19,986,956
TOTAL Residential Treatment	\$48,570,961	\$49,056,670	\$50,127,756	\$50,629,034
State Mental Health Hospitals				
LSH	\$66,584,618	\$69,605,400	\$70,751,860	\$69,990,380
OSH	41,497,812	41,432,401	42,993,572	42,324,890
RMHF	-	-	-	-
TOTAL MH Hospitals	\$108,082,430	\$111,037,801	\$113,745,432	\$112,315,270
State Hospital Expenditures by KDADS				
Food Service Contract Expenditures ⁶	\$-	\$-	\$-	\$-
State Hospital Diversion Beds	3,855,852	3,855,852	3,855,852	3,855,852
Total State Hospital Expenditures by KDADS	\$3,855,852	\$3,855,852	\$3,855,852	\$3,855,852
Other Mental Health Funding				
Juvenile Crisis Centers ⁷	\$-	\$6,000,000	\$500,000	\$2,000,000
Health Homes ⁷	-	2,500,000	1,250,000	2,500,000
Medicaid Reinstatement Policy ⁷	-	425,000	425,000	425,000
Juvenile Transition Crisis Center Pilot ⁸	-	300,000	300,000	300,000
Mental Health Pilot Program ⁸	-	10,000,000	7,953,886	7,953,886
Total Other Mental Heal Funding	\$-	\$19,225,000	\$10,428,886	\$13,178,886
TOTAL MENTAL HEALTH SERVICES	\$442,288,489	\$472,593,612	\$469,082,047	\$471,055,639

Note: Capital improvements are not reflected in the above chart

FOOTNOTES

¹ The 2012 Legislature restored \$1.8 million under Consolidated Grants for non-Medicaid MH screening in FY 2013 after it was eliminated for the single fiscal year of 2012.

² Beginning in FY 2012, the administration for the Mental Health Prepaid Ambulatory Health Plan (PAHP) (approx. \$12 million) is now included in the Medicaid Payment totals. It is not included in the Medicaid Payment totals in FY 2008-FY 2015.

³ 2018 HB 2194 provides funding for Clubhouse Model programs up to \$1.0 million in FY 2019 and up to \$2.0 million for FY 2020 through a transfer from the Kansas Lottery from vending machine revenue. In the Governor's Budget Report Vol. 1, page 49, the estimate for FY 2019 was revised to \$300,000. Due to a technical error, as of February 20, 2019, revenue and expenditures through these transfers is not included in the budget for the Kansas Department for Aging and Disability Services (KDADS) for both FY 2019 and FY 2020. Representatives from KDADS report the agency has included \$250,000 in funding for Clubhouse Model programs in FY 2019 and have requested \$1.0 million from the State General Fund to make up for a projected shortfall of lottery vending machine revenue. The Governor's recommendation does not include the additional \$1.0 million from the State General Fund to replace this revenue in FY 2019.

⁴ 2018 House Sub. for SB 109 included \$1,885,000 from the State General Fund for base Community Crisis Center funding for Comcare in Wichita (\$1.3 million), Valeo in Topeka (\$500,000), and a facility in Salina (\$85,000) in both FY 2018 and FY 2019. The Governor's recommendation for FY 2020 continues this level of funding from the State General Fund. 2018 HB 2194 provides funding for Community Crisis Centers up to \$3.0 million in FY 2019 and up to \$6.0 million for FY 2020 through a transfer from the Kansas Lottery from vending machine revenue. In the Governor's Budget Report Vol. 1, page 49, the estimate for FY 2019 was revised to \$1.2 million. Due to a technical error, as of February 20, 2019, revenue and expenditures through these transfers is not included in the budget for KDADS for both FY 2019 and FY 2020. This does not affect the State General Fund appropriation for Community Crisis Centers in FY 2019 and FY 2020.

⁵ The Governor's recommendation in FY 2019 includes \$1,885,000 from the State General Fund from line-item appropriations and \$725,000 from the State General Fund for Community Crisis Services in Pawnee from funding reappropriated from FY 2018 due to delayed implementation of other projects.

⁶ Facility food service contracts for state hospital patients are included in the budget for each hospital, aside from FY 2014-FY 2016 when these expenditures were included within the budget for the Kansas Department for Aging and Disability Services (KDADS).

⁷ Funding for these projects is included in the budget for the Kansas Department of Health and Environment (KDHE).

⁸ Funding for these projects is included in the budget for the Department of Education.

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