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October 29, 2020

To: Special Committee on Kansas Mental Health Modernization and Reform

From: Megan Leopold, Fiscal Analyst

Re: A Brief History of the Mental Health System in Kansas

THE HISTORY OF THE KANSAS MENTAL HEALTH SYSTEM

This document provides a brief history of the Kansas public mental health system, including information on mental health reform, institutional services, community-based services, financing, and closure of facilities. This memorandum does not address issues regarding specific populations, such as the elderly and youth involved in the child welfare system. A time line of events can be found at the end of the memorandum.

Shifting From Institutionalization to Community-Based Care

Kansas has provided institution-based services to mentally ill individuals since the late 1800s. Osawatomie State Hospital (OSH) opened in 1866; Topeka State Hospital opened in 1872; Larned State Hospital (LSH) began admitting patients in 1914; and Rainbow Mental Health Facility (Rainbow), originally a low-security unit at OSH, was established as a separate state institution by law in 1978. In 1954, approximately 4,500 patients were served in state institutions.

Beginning in the late 1950s and early 1960s, the concept of community-based mental health services began to gain support. In 1961, legislation was enacted to provide for the organization and local financial support for a system of local mental health agencies and placed responsibility for these centers under the Department of Social Welfare, the predecessor agency to the Department of Social and Rehabilitation Services (SRS), which preceded the current Kansas Department for Aging and Disability Services (KDADS). The 1961 legislation defined services to be provided, delineated the responsibilities of local governance, allowed counties to establish a mill levy to fund services, and allowed counties to create centers to cover a broader geographic or catchment area. State funding for community mental health centers began in 1974.

Funding for community-based services also shifted around this time with The Kansas Community Mental Health Centers Assistance Act (KSA 65-4431 *et seq.*). Originally enacted in 1987, this act created a State Aid Grant to fund community Mental Health Centers (CMHCs). The formula used to calculate the distribution was based on the local money that CMHCs were

able to raise and not on the amount of funding needed to provide services. The law governing the amount of the grant has not been changed since it was enacted, and thus, the State Aid amount for CMHCs has remained at approximately $10.2 million per year from the State General Fund (SGF). In turn, this amount and additional grants are certified by the CMHCs as match to draw down additional federal funding.

After the establishment of community-based services, institutions continued to consume a majority of state mental health service financing. A 1988 Legislative Division of Post Audit report indicated more than 75 percent of state funding for mental health services was going to support institutions. At that time, approximately 25 percent of patients admitted to state hospitals were first screened by a CMHC. The Kansas mental health system was criticized for having a high hospitalization rate compared to rates in other states and a lack of organization for determining who should be hospitalized. A national report, published in 1998, ranked Kansas 42nd among states in providing community-based mental health services.

Mental Health Reform Act (1990)
*(*KSA 39-1601 *et seq.*)

In response to the evolving desire to serve persons with mental illness in the community, Kansas' mental health care services system was studied by several joint and interim committees, the Legislative Division of Post Audit, and by a Governor's Commission on Mental Health Reform. Spurred by these efforts, the 1990 Legislature passed the Mental Health Reform Act, which became law. Among other things, the Act contains the following provisions (some of which are updated to reflect current regulatory oversight):

- Within the limits of appropriations, no person shall be inappropriately denied necessary mental health services from any CMHC or state psychiatric institution.

- Kansas residents in need of mental health services are to receive the least restrictive treatment and most appropriate community-based care through coordinated utilization of the existing network of CMHCs and state hospitals.

- Funds from the State are to follow clients from state facilities into community programs as more people are treated in the community and diverted from state hospitals.

- The Secretary for Aging and Disability Services (Secretary), KDADS, (originally, the Secretary for Social and Rehabilitation Services) is directed to oversee the establishment of standards for providing community-based mental health services, assure the establishment of specialized programs, monitor the establishment and continuing operation of community-based services, and adopt rules and regulations to ensure the protection of people receiving mental health services.

- The Secretary is to review and approve an annual coordinated services plan for each CMHC, and withhold state funds from any center not being administered in accordance with the provisions of its annual plan.

- The Act provides for participation by service consumers, their families, and advocates in the planning and delivery of services.

These community-based services are to be provided for a "targeted population," which is defined as the group determined to be most in need of mental health services funded by state or other public moneys. The targeted population, defined in KSA 39-1602(a), includes adults with severe and persistent mental illness, severely emotionally disturbed children and adolescents, and other individuals at risk of requiring institutional care.

The Act specifies the Secretary is to enter into contracts with CMHCs to ensure each area of the state has a participating center. These participating centers act as the entry point for admission into the state mental health hospital system through the use of a screening process. "Screening" means the process performed by CMHC personnel to determine whether a person, under either voluntary or involuntary procedures, can be evaluated or treated in the community, or should be referred to the appropriate state psychiatric hospital for evaluation and treatment.

The Mental Health Reform Act established a financing plan that provided for the development services needed to serve people in the community. The plan assumed base expenditures and included inflationary adjustments to the base funding of 5.0 percent each fiscal year (FY) through FY 1997, when the Act would be fully implemented. Funding was intended to support both the entry point and screening functions of CMHCs as well as the community-based services provided. Total costs anticipated in the original financing plan were $18.7 million from the SGF in FY 1997.

This legislation represented a significant shift in the role CMHCs and state institutions played in the overall mental health system. Over the years following enactment of mental health reform in Kansas, CMHCs shifted from providing preventative short-term treatment and screening for entry into the state mental health hospital system toward providing more costly, public long-term treatment and care. As the number of patients with mental health conditions treated in community settings rose, the need for state hospital beds decreased. Through a series of initiatives to decrease these hospital beds over the course of two decades, the number of patients seeking services through community-based mental health providers increased 222.0 percent between 1990 and 1996 as the average state hospital census declined by 50.0 percent.

The Role of State Hospitals

Although mental health reform was designed to support people with mental illness in the community, it did not end the important role the state mental health hospitals serve to persons experiencing serious symptoms of severe mental illness. In this role, the hospitals continue to be an integral part of the mental health system. Generally, persons who have been determined to be a danger to themselves or others are referred to state mental health hospitals. The Care and Treatment Act for Mentally Ill Persons, (KSA 59-2945 *et seq.*) provides definitions and guidance for admission to the state hospitals. These individuals generally exhibit symptoms that community providers cannot treat safely and effectively. Once severe symptoms are stabilized, the individuals can successfully return home with support provided by their community-based mental health centers. The state mental health hospitals also serve prisoners needing inpatient mental health treatment and persons committed as violent sexual predators. In addition, state hospitals complete mental health evaluations on persons referred by the courts.

State Hospital Closures

In addition to establishing a coordinated system of care, the Mental Health Reform Act also contains provisions requiring the reduction in capacity at the state hospitals. This reduction was designed as a phased program to happen between 1991 through 1996 and corresponded to the Osawatomie, Topeka, and Larned catchment areas. As more community services were developed in each catchment area, the Act specified a quantity of beds to be eliminated at each state hospital. The reductions in capacity were completed in October 1995 with the closure of the final 30 beds at LSH.

The additional closures of one 34-bed ward within the Special Security Program at LSH and one 30-bed ward at OSH, effective September 18, 1995, were not bed reductions specified in the Mental Health Reform Act. Both of these closures were in response to lower-than-anticipated average daily census figures.

The downsizing of state hospitals under the Mental Health Reform Act created pressure to close a State hospital and shift the funding into community-based services. A 1992 report prepared by SRS studied the feasibility of closing a mental health institution. In the report, the agency concluded a hospital could be closed, provided that adequate, accessible, and appropriate community services were in place; safeguards were in place to protect the economy of the affected community; and safeguards were in place to protect state finances from the loss of federal disproportionate share hospital (DSH) funding. Additionally, the report concluded that community-based services were not consistently available in all parts of the state.

The 1995 Legislature created the Hospital Closure Commission. The 11-member Closure Commission (with 7 members appointed by the Governor and 4 appointed by legislative leadership) was required to submit recommendations to the Governor by December 1, 1995, for the closure of both a mental retardation hospital and a mental health institution, or recommend that no institution be closed. The language specified the types of recommendations to be made and the factors to considered. Finally, the legislation specified that the recommendation would become effective if not rejected by the Legislature before the 45th day of the session. The Closure Commission recommended Winfield State Hospital and Training Center and Topeka State Hospital be closed. The decision was accepted by the 1996 Legislature. Topeka State Hospital closed in 1997, and Winfield State Hospital and Training Center was closed in 1998.

Future of Kansas Mental Health Hospitals Report

The Future of Kansas Mental Health Hospitals Report, released in December 2003, was the result of the work of an SRS steering committee and the culmination of an effort begun in 1999 to work with mental health system stakeholders. The report confirmed the value of state hospitals to the array of mental health services and concluded that, at that time, there was no room for additional capacity reductions at the state hospitals. Additionally, the report stated any future reductions at the hospitals should occur only with planning and input from all affected stakeholders and implementation of capacity building plans in communities impacted by the reductions. The report went on to recommend short- and long-term strategies to stabilize community-based services and explore new public/private partnerships to deliver acute care services.

Facilities Closure and Realignment Commission

During the 2009 Legislative Session, the Governor created the Facilities Closure and Realignment Commission by Executive Order 09-01. The Commission was charged to study and evaluate closure, realignment, and alternative uses of various state facilities in order to find efficiencies and cost savings in state government. Specifically, the Commission was directed to study the Kansas State School for the Deaf, Kansas State School for the Blind, the Beloit Juvenile Correctional Facility, the state developmental disability hospitals, and Rainbow. The Executive Order required the Commission to submit recommendations regarding these and any other facilities studied to the Governor and the Legislature.

The Commission recommended Rainbow be kept open and functioning. Further, the pursuit of public/private partnership with community hospitals was recommended with an integrated health model, inclusive of CMHCs, as well as moving toward the closure of state hospitals.

Rainbow Mental Health Facility

At the time the Facilities Closure and Realignment Commission created its recommendation to keep Rainbow open, the facility had already been through some significant changes. In FY 2001, administrative services for Rainbow were consolidated with OSH with the result that the two hospitals shared an administrative team, including the superintendent and other managers, who oversaw both facilities. In FY 2008, Rainbow ceased treatment of adolescents and children. Until June 2007, Rainbow provided treatment to children and adolescents with serious emotional disturbances. Beginning July 2007, Kaw Valley Behavioral Healthcare, Inc. (KVC) began serving the youth who would have otherwise been referred to Rainbow.

In 2009, as part of a submitted 10.0 percent reduced resources option prepared at the direction of the Senate Ways and Means Committee, SRS included the closure of the Inpatient Psychiatric Treatment Unit for Youth located on the LSH campus. These services were contracted out to KVC, which began operating in spring 2010 in Hays, Kansas.

Closure of Rainbow

In December 2010, the federal Centers for Medicare and Medicaid Services (CMS) completed a survey of Rainbow in Kansas City and asserted that some units required staffing beyond what the hospital was able to provide. Corrective action alternative plans submitted by the agency were rejected by CMS, and, as a result, these units were closed in March 2011, reducing the licensed census from 50 to 36 patients. LSH opened 11 additional beds, resulting in an overall reduction of 3 beds in the state mental health hospital system and a shift to the catchment areas for the mental health hospitals.

On November 9, 2011, safety code violations necessitated the move of Rainbow patients from their treatment environment in Kansas City to OSH. A 6-bed Admissions and Evaluation Center remained at the location in Kansas City to serve as the primary arrival point for new patients, however, any patients requiring treatment likely to take more than 4 days were taken to OSH, where a 30-bed wing was opened until safety and security renovations were completed at Rainbow.

The 2012 Legislature approved funding for repairs and renovation of Rainbow that would allow it to return to a capacity of 50 beds; however, the 2013 Legislature concurred with the recommendation of the Governor to combine the operations of OSH and Rainbow into one agency to eliminate redundancies in one management team operating two separate agencies. The 2014 Legislature transferred Rainbow's finances and full-time equivalent positions to OSH as part of the closure of Rainbow. The Legislature also enabled KDADS to begin the process of selling the Rainbow property to the University of Kansas Medical Center or the Kansas University Endowment Association at the discretion of the University of Kansas Chancellor.

Hospital Capacity

During May 2010 and July 2010, SRS temporarily suspended voluntary admissions to the three Kansas mental health hospitals. According to the Department, all three facilities were full beyond licensed capacities, and the agency did not have additional resources to serve persons seeking voluntary admissions. The hospitals continued to accept people ordered to the facilities by the courts or escorted by police, but voluntary admissions required a referral by one of the state's 27 CMHCs. When the hospitals were full, the CMHCs were expected to find placement alternatives for people who otherwise would be admitted.

In 2014, OSH began having supply issues when total yearly admissions reached a high of 2,684 patients for its 206 licensed beds. That year, the daily census sometimes exceeded 250 patients. Running over maximum capacity led to a series of inspections that identified issues both with care and the facility itself. Under pressure to renovate and provide better care, OSH management suspended voluntary admissions, created waiting lists, and reduced bed capacity to 146 beds.

In December 2015, OSH was decertified for federal reimbursements by CMS. Since January 2016, the hospital has been unable to obtain federal revenue through Medicare and Medicaid reimbursements and federal DSH payments for at least a portion of its beds. OSH responded to the surveys by making structural changes to improve patient safety, increasing staffing levels, and instituting new operating practices. In August 2016, two living units were functionally separated from OSH to form Adair Acute Care (AAC). AAC is considered a functionally free-standing unit, though it is included in the overall total of licensed OSH beds. AAC passed its initial CMS certification survey in August 2017 and a second survey in November 2017. In December 2017, OSH was informed by CMS that the 60 beds of AAC were recertified for federal reimbursements and the hospital would begin to receive partial DSH payments. The moratorium on voluntary admissions was left in place.

In 2019, the current Secretary for Aging and Disability Services created the State Hospital Commission to provide leadership, guidance, direction, oversight, and training and support to the state hospitals. This entity is tasked with ensuring compliance with state and federal laws, including conditions for certification with CMS and state license requirements, and has the goal of creating a plan to lift the OSH moratorium.

Nursing Facilities for Mental Health (NFMH)

Nursing facilities for mental health (NFMHs) provide out-of-home residential care and treatment for persons experiencing severe symptoms of mental illness. Persons seeking placement in NFMHs are screened to determine whether their needs can be met with community-based services before their admission to the NFMHs is authorized. To comply with

the 1999 U.S. Supreme Court *Olmstead* decision, and a Kansas 2002 legislative proviso, CMHCs began administering annual screenings for continued stays in fall 2002.

NFMHs are classified by CMS as institutions for mental disease (IMDs). CMS does not allow payment of Federal Financial Participation (FFP) to IMDs for persons between 22 and 64 years of age. Public payment for persons in this age range is funded entirely through the SGF. NFMH facilities have experienced an increase in the number of people not eligible for FFP, creating a need for additional state funds.

In May 2005, one NFMH, Gatewood Care Center, closed. Some of the persons served by this facility were moved to community-based services. Funds needed to support those persons successfully in community-based services were moved from the NFMH budget to community-based services grants so persons losing NFMH services would continue to receive the services they need in the community.

In 2011, as state hospitals operated at or above capacity, NFMHs faced similar challenges. With 11 facilities and 716 beds across the state, NFMHs began reporting that they too were operating at or above capacity, requiring many individuals to be placed on waiting lists. In addition, programs were voicing the challenges of continuing to provide quality services while experiencing budget cuts. In 2018, the number of active NFMHs dropped to ten, where it remains in 2020.

Psychiatric Residential Treatment Facilities (PRTFs)

Rainbow and LSH ceased treatment of children and adolescents in 2008 and 2010, respectively. These service gaps were filled by psychiatric residential treatment facilities (PRTFs). PRTFs are licensed facilities that provide comprehensive mental health inpatient treatment for youth who cannot otherwise be served safely and effectively in a less-restrictive environment. Youth are screened by CMHCs to determine the medical necessity for this level of care, and treatment is uniquely designed to support reintegration to family and community living environments utilizing coordinated care support systems and community-based services.

In spring 2011, utilization of PRTFs dropped in response to increased utilization review efforts, as did the number of PRTFs in Kansas. There are currently 8 such facilities in Kansas while, in 2011, there were 17.

Community Mental Health

Community Mental Health Centers

CMHCs are the single point of entry for publicly funded mental health services and serve as a safety net for Kansas citizens. CMHCs are created by county commissioners, which have a role in determining the governing structure for the center and providing financial support, including mill levies. CMHCs are required to provide services to persons with mental illness regardless of their ability to pay. All CMHCs are licensed by KDADS and must meet Medicaid and Medicare standards.

Target populations served by CMHCs, as designated by the Mental Health Reform Act, include adults with severe and persistent mental illness (SPMI) and children with serious emotional disturbance (SED). Centers also provide services to anyone experiencing a mental health crisis, and non-target populations, such as individuals with non-SED and non-SPMI. These are individuals who experience mental health problems but who continue to function and do not have a brain disorder or mental illness. Issues being dealt with by this population may be anxiety, depression, reactions to job losses, deaths of family or friends, and addictions. Services most accessed by this population, referred to as traditional services, include individual and group therapies, medication evaluation and management, and crisis intervention.

Waiver for Children with Serious Emotional Disturbance

CMHCs provide services to children eligible for the Medicaid Home and Community-Based Services (HCBS) Waiver for Children with SED. Waiver services are available to children with SED and who are financially eligible and meet the admission criteria for a state mental health hospital. Parental income is not considered when determining financial eligibility, which allows children to access services that would not otherwise be available due to family income. Services provided through the waiver include wrap-around facilitation and community support, independent living and skill building services, parent support and training, and respite care. Other services, such as case management and attendant care, are available to children through the regular Medicaid program. A quality assurance process provides utilization review, authorization of care plan, annual eligibility evaluation, and a complaint and grievance process. In FY 2005, an average of 1,940 persons were served each month at an average monthly cost of $881,338. In 2020, this had increased to an average of 3,110 persons served each month and an average monthly cost of $5.5 million.

Other Community Supports

Although the CMHCs coordinate and provide a majority of services in the community, other organizations may provide services that enhance and complement CMHC services. Consumer-run organizations (CROs) are primary providers of such services. CROs provide a variety of opportunities for people with mental illness to participate in their own treatment programs, a goal of Mental Health Reform. Opportunities can include short-term living quarters, educational and vocational services, social support, and help with organization and management. Consumers can participate in peer counseling and may participate in speakers bureaus that help educate the public about mental illness.

Regional mental health crisis services are another type of service that work alongside CMHCs. These centers, which are designed to provide short-term stabilization services, provide an increased opportunity for individuals to receive the services they need while remaining in their community. In 2017, there were three centers across the state (Rainbow Services Inc. in Kansas City, Valeo Behavioral Health Care in Topeka, and COMCARE in Wichita), but KDADS has recently added contracts in Salina and Manhattan. These centers provide services such as 24-hour assessment and triage for individuals experiencing a mental health crisis, crisis observation, and short-term crisis stabilization for adults.

Efforts to Increase Accessibility

Mental Health Parity Act

Federal Law

The federal Mental Health Parity Act (MHPA) was enacted in 1996. The law applies to fully insured group health plans and self-insured group health plans. The MHPA prohibits these groups from imposing less favorable benefit limitations on mental health benefits than those applicable to medical or surgical benefits. The MHPA included an exemption to certain requirements of the MHPA for health plans that demonstrated costs would increase at least 1.0 percent as a result of compliance. The MHPA does mandate mental health coverage but applies only to plans that offer mental health benefits.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). The MHPAEA preserves the MHPA protections and adds new protections. The enacted MHPAEA also applies to large group health plans and includes the cost exemption; however, new limitations were imposed on the exemption. The MHPAEA prohibits differences in treatment limits, cost-sharing, and in-and out-of-network coverage. The MHPAEA extends applicability to the treatment of substance use disorders. The Patient Protection and Affordable Care Act (ACA) [2010] defines coverage of mental health and substance use treatment as one of the ten essential health benefits, meaning all health insurance plans in the individual and small-employer marketplaces must include mental health and substance use disorder coverage, and this coverage must abide by MHPAEA requirements. The MHPAEA also applies to Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid-managed care plans, and state Children's Health Insurance Plans.

State Law

Since 1977, Kansas has mandated a level of insurance parity, beginning with mandating certain health insurance policies provide the same level of reimbursement or indemnity to covered individuals for alcoholism treatment if the health insurance policy provided reimbursement or indemnity to an individual in a medical care facility. Through the years, this law was expanded to include substance abuse treatment and other health insurance policies and in 1996 was expanded to require the Kansas State Employees Health Care Benefits Program to abide by the parity mandate.

In 2000, the Mental Health System Task Force (Task Force) convened and provided recommendations to the 2001 Legislature. Included in the recommendations concerning the mental health delivery system, the Task Force recommended the 2001 Legislature introduce legislation mandating mental health parity in all health insurance policies. The recommendation noted the legislation should be exempt from the provisions of current law requiring that mandates be tested on state employees first due to the fact that parity has been provided to state employees for a number of years. In response, the 2001 Legislature passed Senate Sub. for HB 2033, which requires any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical services corporation contract, or fraternal benefit society or health maintenance organization that provides coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after January 1, 2002, to include coverage for diagnosis and treatment of mental illnesses. This

coverage requires annual coverage for both 45 days of inpatient care for mental illness and for 45 days for outpatient care for mental illness.

In 2009, Kansas enacted The Kansas Mental Health Parity Act (KMHPA) [KSA 40-2,105a *et seq*.]. This act states any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides medical, or surgical or hospital expense coverage shall include coverage for diagnosis and treatment of mental health illnesses and alcoholism, drug abuse, or other substance use disorders. Such coverage shall be subject to the same deductibles, co-payments, co-insurance, out-of-pocket expenses, treatment limitations, and other limitations as apply to other covered services. Treatment includes inpatient care and outpatient care for mental illness, alcoholism, drug abuse, or substance use disorders. Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

Increased Scope of Practice

In the past decade, several professions in the field of mental health have seen shifts in their scopes of practice that alter the requirements for licensure and the associated capabilities. In general, these changes allow professionals to more easily reach a wider range of individuals experiencing mental illness and substance use disorders.

Addiction Counselors

HB 2615 (2016) created a new category of licensure for master's level addiction counselors, who engage in the practice of addiction counseling limited to substance use disorders. HB 2615 also eliminated the requirement that master's addiction counselors practice only in a facility licensed by KDADS. HB 2615 also grandfathered in credentialed or registered alcohol and other drug counselors who complied with specific requirements prior to July 1, 2017.

Mental Health Technicians

HB 2025 (2017) amended the Mental Health Technician's Licensure Act to change the description of services in the definition of "practice of mental health technology" by deleting "responsible nursing for patients with mental illness or intellectual disability" and inserting "participation and provision of input into the development of person-centered treatment plans for individuals or groups of individuals specified in paragraph (b)" (those specified in paragraph (b) are "the mentally ill, emotionally disturbed, or people with intellectual disability") and including facilitating habitation of individuals. The bill also replaced the term "patient" with "individual."

Professional Counselors

SB 386 (2018) amended the Professional Counselors Licensure Act with regard to educational requirements for licensure as a professional counselor. The bill allowed licensure for an applicant who earned a graduate degree in a counseling-related field if the remaining qualifications set forth in statute are met.

Psychiatrists

HB 2615 (2016) also provided for a temporary license, not to exceed two years, to be issued to persons who have completed all requirements for a doctoral degree approved by the Behavioral Science Regulatory Board (BSRB), but have not received such degree conferral, and who provide documentation of such complication.

Social Workers

SB 15 (2019), as it pertains to social workers, provided for licensure by reciprocity for social workers at the baccalaureate, master's, and specialist clinical levels; provided for provisional licenses for applicants deficient in the qualification or in the quality of educational experience required for licensure to allow the applicants time to fulfill remedial or other requirements prescribed by the BSRB. It also amended licensure requirements for a specialist clinical social worker by reducing the number of postgraduate supervised experiences required to 3,000 hours and the number of hours of clinical supervision to not less than 100 hours.

Funding for Community-Based Mental Health Services

Mental health services in the community are funded through a variety of sources. In addition to state and federal funding, CMHCs receive local funds, insurance payments, payments directly from clients, and charitable donations.

Medicaid

The largest source of state funding for community-based mental health services comes from Medicaid. During 2000, SRS and the CMHCs met to review options for funding improvements in the community mental health system. This effort, called Mental Health Initiative 2000, was designed to address gaps in the system around crisis supports, access to care, and accountability. Integral to the goals established around these three areas were changes in the financing structure to increase funding to the CMHCs. The group was able to successfully increase Medicaid reimbursement rates to increase federal dollars for the CMHCs.

In 2012, after Executive Reorganization Order No. 41 established KDADS, Kansas submitted a Section 1115 waiver to CMS to implement KanCare, a Medicaid reform initiative that included the implementation of managed care contracts for all medical programs and services. KanCare manages the Medicaid-funded Community Mental Health Services. The three KanCare managed care organizations (MCOs) contract with a variety of community mental health providers that include CMHCs and other private mental health practitioners to provide Medicaid-funded mental health services throughout the state. The MCOs are responsible for ensuring persons with mental illness who are Medicaid eligible receive a comprehensive array of timely, quality, accessible, and effective mental health services in all areas of the state.

In order to maximize federal Medicaid funding, CMHCs are paid through a certified match process. In this process, CMHCs certify grant funding received from the State as part of the state match for Medicaid. Certified match funds are then used for services provided to those children with a SED, children referred to CMHCs by Children and Family Services contractors, and all other children and adults who are Medicaid eligible. Services covered by Medicaid include Targeted Case Management, Comprehensive Medication Services, Personal Care

Services, Pre-admission Screens, Activity Therapy, Group and Individual Psychotherapy, Training and Educational Services, Crisis Intervention, Community Transition, and Respite Care.

Local Funding

In addition to state funding, CMHCs receive county support through mill levies and other taxes. Counties are allowed to levy up to two mills to support mental health services. Some counties do not have specific levies for mental health services, but do provide mental health funding through general levies and taxes. In some counties, CMHCs also receive funding through taxes on liquor by the drink to support mental health and addiction services. Other community-based grant and contract funding includes those for CROs, homelessness, corrections, peer-to-peer services, data development, alternate care, children's crisis, consumer advocates, transitional housing, and other miscellaneous grants.

Funding for State Institutions

The state hospitals are primarily funded through three basic sources. The first is the SGF, which consists primarily of money collected through various statewide taxes. The second is each hospital's fee fund, which includes collections from Medicare, private payments, Social Security, and insurance. The third source is federal Title XIX funding, also known as Medicaid. The federal Title XIX funding is transferred to the KDADS central pool and is redistributed among the four state hospitals. The two state developmental disabilities hospitals, the Kansas Neurological Institute and Parsons State Hospital and Training Center, are Medicaid certified as intermediate care facilities for persons with developmental disabilities, and nearly all of the people living in the facilities are covered by Medicaid. These state hospitals submit annual cost reports that establish *per diem* rates they charge to Medicaid for each day a person covered by Medicaid lives in the facility. The state mental health hospitals (LSH and OSH) establish *per diem* rates in much the same way as the state developmental disabilities hospitals, but are classified as institutions for mental disease. Due to federal rules, most state mental health hospital patients are not eligible for standard Medicaid match, but these hospitals are eligible for Medicaid payments through the DSH program. This program assists all acute care hospitals that serve a disproportionately high number of indigent persons. Kansas is currently pursuing a waiver to the federal rule prohibiting a Medicaid match for institutions for mental disease. In addition, Congress is currently considering changes to federal laws that may allow funding for short periods in cases where a mental impairment is combined with an opioid use disorder.

TIMELINE

1866 – Osawatomie State Hospital opened

1872 – Topeka State Hospital opened

1914 – Larned State Hospital began accepting patients

1954 – An average of approximately 4,500 patients were served in state institutions

1961 – Legislation passed providing for the organization and local financial support for a system of local mental health agencies overseen by the Department of Social Welfare

1974 – Department of Social and Rehabilitation Services created; state aid to community mental health centers (CMHCs) began

1978 – Rainbow Mental Health Facility became an independent institution

1987 – The Kansas Community Mental Health Centers Assistance Act (KSA 65-4431 *et seq.*) was enacted

1988 – A Legislative Division of Post Audit report indicated more than 75 percent of state funding for mental health services was going to support institutions

1990 – Kansas enacted the Mental Health Reform Act

1990 – Number of state hospital beds was approximately 1,000

1995 – The downsizing specified by the Mental Health Reform Act was completed and additional beds were eliminated in response to lower-than-anticipated average daily census figures

1995 – The Legislature created the 11-member Hospital Closure Commission, which recommended Winfield State Hospital and Training Center and Topeka State Hospital be closed

1996 – The Legislature accepted the Commission decision to close the hospitals

1997 – Topeka State Hospital closed

1998 – Winfield State Hospital closed

1998 – A national report ranked Kansas 42nd among states in providing community-based mental health services

2000 – The Mental Health System Task Force, directed by 2000 SR 1849, convened and provided recommendations to the 2001 Legislature

2001 – Administrative services for Rainbow Mental Health Facility were consolidated with Osawatomie State Hospital (OSH)

2002 – CMHCs began administering annual screenings for continued stays in nursing facilities for mental health

2003 – The Future of Kansas Mental Health Hospitals Report concluded there was no room for additional capacity reductions at the State hospitals

2007 – Rainbow Mental Health Facility ceased treatment of children and adolescents, transferring these services to Kaw Valley Behavioral Healthcare, Inc (KVC)

2009 – Kansas enacted the Kansas Mental Health Parity Act in response to 2008 federal law [KSA 40-2,105]

2009 – The Governor created the Facilities Closure and Realignment Commission by Executive Order 09-01

2010 – Larned closed its inpatient unit for youth and contracted services out to KVC in Hays, Kansas

2010 – Voluntary admissions suspended for May and July due to capacity concerns at state hospitals

2011 – Rainbow Mental Health Facility stopped accepting patients who would require long-term treatment, and Osawatomie State Hospital expanded bed capacity to fill the additional need

2012 – Executive Reorganization Order No. 41 established the Kansas Department for Aging and Disability Services

2013 – KanCare is implemented

2013 – Governor recommended Rainbow Mental Health Facility be combined with Osawatomie State Hospital

2014 – Rainbow Mental Health Facility closed and sold to the University of Kansas

2014 – Osawatomie State Hospital management suspended voluntary admissions, created waiting lists, and reduced capacity to 146 beds under pressure to renovate and provide better care

2016 – Osawatomie State Hospital decertified by the federal Centers for Medicare and Medicaid Services (CMS)

2017 – CMS recertifies 60 beds in the Adair Acute Care unit of Osawatomie State Hospital

2019 – State Hospital Commission created by Secretary for Aging and Disability Services Laura Howard