Approved: February 15, 2011
Date

MINUTES OF THE HOUSE AGING & LONG-TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 9:05 a.m. on January 18, 2011, in Room 144-S of the Capitol.

All members were present except:
Representative Bill Otto- absent
Representative Scott Schwab- absent

Committee staff present:
Katherine McBride, Office of Revisor of Statutes
Gordon Self, Office of Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Craig Callahan, Kansas Legislative Research Department
Estelle Montgomery, Fiscal, Legislative Research Department
Linda Martin, Committee Assistant

Conferees appearing before the Committee:

Bill Rein, Acting Secretary on Aging, KDOA
David Halferty, Director Nursing Facility & PACE, KDOA
Michael Hammond, CMHCS of Kansas
Cathy Harding, Ks. Assoc. of Medically Underserved (KAMU)
Cindy Luxem, KHCA
Carolyn Smith & Bruce Witt, Via Christi Health in Wichita
David Wilson, President, AARP

Others attending:
See attached list.

Chairman Bethell asked each of the Committee members and the staff to introduce themselves.

Following these introductions, Chairman Bethell called on the presentors to introduce themselves and to give an overview of their organization/agency. Those speaking today were:

Bill Rein, Acting Secretary on Aging, KDOA (Attachment 1)

David Halferty, Director Nursing Facility & PACE, KDOA (Attachment 1)

Michael Hammond, CMHCS of Kansas (Attachment 2)

Justin Loewen, CEO, Via Christi Hope & Bruce Witt, Via Christi Health in Wichita (Attachment 3)

Cathy Harding, Ks. Assoc. of Medically Underserved (KAMU) (Attachment 4)

Cindy Luxem, KHCA (Attachment 5)

David Wilson, President, AARP (Attachment 6)

Chairman Bethell stated that two bills were being introduced at the request of The Silver Haired Legislature:

1. Enacting geriatric mental health act & establishing a mental health program administered by KDOA.
2. Dept. on Aging setting up a service fund for disposition of lottery proceeds.

Minutes of the House Aging and Long-Term Care Committee at 9:00 a.m. on January 18, 2011, in Room 1441-S of the Capitol.

Representative Worley moved that the committee introduce the two bills. Representative Hill seconded. The motion was carried unanimously.

Chairman Bethell introduced his new intern, Daniel Goodwin.

The committee rules and information for conferees were distributed. (Attachment 7)

The next meeting is scheduled for January 20, 2011.

The meeting was adjourned at 10:32 a.m.

PLEASE CONTINUE TO ROUTE TO NEXT GUEST

HOUSE AGING & LONG-TERM CARE COMMITTEE GUEST LIST

DATE: Jan 18, 2011

NAME	REPRESENTING
Paje Routhier	Hein Law Firm
Bruce Wilk	Via Christ Health
TED Henry	CAPITOL STRATEGIES
Mike Oxford	Topeka Independent Living Resource Center
Daniel Goodwin	Intern for Rep Bethell

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Bill Rein, Acting Secretary

Department on Aging

Sam Brownback, Governor

House Committee on Aging and Long-Term Care
January 18, 2011

Update regarding the
Nursing Quality Care Assessment

Dave Halferty, Director
Nursing Facility and PACE Division

Current Status

The Quality Care Assessment (QCA) is currently under review by the Centers for Medicare and Medicaid Services (CMS). The review period was extended an additional 90 days, to February 15, 2011, when CMS sent the State a request for additional information in November. CMS regional office staff has indicated the provider tax complies with federal laws and they have also said the related state plan amendment is in order. Once the assessment is approved it will be retroactive to July 1, 2010.

Kansas Administrative Regulation 129-10-31 was written to specify several provisions of the quality care assessment that were left for the agency to determine. It defines the precise assessment rates, the registration date for continuing care retirement communities (CCRC), and thresholds for small homes and high Medicaid homes.

Provisions of the Bill

The QCA allows for a per bed assessment of up to $1,950 on all licensed nursing facility beds. It states that the assessment rate for CCRC, small homes, and high Medicaid homes will not exceed 1/6 of the general rate.

The legislation also prescribes how the QCA funds will be used. First, Medicaid nursing facility rates are to be reestablished using current cost data and inflation. Second, the 10% cut implemented between January 1, 2010 and June 30, 2010 for Medicaid nursing facility providers is to be paid back. Third, the Medicaid share of the QCA is to be passed through to providers. There are also provisions to eliminate the private pay limit from the nursing facility reimbursement methodology, and to sunset the QCA after four years.

Licensed Bed Assessment

There will be two assessment rates. A general rate of $1,500 per bed per year will apply to most providers. Small nursing homes, high Medicaid nursing homes, and CCRC providers will pay a rate of $250 per bed per year. Small nursing homes will be those homes with less than 46 licensed beds. High Medicaid homes will be those that provide 25,000 or more Medicaid days of service per year. CCRC providers will be those that were registered as continuing care providers with the Kansas Insurance Department as of July 1, 2010. The Kansas Soldiers Home and the

HOUSE AGING & LTC

DATE: 01/18/11

ATTACHMENT # 1

Kansas Veterans Home will be exempt from the assessment. The estimated revenue from the assessment is $23.1 million.

Reimbursement Rate Changes for FY 2011
Several changes will be made to nursing facility rates using the QCA funds. The cost data used to determine rates will be updated to 2007-2009. Cost data will be inflated to December 31, 2010. The Direct Health Care cost center limit will be increased to 130% of the median cost. The Incentive Factor add-ons will be increased 150%. There will be no limit imposed based on private pay rates. Transition rates will be used to ensure that each provider realizes at least a 3.22% increase in their rate.

10% Cut Payback
The QCA provides for the payout of the 10% cut that was imposed between January 1, 2010 and June 30, 2010. The amount that was cut from each nursing facility provider's payments will be paid out in installments relative to the share of each home's provider assessment that has been paid.

Pass-Through of Medicaid Share of Assessment
The legislation made the QCA an allowable expense and included a provision to pass-through the Medicaid share of this new expense. The Medicaid share will be determined by multiplying each home's assessment payment by that home's Medicaid occupancy percentage.

Provider Impact
Most nursing homes will receive a net gain from the provider assessment and related reimbursement changes, but some will have a net loss. Of the 344 licensed nursing homes in Kansas, 324 will have a net gain averaging $135,000. There will be 19 nursing homes that will have a net loss averaging $31,000. One home will have a no impact.

Program Impact
The QCA will have a significant impact on the nursing home program overall. Approximately $34.2 million will be expended to rebase and inflate rates. Another $19.2 million will be used to pay out the 10% cut. About $12.9 million more will be paid to pass-through the Medicaid share of the provider assessment. An additional $130,000 is allotted for agency administration. The total increase in program expenditures is estimated to be $66.4 million with a net increase to providers of $43.2 million.

Quality Care Assessment Panel
Another provision of the QCA is the creation of the Quality Care Assessment Panel. This panel of eleven stakeholders will make recommendations on how the QCA funds should be expended. The panel includes two persons to be appointed by each of the nursing facility trade associations; the Kansas Association of Homes and Service for the Aging, and the Kansas Health Care Association. It includes one person appointed by each of the following entities; the Kansas Advocates for Better Care, the Kansas Foundation for Medical Care, and the Kansas Hospital Association. The panel also includes one person appointed by the Governor to represent each of the following groups; the Kansas Adult Care Executives, the Kansas Department on Aging (non-voting), the Kansas Health Policy Authority (non-voting), and residents/family members.

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Sam Brownback, Governor

Aging and Long Term Care Committee

January 18, 2011

Acting Secretary Bill Rein
Kansas Department on Aging

Mr. Chairman and members of the committee, thank you for the invitation to provide an update of the 'Nursing Facilities Provider Assessment'.

My name is Bill Rein and I am Acting Secretary of the Kansas Department on Aging. I will only serve as Acting Secretary until Secretary-Nominee Shawn Sullivan will assume his duties on January 24, 2011.

Mr. Bill McDaniel, Commissioner of Program and Policy, and Mr. Dave Halferty, Director of the Nursing Facility and PACE Division, are with me today.

Dave has been working with provider assessment issues during the past year and he is prepared to update the committee on the status of that initiative.

So, unless you have questions of me, I'll ask Mr. Halferty to address provider assessment and respond to any questions the Committee may have.

Thank you again. We appreciate the opportunity to be here.

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House Committee on Aging and Long Term Care

CMHC System Over and Impact of Budget Cuts

January 18, 2011

Presented by:

Michael J. Hammond, Executive Director
Association of CMHCs

Mr. Chairman and members of the Committee, my name is Mike Hammond, I am the Executive Director of the Association Community Mental Health Centers of Kansas, Inc. The Association represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week. I have included in your packet today a map of the CMHC system.

In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered. In Kansas, you first must be designated by your County to serve as the CMHC to the county residents, then you must secure a license from the Kansas Department of Social and Rehabilitation Services (SRS), to become the publicly funded CMHC and recognized as such by the State of Kansas. Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. Together, they employ over 4,500 professionals.

The CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs. Collectively, the CMHC system serves over 115,000 Kansans with mental illness. Some of the demographics of those we serve are listed below.

Characteristics

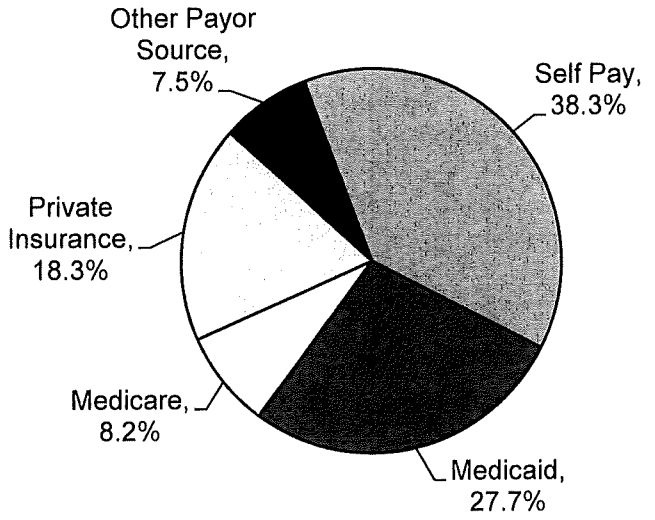
SPMI	18,764	16.40%
SED	19,682	17.21%
Non-SPMI	62,274	54.44%
Non-SED	13,660	11.94%

Age

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

Gender

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



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

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

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

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

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

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

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

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

Highlights of funding reductions sustained by the CMHC system:

1. **$20 million reduction in Mental Health Reform grants since FY 2008 – a 65 percent reduction.**
2. **$9.6 million all funds in Medicaid rate reductions during FY 2010 as a result of the 10% rate reduction.**
3. **$3.1 million in MediKan funding in FY 2010 – a 45 percent reduction.**
4. **$560,000 SGF in Community Support Medication Program funding during FY 2010 – a 53 percent reduction.**

These cuts listed above have not been restored.

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

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

Cuts in Mental Health Reform Funding

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

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

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

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

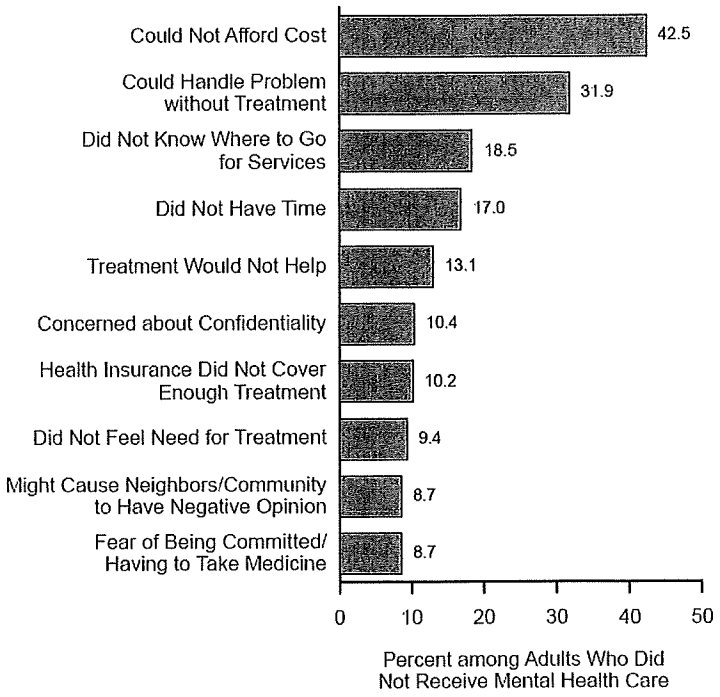
Mental Health Reform Funding

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

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

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

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



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

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

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

MediKan

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

MediKan – Mental Health

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

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

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

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

Community Support Medication Program

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

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

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

Cuts Proposed by the new Administration for FY 2012

State Aid

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

Examples of services paid with this funding stream include:

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

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

Family Centered System of Care

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

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

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

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

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

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

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

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

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

Why Investing in Mental Health is Important

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

- Evidence is being identified that the occurrence of severe psychiatric disorders may be increasing. The number of individuals on SSI/SSDI between 2000 and 2008 increased by 33 percent, while persons who have a mental disorder who are on SSI and SSDI, increased by 57 percent during the same time frame. The U.S. population increased by only 8 percent in this same time period.
- A growing number of employers have dropped health insurance for their employees and in some cases their dependents – many of whom show up on the doorsteps of community providers seeking services that we must provide, regardless of their ability to pay. These are men, women and children who will turn to community providers for help, when untreated problems build and result in a behavioral healthcare emergency. And we know from experience that, in crisis, care is more expensive to deliver. When they walk through our doors, for whatever reason, our challenge and commitment is to serve them.

Psychiatric Inpatient Capacity

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

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

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

I can stand here today and report that there was no tragedy in any of our communities as a result of these two occasions where voluntary admissions were temporarily suspended. Both occasions were very short in duration. However, what happens in the future if the frequency increases as does the duration? To be honest, I think we as a system are pressing our luck and it remains very concerning to us and those we serve that in a critically important situation where a person with mental illness is in crisis and require psychiatric inpatient care, they may not have access to inpatient care when they need it and there will be dire consequences.

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

- Extra staff were placed on call to provide support and services in the community if at all possible.

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

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

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

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

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

It is important to note that the agency did submit to the Governor as part of their enhancement request for FY 2010, a proposal for establishing local private mental health inpatient beds across Kansas, with a request of $7.8 million, including $5 million in SGF. This would reimburse private hospitals for additional days of psychiatric treatment for people who would otherwise be transferred to State Psychiatric Hospitals. This would occur in two different ways: the first part would allow adjustments to the Medicaid reimbursement methodology to fund extended lengths of stay for people who need more time to complete their treatment in the local hospital. The second part would provide a state only payment for inpatient psychiatric hospital treatment for persons who have no private or public insurance and no other method to pay for their treatment. While the situation has not changed at all, the agency, due to the State's continued financial crisis, did not submit this budget enhancement for FY 2011.

The Importance of Inpatient Resources

The vast majority of persons treated in the CMHC system are either indigent or low income with few resources to pay for private care. Because CMHCs function as an out-patient safety net resource for large numbers of persons with the most severe forms of mental illness, it is vitally important that we, in turn, have

access to a safety net resource for those consumers whose illness simply cannot be managed in a community setting, and who have no resource to pay for private care. For us, and those consumers, the State Psychiatric Hospital is the safety net.

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

Inpatient capacity of our State Psychiatric Hospital system can be at critical stages of maximum utilization several times throughout the year. The mental health system did not anticipate the explosion of need for State Psychiatric Hospital beds in the past few years. That explosion is in part due to the continued decline of private psychiatric hospital beds – resources the CMHCs relied upon at the community level.

OSH Days Over Budgeted Census

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

Source: SRS

RMHF Days Over Budgeted Census

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

Source: SRS

LSH Psychiatric Services Days Over Budgeted Census

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

Source: SRS

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

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

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

Note: In FY08 RMHF began serving only adults

Source: SRS

Factors Impacting Increased Admissions at State Psychiatric Hospitals

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

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

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

- A loss of $20 million in SGF Mental Health Reform funding since FY 2008 – a 65 percent reduction.
- A loss of $3.1 million SGF in MediKan funding in FY 2010 – a 45 percent reduction.
- A loss of $560,000 SGF in Community Support Medication Program funding in FY 2010 – a 53 percent reduction.
- Proposed cuts by the current Administration total an additional $15.2 million.

There has been a significant decline in private psychiatric hospitals.

- Local inpatient psychiatric bed capacity statewide has been declining since 2002, from 488 beds to 324 today – a 34 percent decline. The Veterans Administration Hospitals in Kansas have only 58 psychiatric beds for adults, in two locations in Kansas. Northwest Kansas has lost the only inpatient psychiatric unit (21 beds) between Salina and Denver, Kearney, Nebraska and Wichita/ Hutchinson during this time period also. Last year, Coffeyville Regional Medical Center closed its 17 bed psychiatric unit. Just last week, Southwest Medical Center in Liberal announced they will close the hospital's 12 bed psychiatric unit, citing lose of money and difficulty recruiting psychiatrists as the reasons for the decision.

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

- According to national data provided by the U.S. Dept. of Health and Human Services, Center for Mental Health Services, the number of mental health organizations providing 24-hour hospital or residential

treatment care private psychiatric hospitals nationwide declined by 53 percent between 1992 and 2002. The data shows that for Kansas, the decline was 89 percent.

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

What is happening in Kansas is not unique to Kansas.

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

January 14, 2011

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

FY 2012 Governor's Budget Recommendation

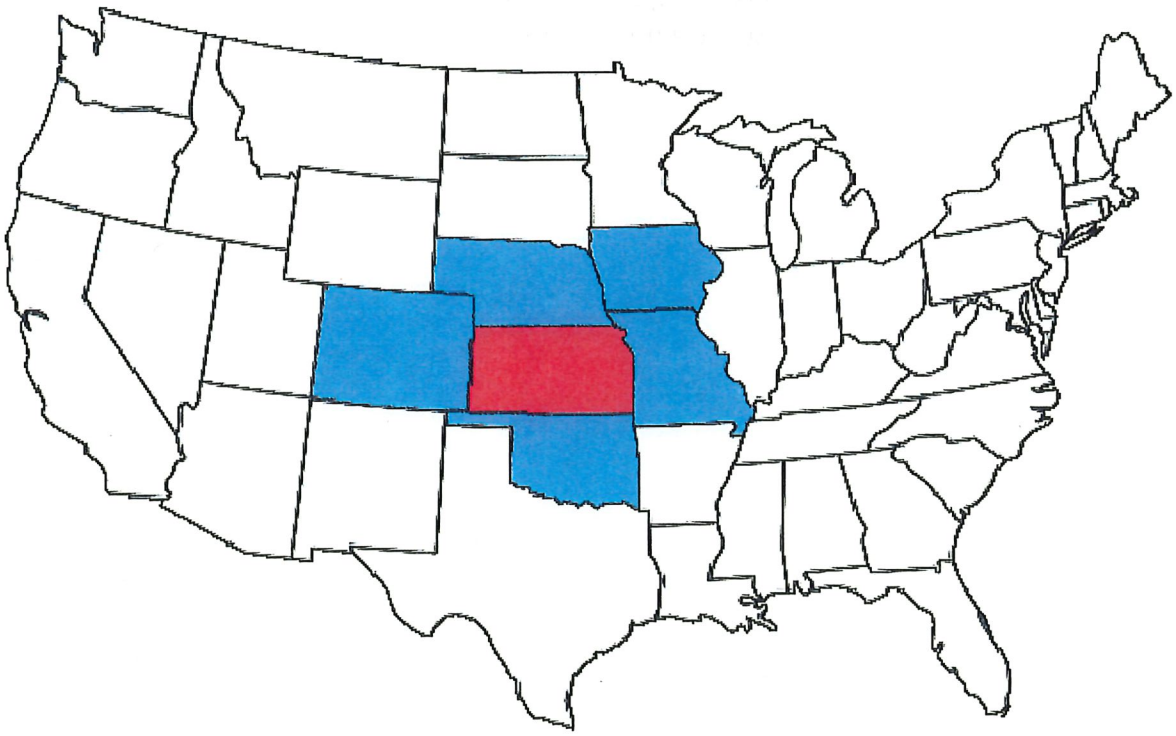
Impact to Community Mental Health Centers
House Committee on Aging and Long Term Care

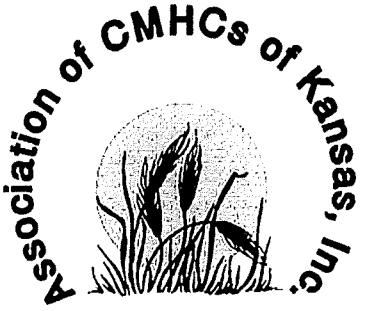
Rep Bob Bethell		
The Center for Counseling and Consultation		($358,704)
Horizons Mental Health Center		($711,930)
	Total	($1,070,634)
Rep Ron Worley		
Johnson County Mental Health Center		($1,589,069)
Rep Broderick Henderson		
Wyandot Center for Community Behavioral Health		($1,064,956)
Rep Don Hill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

How Kansas Stacks Up

A Regional and National Comparison of Mental Health Care Services

November 2009





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How Kansas Stacks Up: A Regional and National Comparison

Executive Summary

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

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

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

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

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

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

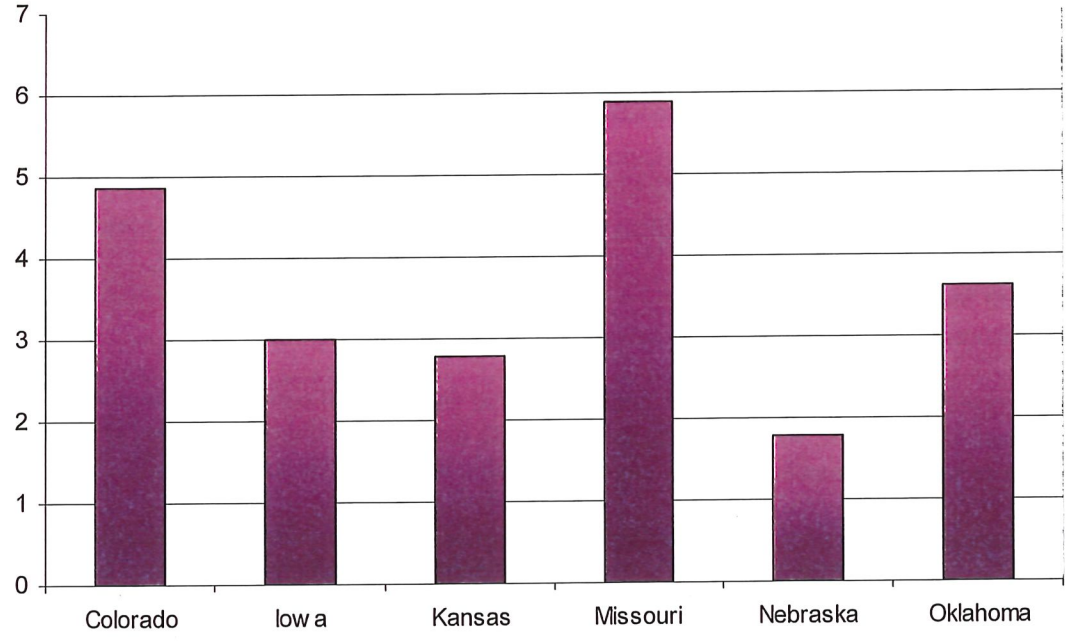
- Kansas serves more individuals in its public mental health system than neighboring States.
- Kansas has a slightly lower hospital utilization rate than surrounding states and the national average. This takes into account State Hospitals and other inpatient facilities.
- Readmission rates in Kansas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

2-19

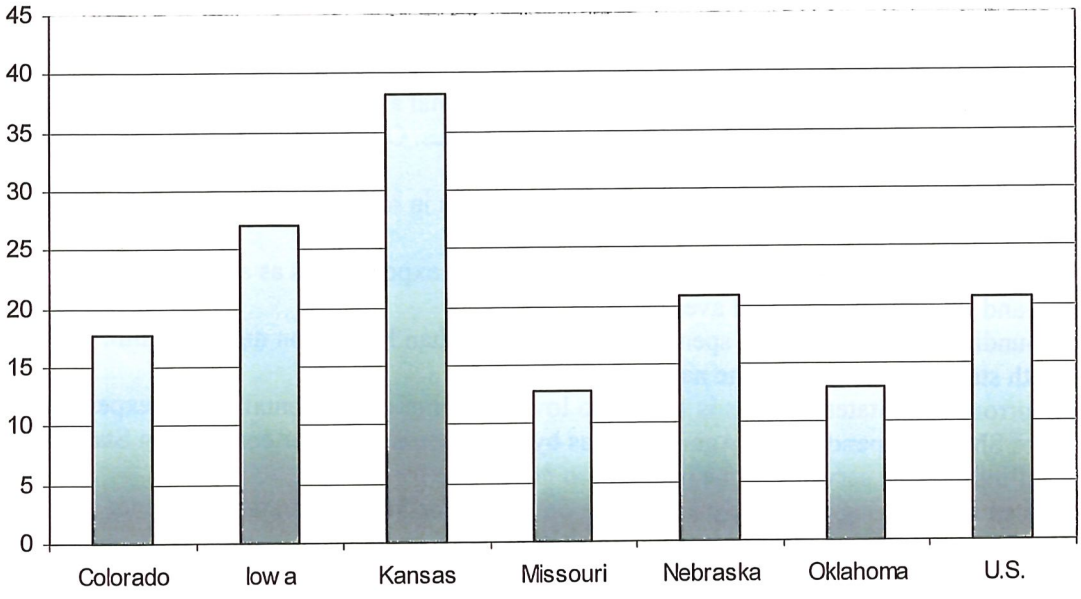
Populations and Numbers Served

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

2007 US Census Bureau Population Estimates
(in millions)



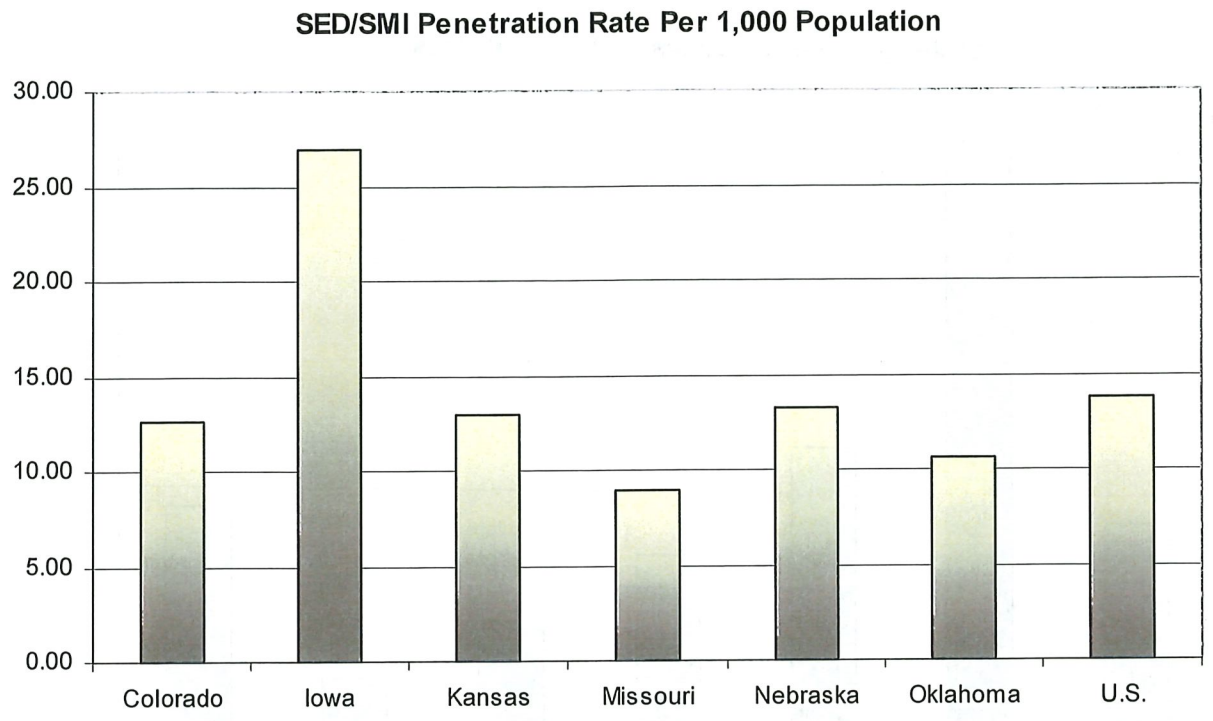
Total Number of Consumers per 1,000 Population



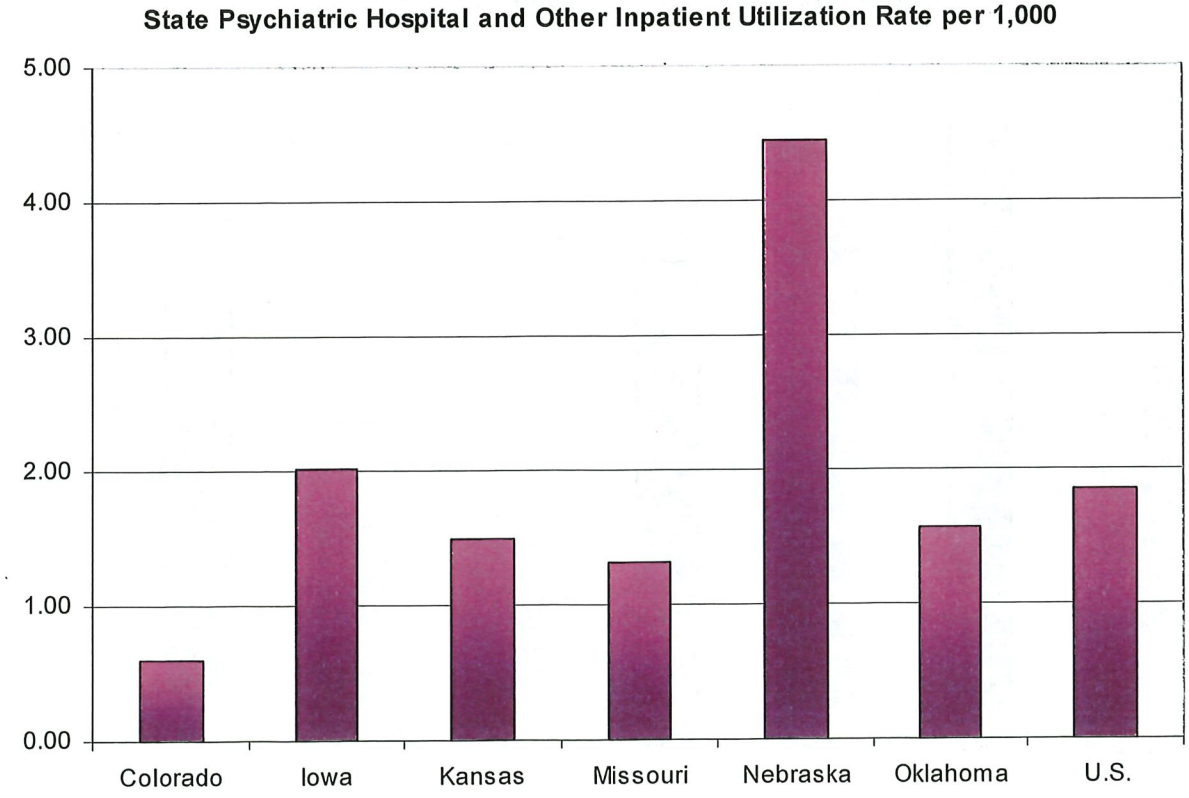
2-20

SED/SPMI Penetration Rates and Hospitalizations

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



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

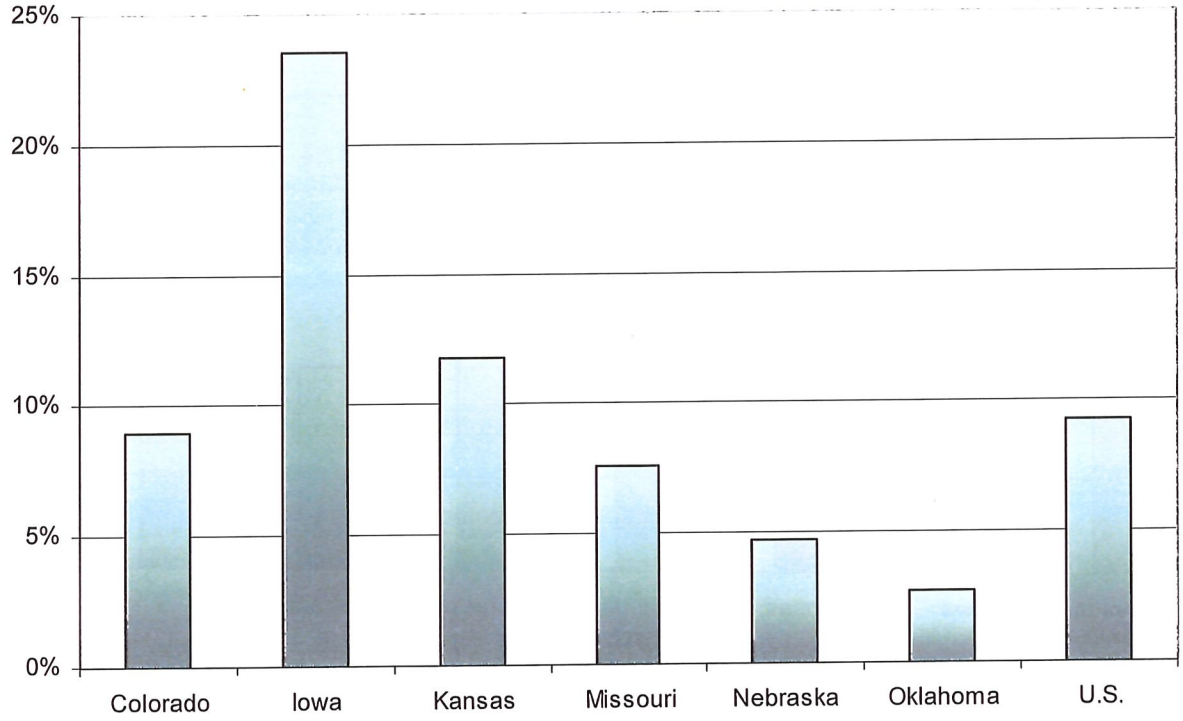


2-21

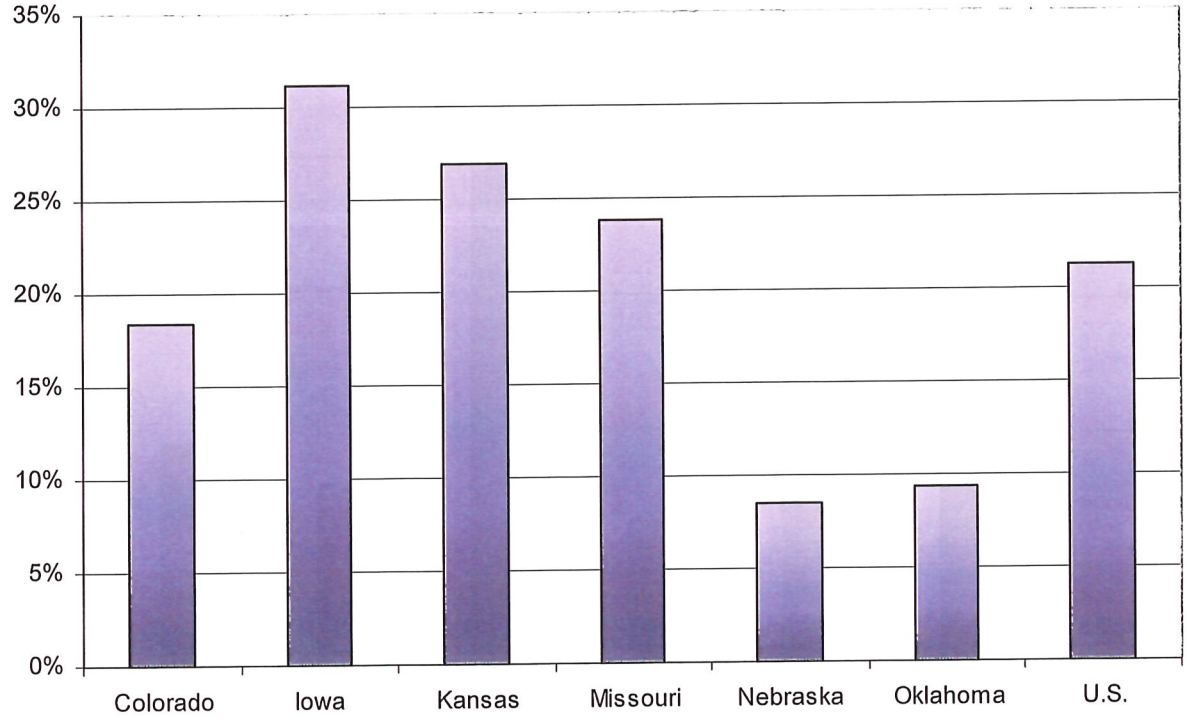
Hospital Readmission Rates

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

State Hospital Readmission Rate: 30 Days



State Hospital Readmission Rate: 180 Days

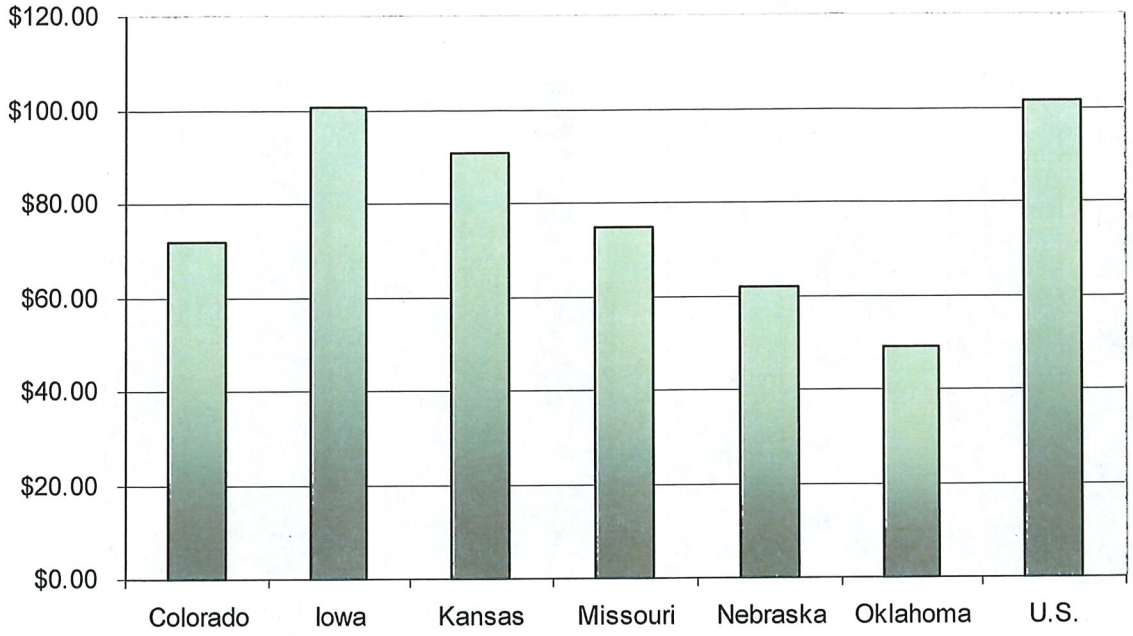


2-22

Expenditures

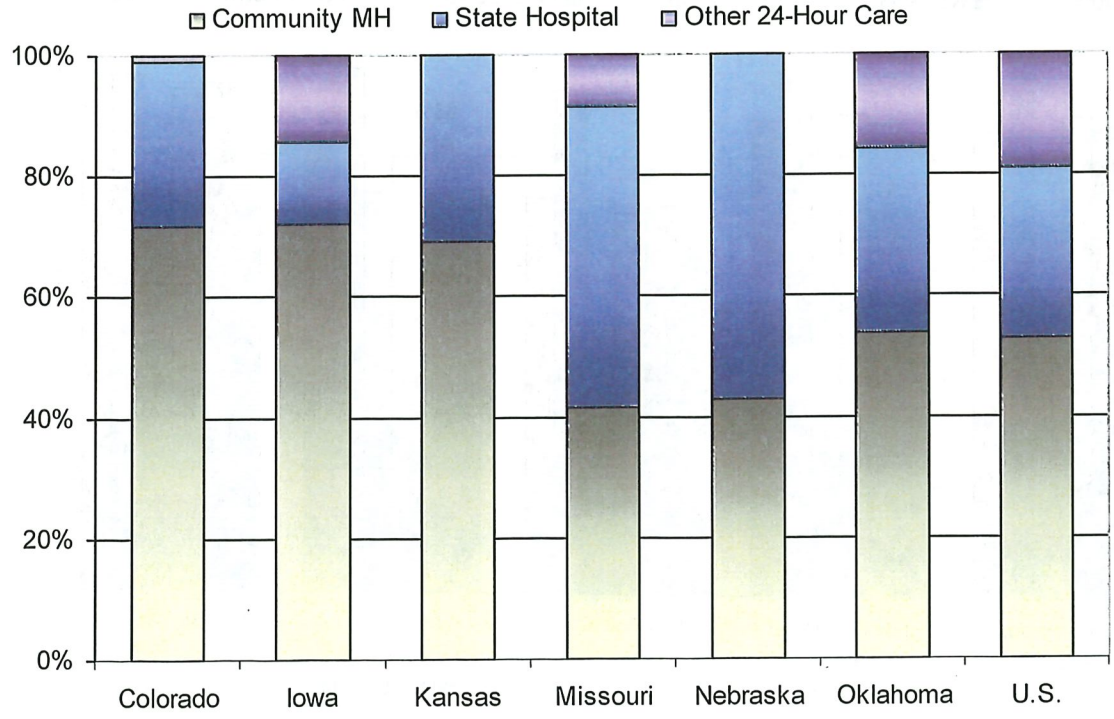
When looking at total mental health expenditures by state, Kansas is higher than most surrounding states but still lags the national average by approximately 11%.

Per Capita Total SMHA Mental Health Expenditures



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

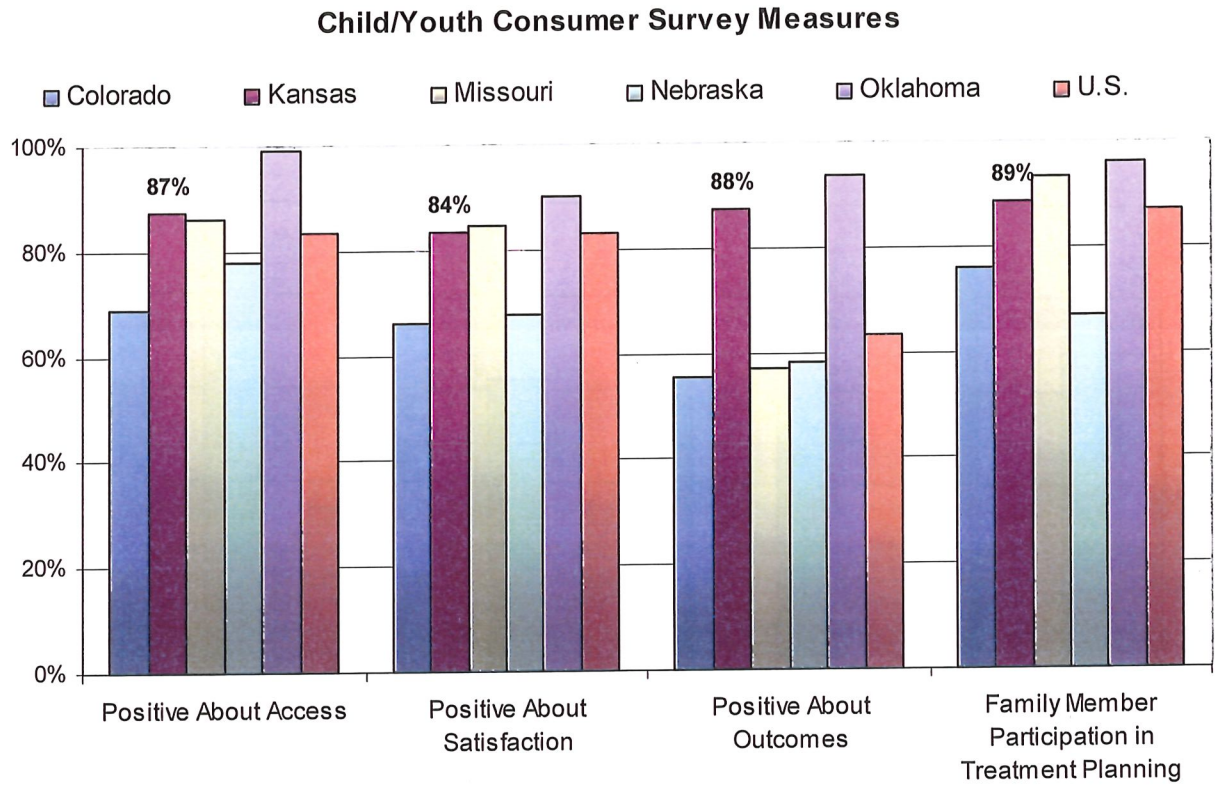
Expenditure Source as a % of Total SMHA Controlled Expenditures



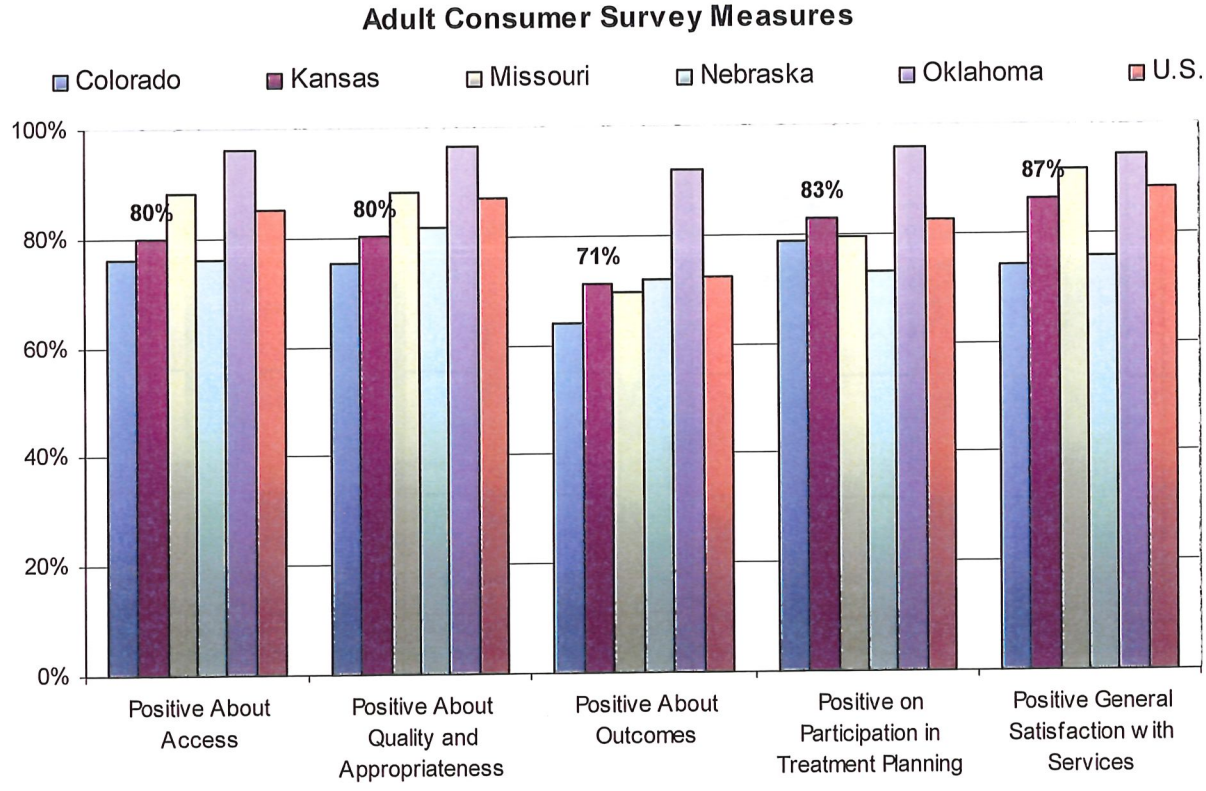
2-23

Consumer Survey Measures

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



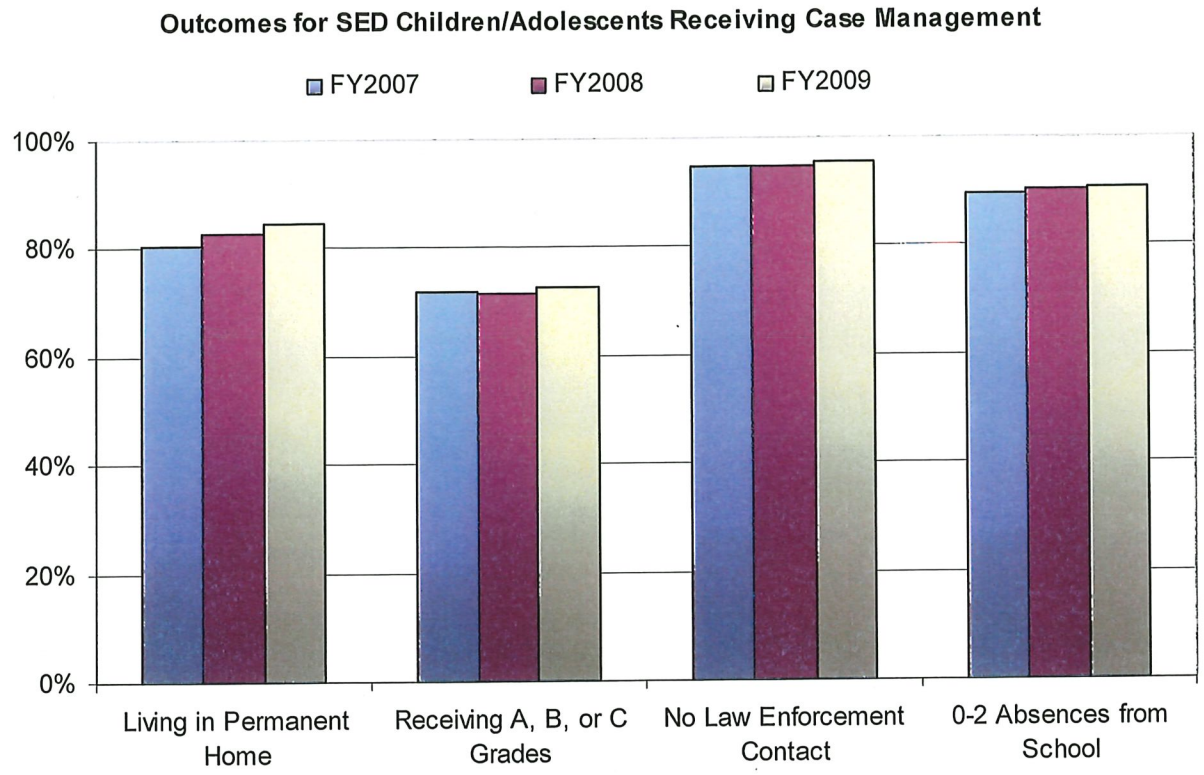
Kansas also scores highly among the Adult Consumer Survey measures.



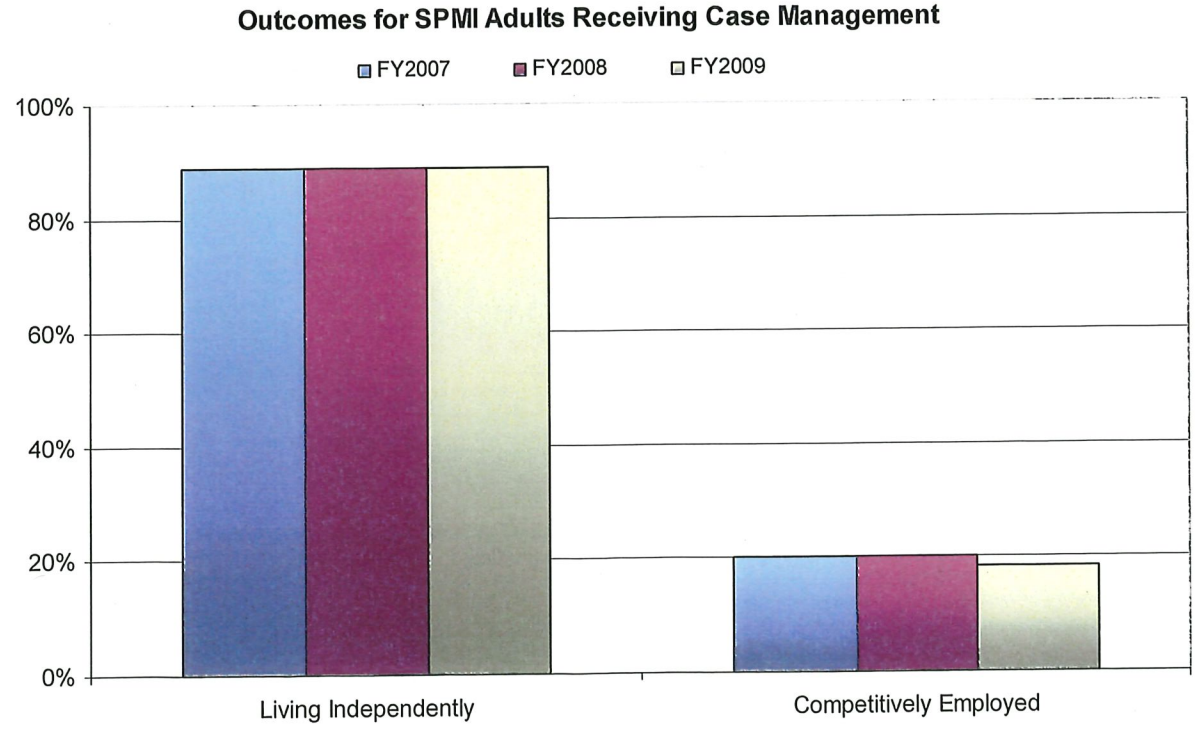
2-24

Kansas Outcomes

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

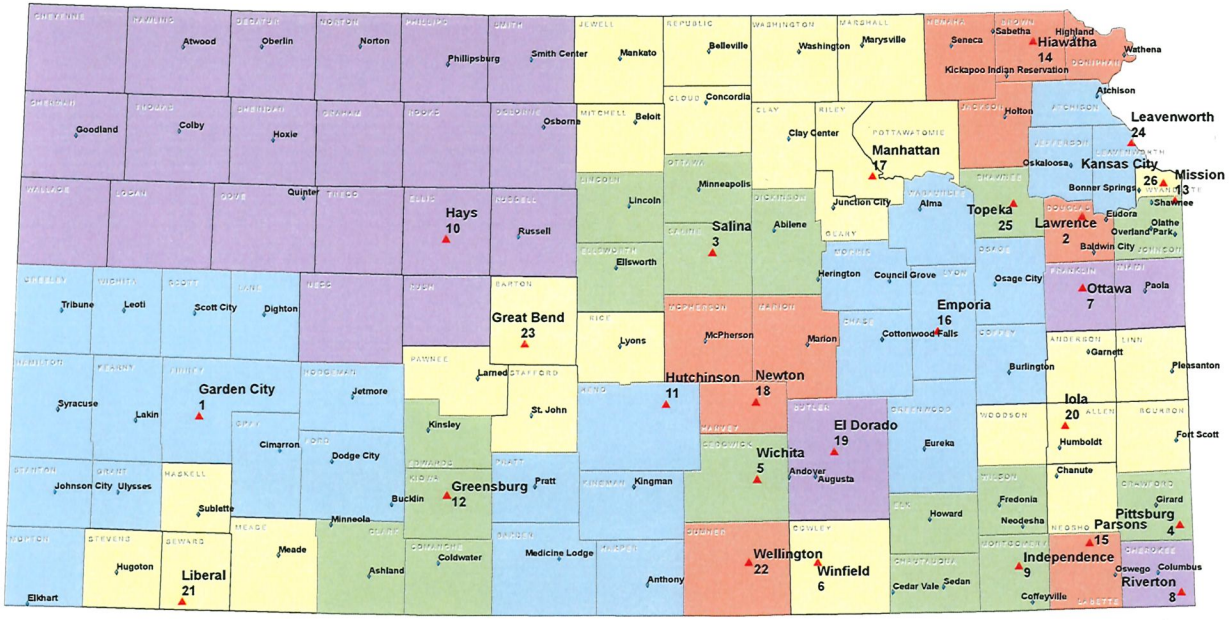


Outcomes for SPMI adults have remained flat over the last three years, sustaining an already high level of care. Only Competitive Employment fell over the last three years, most likely due to the financial crisis of 2007–2009 and ensuing recession.



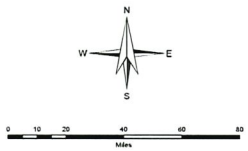
2-25

Community Mental Health Centers of Kansas



▲ MAIN CENTERS

◆ SATELITE CENTERS



Locations of Community Mental Health Centers
Key to Map

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

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

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

   Satellite offices in Eudora and Baldwin.

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

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

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

   Satellite office in Girard

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

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

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

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

   Satellite office in Paola

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

   Satellite office in Columbus.

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

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

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

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

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

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

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

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

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

    Satellite offices in Olathe, Overland Park and Shawnee.

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

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

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

    Satellite office in Oswego

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

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

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

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

    Satellite offices in McPherson and Marion.

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

    Satellite offices in Andover, August, and Rose Hill

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

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

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

    Satellite offices in Sublette, Hugoton, and Meade

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

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

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

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

    Satellite offices in Atchison and Oskaloosa.

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

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

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

    Satellite office in Bonner Springs.

AIMS
AUTOMATED INFORMATION MAPPING SYSTEM

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December 21, 2006

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Via Christi HEALTH

Date: **January 18, 2011**

To: **The Honorable Bob Bethell, Chair**
House Aging and Long-Term Care Committee
Members, House Aging and Long-Term Care Committee

From: **Bruce Witt, Director**
Government Relations
Justin Loewen, CEO
Via Christi HOPE, Inc.
Via Christi Villages

Re: **Via Christi Villages and HOPE**

Date: **January 18, 2011**

Good morning. Chairman Bethell and members of the Committee, I am Bruce Witt, Government Relations Director for Via Christi Health, the largest provider of health care services in Kansas.

I appreciate the opportunity to tell you about the programs and services we offer to seniors and why we take our role as advocates so seriously. Via Christi Villages provides a diverse array of services for seniors in Kansas and north-central Oklahoma. We own or manage sixteen (16) senior living ministries ranging from independent living, assisted living to skilled nursing facilities. Collectively, we currently care for over 1,700 seniors in these ministries.

Via Christi Villages also offers seniors several different and innovative services including Via Christi InMyHome and Via Christi HOPE, a cost-effective care model designed to allow seniors to remain in their homes as long as safely possible.

Via Christi HOPE was the first PACE (Program of All-Inclusive Care for the Elderly) program in Kansas. Since opening the program in the fall of 2002, the Wichita PACE program has served over 530 adults in Sedgwick County and currently has an enrollment of 213.

Via Christi HOPE is a program that is attractive to seniors and has great potential for savings to the Kansas Medicaid program at a time when caseloads are increasing and our population is aging. To provide you with an overview of just how PACE can play a crucial role in helping keep costs down while offering high-quality care, I have asked Justin Loewen to tell you more about our PACE model, Via Christi HOPE functions. Justin is the CEO of Via Christi HOPE.
The PACE philosophy is to keep older adults at home with supportive medical care, homemaker and nursing services and coordinated physician interventions for as long as it is medically safe. PACE is an

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ATTACHMENT #3

alternative to traditional long-term care placement and operates as a capitated, managed care model for preventive, acute and long-term care services.

Via Christi HOPE is a fully capitated program receiving a single monthly payment from Medicare, Medicaid and in some cases, private pay (for those enrollees not eligible for Medicaid). PACE assumes all costs included in the program. This combination of funding sources creates a funding pool for these services:

- ✔ **Primary Care**
- ✔ **Physician Services**
- ✔ **Pharmacy**
- ✔ **Laboratory & X-Ray**
- ✔ **Long-Term Care – Nursing Facility or Assisted Living**
- ✔ **Acute Care – Inpatient & Outpatient**
- ✔ **Durable Medical Equipment**
- ✔ **Transportation**

In addition, we provide over 4,000 hours of home care services each month to promote independence and safety as individuals remain in their home. Under the capitated payment methodology, the state incurs no additional costs as the needs of our participants increase. Furthermore, Medicaid costs are between 5% and 25% lower in relation to a comparable non-PACE population. Further, Medicaid saves approximately $1,000 per month for every enrollee that would otherwise be cared for in a nursing facility.

While PACE is a managed care program, our payment methodology aligns the incentives of the enrollee and the program. Via Christi HOPE assumes full financial risk for participants' care without limits on the amount, duration, or scope of services. Our organization is at risk for and accountable for the quality and quantity of all services provided. This is to say, our success as a program is dependent on our ability to anticipate, identify and meet the unique needs of our enrollees while promoting safety and independence in their home.

A report compiled by the Program on Aging, Disability, and Long-Term Care, Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill concluded that PACE improves Outcomes for older adults:

- PACE participants are more likely to maintain their physical function.
- PACE participants have lower rates of nursing home admission, and spend fewer days in hospitals, nursing homes and assisted livings, even though all PACE participants are certified for nursing home care.
- PACE enrollees are over three times as likely to have advance directives as the general population.
- In the first 12 months after enrollment, mortality is decreased by 32%.
- Overall, PACE participants have lower mortality rates, compared to similar nursing home patients.
- PACE participants at the end of life are able to die at home more than twice as often as others nationally.

I would happy to provide you more detailed information about Via Christi HOPE or PACE at a later date if invited to do so. It is a unique program that too few policymakers know about yet it offers a win-win for both seniors and the state.

Thank you or allowing me to appear before you today and I am happy to answer any of your questions at this time.

Profiles in Leadership

VIA CHRISTI LEADS INNOVATION IN SENIOR CARE DELIVERY

Capitalizing on demographic trends, enabling technology and unmet market gaps, Via Christi Health (VCH) in Wichita, Kansas, has become a beacon of senior care via a vast portfolio of products and services. Via Christi's innovation and expertise in addressing needs across the elderly population has allowed it to be well-positioned for the upcoming senior population boom as well as payment and delivery model reform.

OVERVIEW

VCH's senior services organization, Via Christi Villages (VCV), owns or manages 16 senior living ministries that include independent living, assisted living and nursing facilities that care for more than 1,700 seniors. Via Christi HOPE's 210-member Program of All-Inclusive Care for the Elderly (PACE) allows state-funded Medicaid participants to age with dignity by providing in-home assistance, proactive medical, physical and emotional care, and nursing facilities under a capitated model. VCV also recently launched InMyHome, a home-based individualized care coordination and long-term care product for more affluent seniors that offers services similar to PACE.

Via Christi HEALTH

> Fulfilling our mission involves providing for the needs of the entire community.
>
> JERRY CARLEY, VCV PRESIDENT & CEO

SUCCESSES

Through its managed care and in-home emphasis, PACE has resulted in 10 percent and 25 percent savings to Kansas Medicaid-only and Medicare-Medicaid dual-eligibles, respectively (saving taxpayers nearly $1,000 per patient per month). HOPE averages 25-45 acute care days per month, about half of that observed in the general population cohort. VCV attributes part of its success to being an independent entity within Via Christi Health, which allows the flexibility and accountability to bid support contracts competitively, which has even prompted the larger system to become more competitive on a greater scale. VCV has achieved its FY2010 6.5 percent operating margin by putting together the right clinical and administrative team that works together to do what's best for the participant and what's best for the program so that they can continually reinvest in program improvements for their very satisfied members.

"I took the position because of my desire to serve in a system where all the pieces were in place."

DIRK SMITH, M.D., HOPE MEDICAL DIRECTOR

VIA CHRISTI HOPE, PACE PROGRAM

Via Christi HOPE is a capitated Program of All-Inclusive Care for the Elderly (PACE) that covers the entire spectrum of needs for its 210 members (197 of whom are on Medicaid). HOPE is designed to keep patients in their home as long as possible through a proactive program that includes home assistance, transportation, home modification, monitoring and care. Patients also have access to clinical care, transportation, exercise facilities, daily activities and, ultimately, skilled nursing care if necessary. As VCV carries full patient risk, HOPE assesses and anticipates member needs, which prompt administrative and clinical leaders to meet every morning to discuss and collaborate on the day's needs of individual patients. By aggregating service capabilities in-house rather than contracting, VCV ensures higher efficiency, quality and aligned incentives. VCV's ownership of a skilled nursing care facility makes it one of only two PACE programs in the country with its own such facility, essentially enabling VCV to own all of the major components of the continuum, rather than contracting for services. A similar initiative in home care services enables VCV to provide 60 percent of such services itself.

INMYHOME PROGRAM OVERVIEW

Over time, VCV consistently heard its elderly patients lament that they would like to age in their home, but they have little available support to do so. In parallel to the HOPE program, InMyHome (IMH) is designed to do just that, but for affluent individuals who would not yet qualify for skilled nursing. IMH provides members with personalized care coordination and at-home services, much like what adult children would arrange for their parents if they were available to do so. Members pay an age-adjusted entry fee ranging from $25K - $45K and a monthly maintenance fee of approximately $400. Initial entrants must not have any disqualifying medical conditions, but are provided comprehensive services as medical conditions develop throughout the rest of their lives including a discount for residential care when needed. Work is underway to accommodate and reduce costs for members already having long-term care insurance. Launched in January 2010, InMyHome is working with estate attorneys and others to identify new members.

ADVANTRA MEDICARE COLLABORATION

VCH's unique collaboration with Coventry Health is designed to reduce utilization and improve health among a Medicare Advantage population. This initial three-year, 10,000-patient program represents a true provider-payor partnership in which Coventry will collaborate with VCH physicians to improve care delivery and reduce inefficiency. Advantra Total Care will provide care navigation and on-call services in return for a fee-for-service arrangement coupled with a regular monthly patient management fee to physicians. Shared savings will accrue for physicians and hospitals if certain thresholds are met.

IMPLICATIONS FOR ASCENSION HEALTH

The senior services programs have evolved over time at Via Christi and have culminated in a full and comprehensive service offering for the poor and vulnerable as well as the affluent. The organization has been able to bridge the often observed divide between the acute care system and primary, specialty and post-acute care in a cohesive and integrated way that aligns incentives for all stakeholders. The PACE and InMyHome programs will serve as important and valuable models of what a continuum of care can look like as Health Ministries begin to formulate continuum strategies within their own systems. Strong operating margins, important referral streams, high patient and provider satisfaction, tied together by the relationship with the patient is a strong value proposition at VCV.

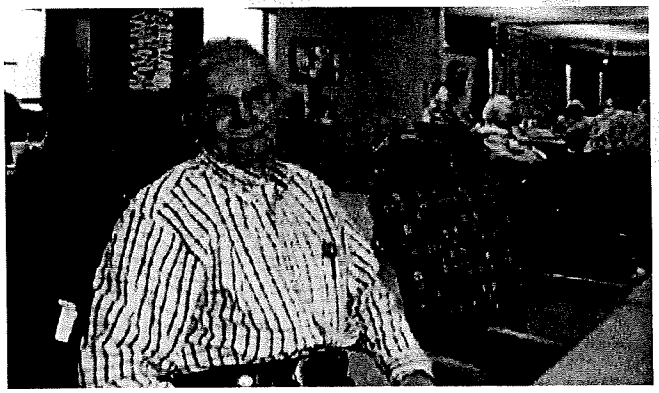
CONTINUED

Aging with Dignity

VIA CHRISTI CONTINUED

Ruth and John Coultis' Story

Ruth joined InMyHome a few months ago and shortly thereafter needed a hip replacement. IMH was immediately on the task of coordinating in-home rehabilitation services for Ruth, eliminating the need for her to find and obtain any of the necessary services herself. Her surgical outcome has been remarkably successful, but even that outcome pales in comparison to her satisfaction with her IMH caregiver, Tina. "There is a time in your life when someone like Tina can make your life so much better. I have the assurance that someone is always available to talk to us and is there to help," she said. IMH is a strong fit with the Mission of Via Christi Health and Ascension Health. John and Ruth feel a personal connection with Tina, and believe that IMH is an extension of Via Christi Health's Catholic culture, as the program's philosophy is centered around truly caring for the patient in all aspects – physical, emotional and spiritual.



Rachel and Wayne Jones' Story

After spending two months in the hospital with congestive heart failure, Rachel joined HOPE. Rachel was bedbound and fragile, and HOPE helped to provide her with medication, coordinated care, and facilitated activities through its daytime programs. "HOPE has saved my life," she said. "I was in a wheelchair when I came in. I couldn't climb steps. Now I can go up the front steps, and I can walk with a walker ... and even use a cane at home. They have just worked miracles with me." Rachel's husband, Wayne, joined HOPE within a year of Rachel, and daughter Ann is extremely thankful. "This program has been a godsend for all of us," she said. "We couldn't have asked for anything better. You don't have to feel all alone."

These pages were excerpted from
Profiles in Leadership: Leading Practices Across
Ascension Health Fall 2010.

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3-6

#4

KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS
strength
unity
advocacy

Testimony on:

Overview of the Kansas Association for the Medically Underserved

Presented to:

Aging and Long Term Care Committee

By:

Cathy Harding, Executive Director
Kansas Association for the Medically Underserved

January 18, 2011

For additional information contact:

KAMU
1129 S Kansas Ave., Ste. B
Topeka, KS 66612
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DATE: 01/18/11
ATTACHMENT #4

Good morning Mister Chairman and members of the Aging and Long Term Care Committee.

I am Cathy Harding, Executive Director of the Kansas Association for the Medically Underserved, (KAMU). We were asked today to provide an overview of our association, and to identify issues affecting us this session. I am pleased to be here today to provide you with this information.

KAMU was designated the Primary Care Association of Kansas by the federal Bureau of Primary Health Care in 1991 and maintains that designation today. As the Primary Care Association, KAMU represents 39 primary care safety net clinics that all share the same mission of providing health care services without regard for patients' ability to pay. KAMU and our members believe Kansas should be a state where all individuals have access to comprehensive, affordable and quality health care. The 39 Safety Net Clinics along with their 26 satellite sites provide Kansans a total of 65 access points. Membership includes public and private non-profit primary care clinics, Federally Qualified Health Centers (FQHC's), one Federally Qualified Health Center Look-Alike, local health departments and the Statewide Farmworker Health Program.

KAMU's mission is to "support and strengthen our member organizations through advocacy, education and communication." Through this work we support our member clinics in becoming a health care "home" where all Kansans have access to comprehensive medical, dental and behavioral health services. Our clinics provide a wide spectrum of quality services that address preventative, acute and chronic health care needs. Seventeen of our 39 clinics provide comprehensive dental services, and ten are partnering with their local Community Mental Health Centers to achieve an integrated model of primary medical and mental health care.

All of our clinics assist their patients in obtaining additional services necessary for optimum health. For example, one of our members (the Community Health Center of Southeast Kansas) has an in-house pharmacy that also serves as our statewide Unused Medications Clearinghouse and distributes unused medications donated by mail order pharmacies and long-term care facilities to our member clinics. As a result of this program, thousands of low-income Kansans receive needed prescription medications that they could not otherwise afford.

In 2009 our 39 clinics provided care to over 223,000 underserved Kansans – a 31.6% increase in patients in just two years (2007-2009). With the current economic climate in our state, the number of individuals who are uninsured and underinsured will continue to rise. Our clinics are challenged now to recruit and retain an adequate workforce and to maintain a healthy financial position given this growth – particularly since 94% of our patients reported incomes below 200% of the Federal Poverty Level, and 74% are either uninsured or are covered through Medicaid/CHIP.

The biggest issue we will face in the coming session is adequate funding for our clinics to meet the growing need for services. Governor Brownback's budget recommends the Kansas safety net clinics receive $7.2 million for SFY 2011 and SFY 2012. Ninety-eight percent of state investment goes directly to the clinics through grant programs. The remaining 2% is used to support the clinics through technical assistance to non-federal clinics and workforce development.

KANSAS ASSOCIATION FOR THE MEDICALLY UNDERSERVED
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tel 785.233.8483 | fax 785.233.8403 | www.kspca.org

Recognizing that this year tough budget decisions will need to be made, I am pleased to state that investing in the safety net clinics is a positive decision – in fact, it actually saves the state money.

- Nationally, studies show that Medicaid patients served by FQHC's **saves** Medicaid an average of about 30% in annual spending per beneficiary due to lower specialty care referrals, ER visits, hospital admissions, and prescription drug costs. So, this is a direct savings to our Medicaid program.
- Safety-net clinic care provides a cost effective return on the State's investment of 10:1; and keeps the working poor healthy and economically contributing members of their Kansas communities. The state's investment amounts to only about $32 per patient for an entire year of care.
- Some of our clinics – FQHCs – are on the cutting edge of outcomes-based medicine. In fact, they are required to track quality measures and report them to the Bureau of Primary Health Care annually. Many of our non-federally funded clinics have participated for years in KDHE's Diabetes Collaborative to improve outcomes of their diabetic patients. Patients that receive care at our clinics receive quality services in a culturally appropriate environment.

Again, thank you for the opportunity to provide this information today. I'm happy to stand for questions.

KANSAS ASSOCIATION FOR THE MEDICALLY UNDERSERVED
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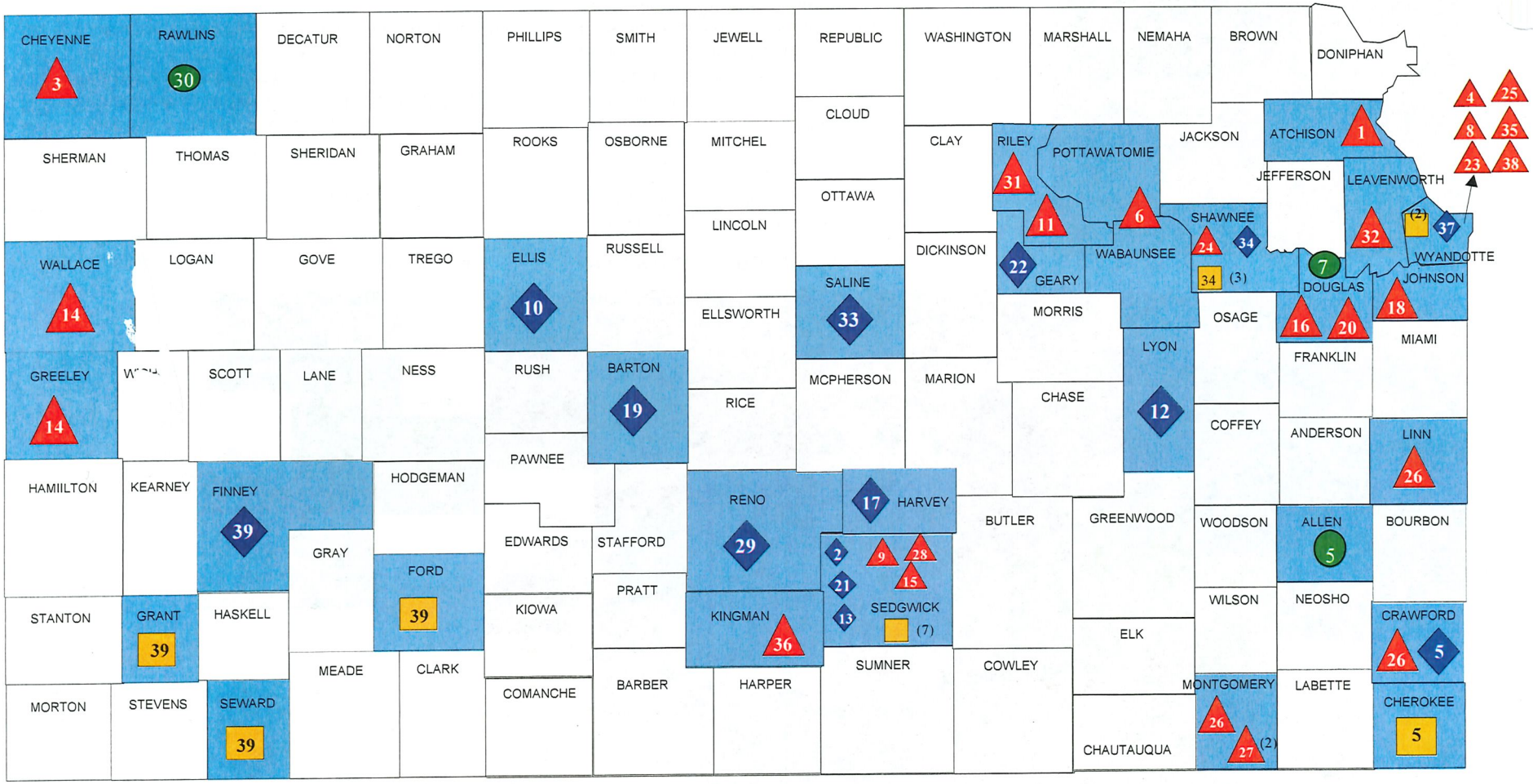
2010 KAMU Primary Care Safety Net Clinics and Satellite Locations



Safety Net Provider Sites (#) Number in the county

FQHC and FQHC Look-Alike Main Sites (#) Number in the county

FQHC Satellite Sites (#) Number in the county

Service Area

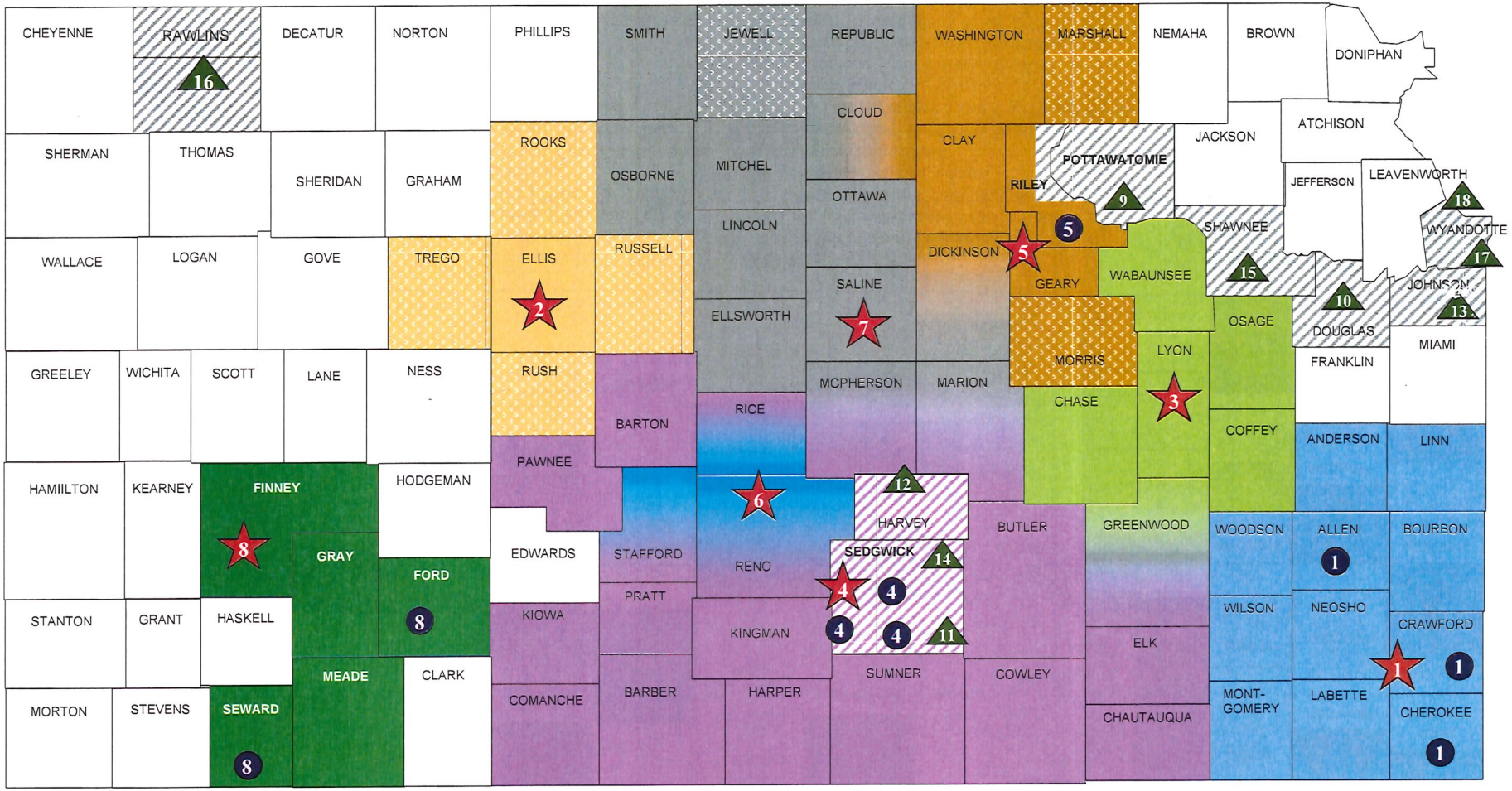
Dental Clinic ONLY

Statewide: The Kansas Statewide Farmworker Health Program has 105 access points.

1. Atchison Community Health Clinic
2. Center for Health and Wellness
3. Cheyenne County Clinic - St. Francis
4. Children's Mercy West, The Cordell Meeks, Jr. Clinic
5. Community Health Center of SE Kansas
6. Community Health Ministry Clinic
7. Douglas County Dental Clinic
8. Duchesne Clinic
9. E.C. Tyree Health Clinic
10. First Care Clinic of Hays
11. Flint Hills Community Clinic
12. Flint Hills Community Health Center
13. GraceMed Health Clinic
14. Greeley County Health Services
15. Guadalupe Clinic
16. Health Care Access
17. Health Ministries Clinic
18. Health Partnership of Johnson County
19. Heart of Kansas Family Healthcare
20. Heartland Medical Clinic
21. Hunter Health Clinic
22. Konza Prairie Community Health Center
23. KU Health Partners/Silver City Health Center
24. Marian Clinic
25. Mercy and Truth Medical Missions
26. Mercy Health Systems: Pleasanton, Arma, Cherryvale and Merry Medical Clinic of Linn Co.
27. Montgomery County Community Clinic (MC3)
28. Mother Mary Anne Clinic
29. PrairieStar Health Center
30. Rawlins County Dental Clinic
31. Riley County Community Health Clinic
32. Saint Vincent Clinic
33. Salina Family Health Care Center
34. Shawnee County Health Agency & Community Health Center
35. Southwest Boulevard Family Health Care
36. St. Gianna Health Clinic
37. Swope Health Wyandotte and Swope Health West
38. Turner House Children's Clinic
39. United Methodist Mexican American Ministries (UMMAM)

9 14 2010

KAMU Kansas Safety Net Dental Clinics, Dental Hubs, and Spokes - 2010



Clinics receiving Dental Hub funding from the State and/or Private Foundations

1. Community Health Center of Southeast Kansas
2. First Care Clinic
3. Flint Hills Community Health Center
4. GraceMed Dental Clinic & Spokes
5. Konza Prairie Community Health Center & Spokes
6. PrairieStar Health Center
7. Salina Family Health Care Center
8. United Methodist Mexican-American Ministries, Inc.

Other Safety Net Dental Clinics

9. Community Health Ministry Clinic
10. Douglas County Dental Clinic
11. E.C. Tyree Health & Dental Clinic
12. Health Ministries Clinic
13. Health Partnership of Johnson County
14. Hunter Health Clinic
15. Marian Dental Clinic
16. Rawlins County Dental Clinic
17. Southwest Boulevard Family Health Care
18. Swope Health Wyandotte and Swope Health West

Existing Hub
Solid color counties surrounding dental hubs show areas that ECP hygienist are providing screenings and other services through portable outreach programs. Patterned shade indicates planned ECP services.

Existing Spoke

Safety Net Dental Clinic

9/16/10

4-5

KHCA
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kcal ahca

#5

House Long Term Care and Aging Committee
January 18, 2011
Chairman Bob Bethell

Good Morning Mr. Chairman and Committee Members.

My name is Cindy Luxem, Executive Director of the Kansas Health Care Association and Kansas Center for Assisted Living, a trade association with a membership of over 185 providing care in nursing homes, assisted living, residential health care, home plus, nursing facilities for mental health and HCBS services. Thank you for the opportunity to testify.

Today, I want to highlight three areas important to our association. The first area to be discussed is funding.

The world of long term care looks different today and it continues to change daily. Over 55% of Kansans depend on Medicaid for their daily care (10,000). Nationally, 64% of 3.4 million people use Medicaid to pay for their daily care. As we have discussed before, long term care is made up of three different pay systems. Today, Medicare is used more and more as homes have increased their capability to admit treat and return home growing numbers of patients requiring intensive rehabilitative care. This is a clear benefit to seniors as well as taxpayers. Performing this rehab in a more expensive hospital would put further strains on federal and state budgets. In senior care settings, Medicaid relies on Medicare funding to supplement its "puny" reimbursement. We must view Medicare and Medicaid funding together, not in isolation.

A recent study Genworth Financial's "Our Family, Our Future: The Heart of Long Term Care Planning" found that only 35% of American's believe they will ever need long term care. In reality, more than two-thirds of people (70%) over the age of 65 actually need long-term care at some point during their lives, Genworth said.

The industry (do not like using this term) but it is an infusion of more than $2.1 billion into the Kansas economy. Nationally, $372 billion with more than 4.4 million jobs, in the Aging and Long Term Care Committee more than 2400 Kansans are employed. This is truly vital to our economy. Those of you who live in rural Kansas know what a huge impact the senior care homes have in your area.

(Mention Economic Impact Statements)

A new national Medicaid study projects Kansas' Medicaid program underfunds the actual cost of providing skilled nursing care. A projected (-$21.61) daily shortfall for Kansas providers.

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DATE: 01/18/11
ATTACHMENT #5

We plan to be a part of the administration's discussion of how to look differently at Medicaid. Until changes, we ask that you maintain Medicaid funding according to methodology currently set in statute and regulation.

The second point I would like to make today is about Kansas providers. They are winners. More than 287 out of 343 homes are a part of Advancing Excellence. The Advancing Excellence initiative looks at areas of Staff Turnover, Consistent Staffing, staff satisfaction, resident and family satisfaction to name a few. In the initial stages of the Advancing Excellence, Kansas led the nation in reduction of use.

Kansas Health Care Association and Kansas Center for Assisted Living saw providers honored at the national level. -press release-

The last area of concern is the health care reform. The complexity of the health care system and the recently signed federal law to reform that system has created more questions than answers. One health care mantra that has been around for a while is "the right care, at the right time, in the right setting." The theory being that monitoring a person's health closely (which consumers should and can do in conjunction with providers) will allow the application of more prevention and early intervention programs with lower cost and better overall results. This leads to better outcomes and more satisfied consumers who can avoid or minimize intrusive acute care interventions requiring a hospital stay.

KHCA continues to work with the state in the Money Follows the Person program. Also, diversion strategies help in diverting almost one in five people to a less restrictive setting and providers are taking the lead in these diversions. Long term care benefits in these diversions because as it turns out, they become the "value" provider in the health care system. Hospitals will definitely be targeted by cost control measures as high-cost providers. On the other end, diversion will slow down but not stop, the movement of people getting services in long term care residences.

We need to continue to get as much information to the public on services available. Second, we must reform the Medicaid eligibility process so that it is consistent, timely and efficient. There is no way for most communities to assume the responsibility of care for a pending Medicaid beneficiary, legally or financially. I believe home and community based options also are constrained because of rates and timeliness of payments.

Thank you for the opportunity to present today. KHCA providers do the majority of the Medicaid services for Kansas seniors so we want to be partners with the state of Kansas. We will all benefit if we sit down and look for opportunities to improve the care of Kansas seniors.

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January 18, 2011

The Honorable Bob Bethel, Chairman
Aging and Long-Term Care Committee

Reference – AARP Kansas Priorities

Good morning Chairman Bethel and Members of the House Aging and Long-Term Care Committee. My name is David Wilson and I am the Volunteer State President for AARP Kansas. AARP Kansas has more than 341,000 members statewide. Thank you for allowing us time this morning to present our priorities including home- and community-based services (HCBS).

AARP is working to help Americans 50+ in Kansas live life to the fullest. We advocate for our members on critical priorities, such financial protection, access to affordable utilities, and independence and choice for all Americans as they age.

This year, the issues that AARP Kansas will focus on in its advocacy on behalf of the 50+ population include long term care, home and community based services (HCBS), nursing contact hours, older workers and utilities.

Long-Term Care: AARP Kansas's has long supported rebalancing long-term care services in Kansas. Rebalancing would entail reaching a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community-based supports. A balanced LTC system offers individuals a reasonable array of … options, particularly adequate choices of community and institutional options. In 2003, at the request of AARP Kansas, the University of Kansas, Office of Aging and Long-Term Care, completed research "Securing Kansas' Future: Next Steps in Long-Term Care." Findings in the research were:

- Statewide surveys of Kansas's older adult population overwhelmingly indicate their preference to receive long-term care services in the community.
- Kansas continued to institutionalize older adults at rates higher than the national average in all age categories. In 2000, the percent of Kansans age 65 and over residing in nursing facilities was 5.57% while the national average was 4.5%.

In 2008, an AARP Public Policy Institute report on the state of long-term care in Kansas, "A Balancing Act: State Long-Term Care Reform", found that Kansas continues to institutionalize older Kansans at a higher rate than the national average. Compared to the U.S. as a whole, Kansas has a significantly higher rate of older people (age 65+) living in nursing homes - 5.15 nursing home residents for every 100 people age 65+ (*6th highest in the nation, and 43% higher than the U.S. average*).

In a 2009, an ARRP Public Policy Institute report, "Profiles of Long-term Care and Independent Living revealed that 66 percent of Kansans receive long-term care services are served in institutional settings versus 33% in home and community based settings.

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The reports also states that:

- The bulk of Medicaid long-term dollars go to nursing home rather than home and community based services.
- On average, Medicaid dollars can support nearly three older people and adults with disabilities in home and community based settings for every person in a nursing facility.

Therefore, AARP Kansas will advocate for budgets and policies to eliminate institutional bias, expand access to HCBS, and allow consumers to choose the setting in which they receive services.

The Long-Term Care Ombudsman (LTCO) Program: Authorized by the Older Americans Act, the LTCO provides an additional mechanism for ensuring quality and protecting residents' rights. The ombudsmen advocate for residents in nursing homes and supportive housing and investigate and respond to complaints for residents in every state.

However, people of all ages now prefer to receive long-term care services and supports (LTSS) in their own homes whenever possible. Under the "Money Follows the Person Grant", received by Kansas in 2007, many individuals placed in nursing or intermediate care facilities can be served in their homes and communities. Home- and community-based services help to preserve individuals' independence and ties to family and friends at a cost less than that of institutional care.

The individuals ombudsmen have traditionally served - residents of long-term care facilities – are now moving into home care settings. Twelve states currently have Long-Term Care (LTC) Ombudsmen with HCBS responsibility. The people being served remain the same, but the settings are different. The role of the ombudsman has always been to hold systems accountable to fulfill their responsibilities to residents. In thinking about a potential role for ombudsmen in a long-term care community setting, the role would be the same – to ensure that the systems that are in place adequately provide for consumers.

AARP believes that states should:

- States should provide adequate funding to permit state LTC ombudsmen to visit all facilities.
- Extend the scope of the ombudsman program to include HCBS and ensure that ombudsmen have adequate funding to monitor such services.

Nursing Hours: AARP Kansas, along with other partners, will ask legislators to consider increasing the number of nursing care hours that residents of Kansas nursing homes receive each day. We believe that the number should to be increased to better meet the care needs of the 18,000 older Kansans who reside in the state's 326 nursing homes. The Institute of Medicine identified positive relationships between nursing staffing and quality of care and reached the conclusion that there is a strong need to increase overall levels of nursing staff in nursing homes. The current standard of required care in Kansas is 2 hours per resident per day. The Institute of Medicine recommends 4.85 hours of nursing care for each resident per day as a minimum standard. In the past year, 132 facilities or 40 percent of all nursing homes in Kansas were cited for abuse, neglect or

exploitation. Studies on staffing and quality of care support the contention that both the level of staffing and mix of staff are directly related to quality of care residents receive.

Culture Change: Growing numbers of facilities are embracing culture-change efforts to transform the settings into more pleasant places in which to work and live. For example, the Green House Project and similar efforts transform nursing homes from institutions into small, home-like settings with private rooms and private bathrooms, focusing on resident-centered care and staff empowerment.

AARP believes that states should encourage and provide incentives including, but not limited to, grants and loans for new, affordable models of (LTSS) that emphasize resident-centered care, a home environment, a positive workplace culture, and opportunities for resident involvement in the community.

AARP supports the Greenhouse Projects in Kansas, bringing Dr Bill Thomas to the state to promote the Greenhouse concept. We are troubled to learn through the Hutchinson News report of 6/1/10 that these houses are now being used for short-term rehabilitation therapy and care rather than their intended purpose of providing a home-like setting for those who need skilled care in place of an institutional setting.

50 + Workers: 50+ workers have been especially hard hit in the economic downturn. Older workers not only are enduring record-high levels of unemployment, but also stay jobless longer than others, according to the Labor Department. Many struggle with unemployment, underemployment and lack of training for available jobs. An economic recovery is unlikely to quickly restore the jobs lost by older workers -- and some might never return. AARP Kansas will propose legislation that would place mentors at employment centers around the state to specifically focus on the needs of older workers and to help they find the information and resources they need to obtain jobs or reduce the barriers that might keep them from finding jobs.

Utilities: The issue of utility costs and energy conservation, especially for older Kansans living on fixed incomes, has long been a concern for AARP Kansas and will continue to be monitored. AARP Kansas will continue to work on behalf of all Kansans to ensure that the cost of utilities is not beyond their reach and doesn't force them to choose between paying for food, rent or medical services.

Once again we thank you for your time this morning and for the opportunity to speak to you regarding our interests in issues that affect older Kansans.

Respectfully,
David Wilson

Attachments: AARP Kansas Fact Sheet
AARP Job Search Flyer
AARP Drivers Safety Program Fact Sheet
AARP Tax-Aide Fact Sheet

AARP Kansas State Office

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State Office Staff

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Ernest Kutzley, Advocacy Director	**785-234-1363**
Mary Tritsch, Communications Director	**785-234-1365**
Andrea Bozarth, Community Outreach Director	**785-234-1364**
Janet Clearwater, Senior Operations Administrator	**785-234-1366**

Volunteer Contacts

David Wilson, Volunteer State President	**913-375-6548**

AARP Kansas works for over 341,000 members in the state, as well as for all Kansas seniors.

KS Congressional District	Preliminary Estimated 2010 Population Aged 50+	Estimated AARP Members
CD 1	226,875	87,319
CD 2	224,336	84,666
CD 3	222,994	86,770
CD 4	220,048	80,815

Source: AARP Insight, 2010.

We advocate for legislation to protect services and options available to seniors, and we educate members and the community on issues that are important to seniors and all Kansans.

AARP Kansas operates with 5 staff, an all-volunteer Executive Council comprised of seven members, who under the guidance of the State President and the State Director carry out AARP's strategic priorities within the state.

AARP Kansas also benefits from the guidance of a Diversity Advisory Council of twelve volunteers. This Council assists in facilitating cultural change, with an emphasis on inclusion in recruitment, retention, and recognition of AARP Kansas volunteers and members.

We work with an essential cadre of volunteers across the state who are instrumental in helping us to reach our goals of educating and serving Kansans.

AARP STATE FACT SHEET
KANSAS

AARP is working to help Americans 50+ in Kansas live life to the fullest. We advocate for our members on critical priorities, such as strengthening Social Security, protecting seniors' access to their doctors, and ensuring all Americans have independence and choice as they age.

AARP serves as a one-stop resource for information on the age 50+ population in Kansas and public opinion research. In addition to serving as a clearinghouse for information about older Americans, we also offer programs and tools that help Americans age 50+ make the best decisions about their health and financial security. We hope the data below and the programs on the reverse side will be helpful to you and your constituents.

Kansas at a Glance

AARP Members
Total number of AARP members in Kansas: 341,339

50+ Voters
78% of Kansas residents 50+ voted in the last election

Employment Profile
50+ Employed Workers (Labor Participation): 53.9%
50+ Unemployed Workers: 4.5%

Social Security
Social Security Beneficiaries: 478,138
Retirees: 314,968
Widow(er)s: 40,996
Disabled Workers: 65,631

Social Security recipients who rely on Social Security for 90% or more of their income: 20.8%
Social Security recipients who rely on Social Security for 50% or more of their income: 50%

Medicare
Medicare Beneficiaries: 429,952

Long-Term Care
Percent in home and community-based services (HCBS):33%
Percent in nursing homes: 66%
Estimated number of family caregivers: 410,000
Unpaid contributions of family caregivers are valued at: $2.7 billion

Retirement Security
Percent of non-government workers (55-64 years old) without workplace retirement benefit: 36%

Contact Information

Kansas: Ernie Kutzley, Associate State Director - Advocacy; ekutzley@aarp.org; 785-234-1363
Washington, D.C.: Pete Jeffries, Interim Director, Congressional Relations; PJeffries@aarp.org; (515) 697-1017

AARP STATE FACT SHEET
KANSAS

AARP: Helping Americans 50+ Live Their Best Lives

AARP is working to ensure Americans have 50+ choice, control and independence through every stage of their lives.

Finding A Job

AARP is helping older workers find jobs through our online job board. This tool allows users to search among more than 1 million job listings. The jobs are searchable by state and zip code, as well as part-time and full-time status and specific company and further broken down by industry, occupation and title. The job board can be found at **http://jobs.aarp.org**.

Preparing For Your Retirement

AARP is helping Americans prepare for retirement by providing a retirement calculator that will allow them to answer key questions: Am I saving enough? When can I afford to stop working? How long will my money last? The calculator can be found at **www.aarp.org/retirementcalculator.**

Affording And Understanding Your Prescriptions

AARP's guide, **Medicines Made Easy**, shows consumers how to safely and effectively manage their medications. They'll learn the right questions to ask health care professionals; the importance of tracking medications; and how to compare drugs for effectiveness and cost. A personal medication record to complete and share at doctor and pharmacy visits is included and can be downloaded from AARP's web page**: www.aarp.org/medicationrecord**.

AARP's **Doughnut Hole Calculator** is a four-step online tool to help people with Medicare Part D save money. This powerful tool calculates when a person with Medicare Part D insurance will fall into the prescription drug coverage gap, or "doughnut hole" and directs users to lower cost, therapeutically similar drugs available in their Part D plan. Using the tool, consumers may be able to reduce their time in the coverage gap or possibly avoid it altogether. Go **to www.aarp.org/doughnuthole**.

AARP's **Drug Savings Tool** helps consumers better understand their prescription drug choices. The new, three-step tool allows users to select the drug they want to compare from Consumer Reports Health's database of about 500 drugs in 26 drug classes. The tool then provides consumers with recommendations on their drug options based on the medications' safety, effectiveness, cost and convenience. Users are also provided with a discussion sheet to help guide conversations with their health care professional. Go to: **www.aarp.org/drugsavings**.

Preserving Your Independence And Choices

Decide.Create.Share^{SM} is AARP's national campaign dedicated to increasing awareness among boomer women about long-term care planning. The campaign website offers timely, relevant news on long-term care, interactive tools and information tailored to women interested in planning for their long-term care, including glossaries, polls, and an online community for women who are considering their options and planning for their future. Go to **www.aarp.org/decide**.

Driving Safely As You Age

Even though older drivers are generally safe drivers, cars have changed. So have traffic rules, driving conditions, and the roads we drive on every day. Older drivers can sharpen their driving skills and refresh their knowledge of the rules of the road by taking the **AARP Driver Safety Program** classroom or online course. To learn more visit **www.aarp.org/drive** or call 1-888-AARPNOW (1-888-227-7669). Also available is the **Getting Around Guide** (**www.aarp.org/gettingaround**) for those who no longer drive or are interested in going "car-lite."

http://www.aarp.org/work/

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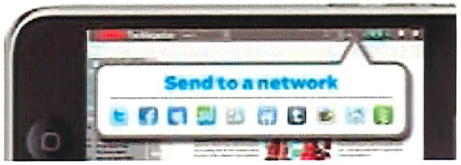
Work: Over 50 Employment, Jobs, Careers, Social Se...



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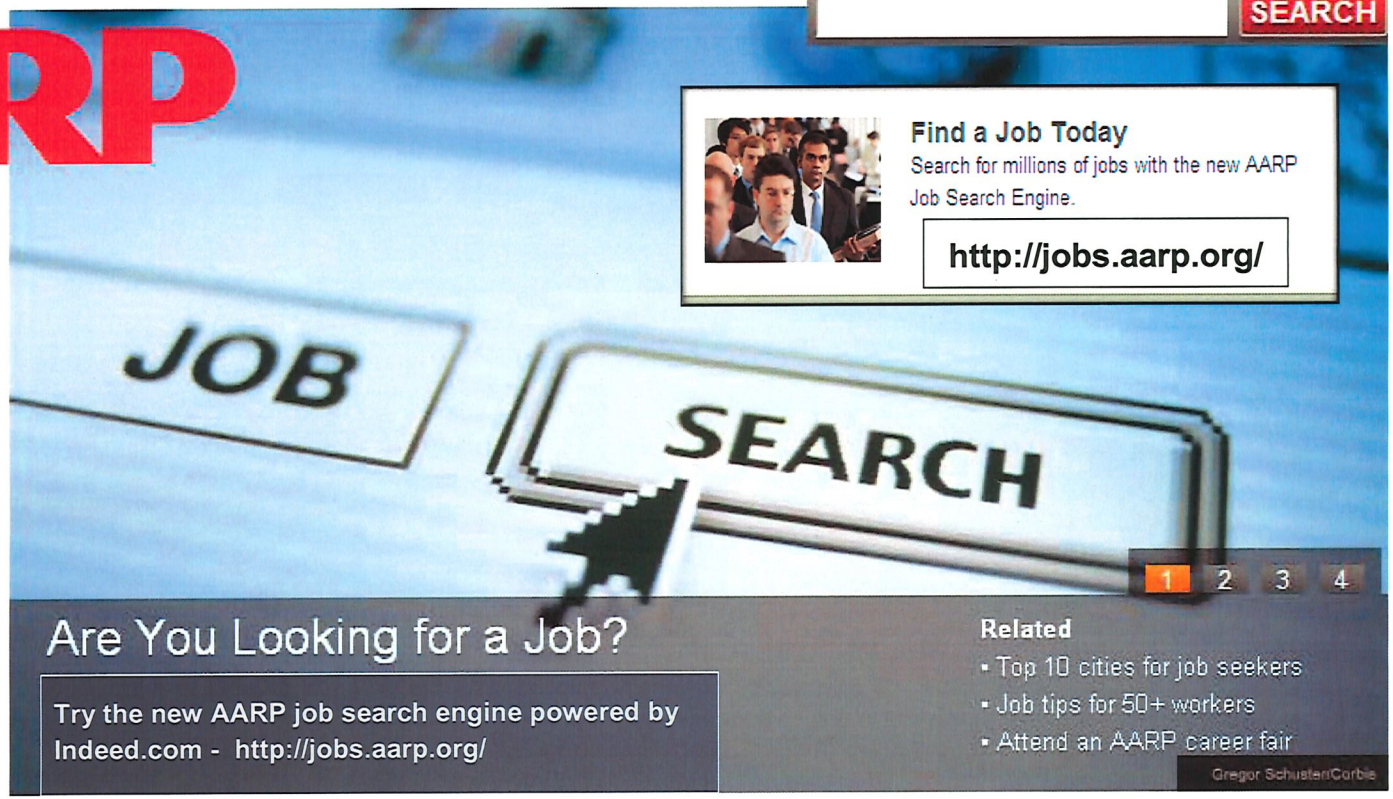
  - Self-Employment
  - Retirement Planning
  - Social Security
  - Work Life
  - Work & Retirement Tools
- PERSONAL GROWTH
- POLITICS & SOCIETY
- RELATIONSHIPS
- HOME & GARDEN



Driver Safety Program by AARP - Defensive Driving, Education Classes/Courses Online - Microsoft Internet Explore...

http://www.aarp.org/home-garden/transportation/driver_safety/?cmp=RDRCT-DRIVE

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Driver Safety Program by AARP - Defensive ...

Join/Renew | Find a Discount | Donate | Volunteer

Welcome, Please Login | My Account | Community | Help | Search Keyword(s)

AARP

- HOME
- HEALTH
- MONEY
- WORK
- PERSONAL GROWTH
- POLITICS & SOCIETY
- RELATIONSHIPS
- HOME & GARDEN
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  - Home Improvement
  - Livable Communities
  - Transportation
  - Gardening
  - Home & Garden Discounts
- FOOD
- TRAVEL
- ENTERTAINMENT
- TECHNOLOGY
- GIVING BACK
- MEMBER BENEFITS

JOIN AARP

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Driver Safety Program Classroom Courses Near You

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Cars have changed. So have traffic rules, driving conditions, and the roads we drive on every day. Brush up on your driving skills to stay safe!

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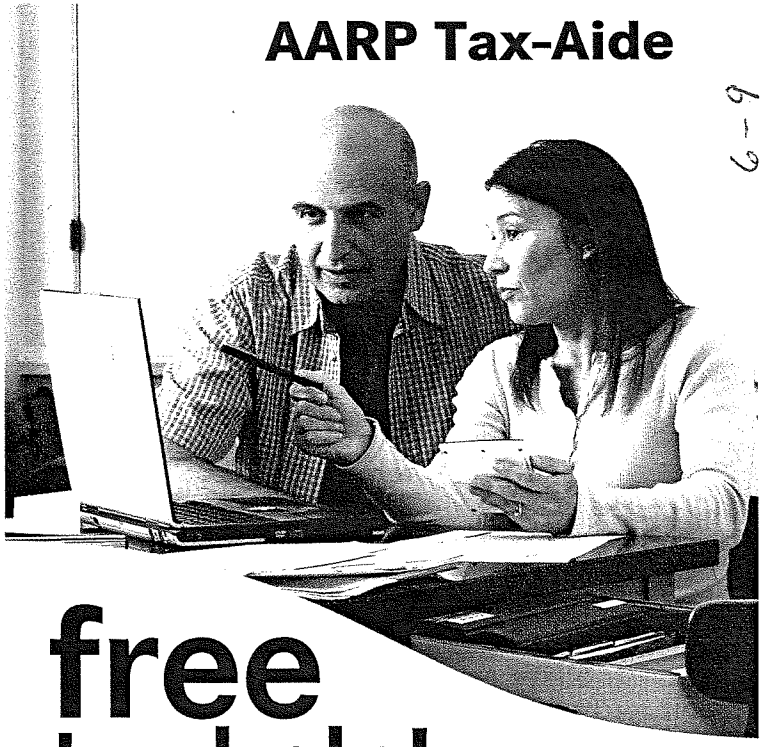
AARP Tax-Aide



free tax help!

For taxpayers with low- and middle-income, with special attention to those age 60 and older.

AARP Tax-Aide is:

- a free, quality service supported by friendly people in your neighborhood
- a confidential service
- a service that prepares tax returns and answers tax questions
- over 32,000 dedicated and proud IRS-certified volunteers
- available for assistance at nearly 7,000 sites nationwide late January/early February through April 15

To locate a site near you, visit our website at www.aarp.org/taxaide or call our toll-free number, 1-888-AARPNOW (1-888-227-7669) from late January/early February through April 15. For year-round assistance, visit www.aarp.org/taxaide.

AARP[SM]
FOUNDATION

COMMITTEE RULES
2011
KANSAS HOUSE OF REPRESENTATIVES
COMMITTEE ON AGING AND LONG TERM CARE

The purpose of these rules is to facilitate the understanding of members of the Committee and the public in reviewing the flow of legislation through this committee. Unless stated to the contrary herein, the rules of the House or Mason's Manual of Legislative Procedure will apply.

PROTOCOL OF MEETING & COMMITTEE INFORMATION

1. Items listed on the agenda shall be brought before the committee in order of appearance. However, the chair may bring to discussion, and possible vote any bills previously heard, at any time.

2. Original motions shall be in order when a bill is pending for consideration. A substitute motion will not be allowed. Amendments to motions are not in order unless approved by the Chair.

3. An amendment to a bill must be "germane" to the area of law that is being proposed or changed. Since committees serve the purpose of examining issues for which there may be multiple solutions or approaches, "germaneness" will be interpreted as broadly as possible. Only the Chair shall determine if an amendment is "germane."

4. The question of adjournment shall be reserved to the Chair and no motion to adjourn shall be entertained.

5. A motion to "table a bill" shall be in order at any time a question (including an original motion) is pending. The motion to "table a bill" is non-debatable and requires a majority vote of members present to pass. A successful motion to "table a bill" shall lay the bill over a minimum of one day. The Chair may refuse to accept a motion to table a bill or move a bill out of committee, with just cause, as determined by the Chair.

6. A motion to "take from the table" shall be in order only when such item is on the agenda or is taken up by the Chair. The motion requires a simple majority and is debatable.

7. A motion to report a bill "without recommendation" shall not be in order.

8. A motion to reconsider a previous successful motion shall only be made by a member voting on the prevailing side of the original motion. A simple majority vote of members present shall be required to reconsider a previous successful motion.

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9. A motion to report a bill out of committee shall not be in order until all amendments, which have been prepared by the Revisor of Statutes office reported to the chairman in advance of the meeting, have been considered.

10. No conferee shall be interrupted, except by the chair, during presentation of their testimony.

11. Questioning of a conferee shall be limited to the subject matter on the agenda for the day unless approved by the Chair. If the questioning of a conferee by a committee member goes beyond "reasonableness," the chair may discontinue the committee member's questioning of that conferee.

12. There shall be no recorded committee votes on committee action. Any committee member may request their individual vote be recorded on a bill.

13. The Chair shall set the Committee Agenda.

14. All requests for committee bills shall only be made by committee members or state agencies.

15. All seating will be assigned by the Chair.

16. Requests for excused absences will be honored. Prior notification of absences shall be communicated to the committee assistant. Any absence by a member not requesting an excused absence, shall be an unexcused absence and recorded as such by the committee assistant unless the Chair makes an exception.

17. ***All cell phones and pagers in the committee room shall be in "silent" mode and use of cell phones in the committee room will not be permitted.***

18. Photography, including cell phones, video, and audio taping is prohibited unless approved in advance by the Chair.

19. All powers, duties and responsibilities not addressed above are reserved to the Chair.

INFORMATION FOR CONFEREES
2011
KANSAS HOUSE of REPRESENTATIVES
AGING AND LONG-TERM CARE COMMITTEE

1. When time is separately reserved on the agenda for proponents and opponents of an issue and the time expires for either side, the testimony shall cease. Conferee's time limit will be determined by the number of conferees and order of business. The chairman may make exceptions for the original sponsor of a bill, Legislative Staff, and State Agency Personnel. Conferees will be recognized in the order as established by the committee chairman. No conferee will be allowed to "yield" their time to another conferee.

2. All conferees are requested to submit a one page summary of testimony. (More lengthy written testimony may be submitted in addition to the one page summary.)

3. All conferees shall have written testimony and shall provide 25 copies to the committee secretary at the time of appearance. If a one page summary and written testimony are both presented, then 25 copies of each **shall** be required.

4. All conferees whose testimony extends more than one page or five minutes **shall** expect their time to be shortened by the chair, if necessary, to expedite the meeting. Exceptions will be allowed for the original sponsor of a bill, staff briefings, and state agency briefings.

5. At the option of the chair, all who are scheduled to testify on a bill may be required to submit written testimony 24 hours in advance of the hearing for distribution to committee members.

6. Anyone wishing to testify before the Committee **shall** contact the Committee Assistant, Linda Martin at 1-785-296-7616, a minimum of 24 hours before the meeting.

7. All cell phones, pagers, and other electronic devices, in the committee room **shall** be in "silent" mode and use of cell phones in the committee room will not be permitted. The owner of any cell phone that rings during a committee meeting shall provide apples or oranges for all committee members and staff. (20)

8. No food or drinks will be allowed in the committee room by guests, spectators or conferees.

9. Any non-committee attendee who sends signals to committee members shall be removed from the committee meeting for the rest of the legislative year.

10. Photography (including cell phones), video recording, audio recording or transmitting of proceedings, and is prohibited unless approved in advance by the Chair.

11. All requests for committee bills shall only be made by committee members or state agencies.

12. Any usage of computers in the committee room by anyone, except legislators and staff, shall be approved by the chair before each meeting.

13. Conferees **SHALL NOT** read their testimony. Rather, testimony should be presented in a summary fashion. Conferees shall introduce themselves, identify on whose behalf they are appearing, identify whether they are a proponent, opponent, or neutral on the bill and as briefly as possible, state the reasons for their position.

14. If suggested amendment(s) are to be offered, a proposed draft of the amendment(s) must be provided with the written testimony.

15. Conferees shall address their remarks during testimony to committee members and staff only.

16. The Chair reserves the right to limit testimony that is cumulative in nature or testimony that is, in the judgement of the Chair, not relevant to the matter under consideration.

17. Testimony shall relate to the subject matter of the measure under consideration. Conferees testifying on unrelated subjects will be admonished and if unrelated testimony continues, the Chair will terminate that conferee's testimony.

18. While the taking of testimony is not preceded with the formality of an oath, by appearing before the committee every conferee hereby certifies that his or her testimony is truthful, based upon facts that are capable of verification and offered in good faith. Conferees shall promptly bring to the committee;'s attention any qualifications of corrections in their testimony.

19. The Chair reserves the right to take such action as may be necessary to prevent disruptive behavior in the committee room during hearings and deliberations.

20. The Chair reserves the right to take such action as may be necessary when a violation of these rules is suspected.

21. Committee members shall not be approached during committee hearings or deliberation by anyone other than fellow legislative members or legislative staff.