Update on the Kansas Community Mental Health System for House Health and Human Services

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Chair Carpenter and members of the Committee, my name is Kyle Kessler, and I am the Executive Director for the Association of Community Mental Health Centers of Kansas, Inc. Our Association represents the 26 licensed Community Mental Health Centers (CMHCs) in Kansas that provide behavioral health services in all 105 counties, 24-hours a day, seven days a week. 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.

We appreciate the opportunity to provide you with an update of the Kansas Community Mental Health System.

Our Primary Goal
The primary goal of CMHCs is to provide quality care, treatment, and rehabilitation to individuals with behavioral health problems in the least restrictive environment. The CMHCs provide services to all those needing it, regardless of economic level, age, or type of illness, and by mandate, regardless of ability to pay. The CMHCs strongly endorse treatment at the community level in order to allow individuals to continue functioning in their own homes and communities, at a considerably reduced cost to them, third-party payers, and taxpayers.

CMHCs provide treatment and recovery services to Kansans covered by Medicare, Medicaid, private insurance, and those who are uninsured and underinsured. The need for mental health care continues to grow, and CMHCs provide services to over 145,000 Kansans each year.

Accountability
The 26 licensed CMHCs operating in Kansas have separate duly elected and/or appointed boards of directors. Each of these boards is accountable to the citizens served, county officials, the state legislature, and the Governor, and all are required to submit data to the state in order to receive federal mental health block grant funding.

Shared Governance
CMHCs are their respective counties' legally delegated authorities to manage mental health care in Kansas and function as the local mental health authorities. The Kansas mental health system is a relationship of shared governance between two governmental entities: the State and the counties. This also includes unique partnerships with local agencies such as law enforcement, health departments, school systems, and community hospitals.

CMHCs have a combined staff of over 5,000 providing mental health services in every county of the state in over 120 locations. Together, they form an integral part of the mental health system in Kansas offering a network of access to a comprehensive array of community-based treatment for mental health and substance use disorders, as well as medical services across the state. The independent, locally owned and operated CMHCs are dedicated to fostering a quality, free-standing system of treatment and programs for the benefit of citizens needing behavioral health care and treatment. Outcome performance measures have been specifically delineated in contracts with the State of Kansas since the Mental Health Reform Act of 1990 was enacted.

The CMHCs operate under extensive state licensing regulations; are subject to licensure site reviews; and provide extensive required data routinely to the Kansas Department for Aging and Disability Services (KDADS). The CMHCs also conform to Medicaid and Medicare standards and audits.

Statutory Authority

- Chapter 19. Counties and County Officers
  - Establishes CMHCs as county designated treatment entities.
- Chapter 39. Mentally Ill, Incapacitated And Dependent Persons; Social Welfare
  - Mental Health Reform Act of 1990 establishes the CMHCs as the public mental health safety net.
- Chapter 59. Probate Code
  - Care and Treatment Act; details the relationship between CMHCs and state mental health hospitals.
  - CMHCs are the "gatekeepers" for the state hospitals and the statute requires that they conduct emergency screenings to determine if state hospital admission is appropriate.
- Chapter 65. Public Health
  - Establishes mental health clinics and joint boards of mental health in certain counties.

Community-Based Focus

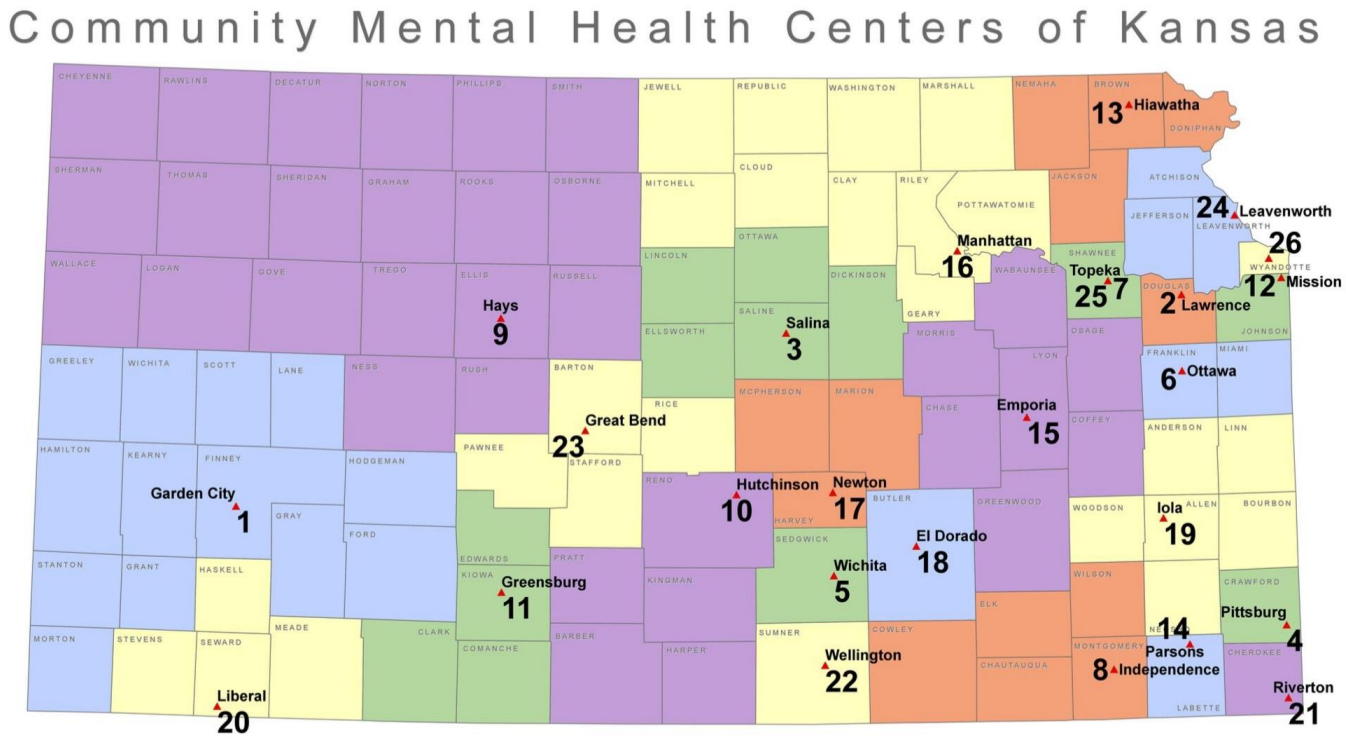
CMHCs were originally established to allow citizens to recover from mental illness in their communities through access to preventative short-term treatment and care. The system dramatically shifted after Mental Health Reform in the early 1990s toward more public, long-term treatment and care, including case management and crisis services.

Kansas originally had state mental health facilities in Osawatomie, Larned, Topeka, and Kansas City. With the closure of Topeka State Hospital and Rainbow Mental Health Facility in Kansas City, the State currently has two remaining state mental health hospitals in Osawatomie, which serves eastern Kansas, and Larned, which serves western Kansas. A third state hospital is scheduled to open in south central Kansas in early 2027, which will provide additional, much-needed inpatient resources.

The statutory authority vested in CMHCs is the foundation on which local, community-based mental health services are provided. Kansas statutes provide that participating CMHCs are the "gatekeepers" for the state hospitals and require that they conduct emergency screenings to determine if state hospital admission (voluntary admission, court ordered admission, or emergency hold admission) is appropriate.

The Mental Health Reform legislation further mandates "that no patient shall be discharged from a state hospital if there is a participating CMHC 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 work with the state hospitals to assist with discharge and aftercare plans, as well as coordinating with private psychiatric facilities and nursing facilities for mental health (NFsMH).

The Mental Health Reform Act ties in with Article 7, Section 1 of the Kansas Constitution which states, "**Benevolent institutions.** Institutions for the benefit of mentally or physically incapacitated or handicapped persons, and such other benevolent institutions as the public good may require, shall be fostered and supported by the state, subject to such regulations as may be prescribed by law.



Implementation of a New Model of Care—Certified Community Behavioral Health Clinics (CCBHC)

Implementation of the Certified Community Behavioral Health Clinic (CCBHC) model represents the biggest transformation of the system since Mental Health Reform. This new model of care focuses on integrated, whole person care; expands the array of services provided to the community; and provides a sustainable funding mechanism through a prospective payment system (PPS) reimbursement mechanism designed to cover the true cost of providing services. The CCBHC is a provider type under the Medicaid program, and through the PPS, provides more funding than the traditional fee-for-service payment model of CMHCs.

According to the National Council for Mental Well-Being, there are now more than 500 Certified Community Behavioral Health Clinics and CCBHC grantees operating in 46 states, plus the District of Colombia and Puerto Rico.

In 2021, Kansas became the first state to mandate statewide implementation of CCBHC when the Legislature passed monumental behavioral health legislation to implement the CCBHC model. The legislation directed the Department of Health and Environment (KDHE) to submit a Medicaid state plan amendment in order to develop a CCBHC prospective payment system and directed the KDADs to develop a process to certify "*any community mental health center licensed by the department*" that provides the nine required CCBHC services, no later than July 20024.

Today, all 26 CMHCs have achieved CCBHC certification. In addition, as of January 1, 2025, following a successful competitive federal funding opportunity, the State of Kansas has become a part of the Centers for Medicare and Medicaid (CMS) CCBHC federal demonstration; this allows the state to receive an enhanced federal match rate for CCBHC services.

Supporting the Clinical Model with Effective Financing

Standard definitions →→→Raises the bar service delivery
Evidence-based care→→→Guarantess most effective clinical care
Quality reporting→→→Ensures accountability
Prospective payment system→→→Covers anticipated costs

Workforce Impact

CMHCs have historically struggled with competition from schools, primary care clinics, private practice, and others for the already limited pool of behavioral health professionals. Often, these other employers are able to offer higher wages and/or schedules that do not require provision of 24/7 access to crisis services and serving the most vulnerable and high-need populations served by the CMHCs.

The additional resources provided through the PPS have allowed our CMHCs/CCBHCs to be more successful in recruiting and retaining staff, which is vital to being able to provide the

required services and to ensure continuity of care for patients. The total number of FTE systemwide has increased since implementation of CCBHC.

Enhanced Service Array

The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes the "CCBHC Certification Criteria[1]," which is a detailed set of requirements across six key program areas: staffing, availability and accessibility of services, care coordination, scope of services, quality reporting, and organizational authority and governance.

There are nine required services that all CCBHCs must provide:

1. Crisis services (including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization)
2. Screening, assessment, and diagnosis
3. Person-centered and family-centered treatment planning
4. Outpatient mental health and substance use services
5. Primary care screening and monitoring
6. Targeted case management services
7. Psychiatric rehabilitation services
8. Peer supports and family/caregiver supports
9. Community care for active duty service members and veterans

In addition, States must determine a minimum set of evidence-based services to be provided by their CCBHCs. Kansas has selected four evidence-based practices that all CCBHCs are required to provide:

1. Assertive Community Treatment (ACT): A service delivery model that features small, shared caseloads, utilizing a transdisciplinary team to provide integrated mental health services and supports in the community, 24/7. The team provides time-unlimited services with a fixed point of responsibility by providing all necessary services for as long as the individual requires them.
2. Individual Placement and Support (IPS): Supported employment services to help individuals with mental illness participate in the competitive labor market by helping them find meaningful jobs and providing ongoing support from a team of professionals to help them maintain employment.
3. Medication Assisted Treatment (MAT):The use of medications in combination with counseling and behavioral therapies to treat substance use disorder.
4. Cognitive Behavioral Therapy (CBT): a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors.

Further, CCBHCs are required to provide crisis behavioral health services. Kansas now has a coordinated, statewide crisis response system, comprised of mobile crisis response (MCR), 988, and crisis stabilization units/crisis intervention centers. When an individual or family member contacts a crisis hotline (e.g., the 988 Suicide Prevention and Mental Health Crisis line or any of the individual-CMHC/CCBHC crisis lines), and the mental health professional who takes the call is unable to effectively de-escalate the crisis situation and determines that a face-to-face intervention is needed, teams are deployed from the local CCBHC with an expectation that contact is made with the individual in crisis within two hours. CCBHCs must ensure that mobile

crisis response is available everywhere in the state 24/7.

While CMHCs historically have generally provided only behavioral health focused services, CCBHCs must also provide an array of physical health screening and monitoring services. Examples include, but are not limited to, adult BMI screening and follow-up; weight assessment and nutrition and physical activity counseling; tobacco screening and cessation; diabetes screening; metabolic monitoring; and cardiovascular health screening and monitoring. They must also ensure children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and that older adults receive age appropriate screening and preventive interventions.

Finally, the foundation of the CCBHC model is care coordination. CCBHCs are required to coordinate care across the spectrum of health services; assist patients and families in obtaining and keeping appointments; and reconcile medications with external providers. In short, the CCBHC must ensure that all of the patient's healthcare needs are met, whether that is through the services they provide directly or through partnership with other health and human services organizations.

Increased Accountability, Outcomes, and Reporting

For the first time, required reporting for CCBHCs provides a way to "compare apples to apples," whether that means looking across Kansas CCBCHCs or comparing Kansas CCBHCs to CCBHCs in other states.

The CCBHC criteria require that the clinic have the ability to "collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services."

Some of the required measure are time to services, depression remission at 6 months, unhealthy alcohol use, screening and brief counseling, screening for clinical depression and follow-up plan, and screening for social drivers of health.

Our Association, in partnership with KDADs, is in the process of implementing a data warehouse. All 26 CCBHCs will be reporting into the data warehouse, and we will be able to create reports and dashboards to share with policy makers. Implementation is in process now, and it is estimated that all CCBHCs will be reporting into the data warehouse, allowing us to run systemwide reports, by late summer or early fall of 2025.

Cautiously Optimistic

The State of Kansas has made a significant investment in this new model of care, and CCBHCs are already achieving promising outcomes, including faster access to care, expanded crisis services, and reductions in staff turnover. A recent report commissioned by KDADs looking at the value analysis of CCBHC in Kansas found that implementation of CCBHC may increase costs by 40 percent (as compared to the CMHC system) but increases access by 75 percent (https://www.kdads.ks.gov/home/showpublisheddocument/4293/638726979088470000).

However, the system is still in transition. It will take some time to realize some of the outcomes other states that implemented CCBHC earlier have achieved, such as reductions in emergency department visits or hospitalizations for individuals with mental illness.

Implementation of CCBHC is no small feat. It requires a large investment of staff and provision of high-intensity services, such as ACT or mobile crisis response, which can be particularly challenging in rural and frontier areas.

It must also be noted that while the CCBHC financing system has been an extraordinary improvement over the previous Medicaid fee-for-service reimbursement model and this new model has finally allowed CMHCs/CCBHCs to cover the cost of the services they provide, PPS reimbursement is only for patients with Medicaid coverage. Our CMHCs/CCBHCs continue to provide services to an increasing number of un- and underinsured patients. It is vital that other funding sources, such as state and local funding, are not reduced, otherwise the system will return to its previous underfunded state.

Success Stories

CCBHCs provide behavioral health treatment and also to remain in their communities, access housing, and seek employment and regain their health and well-being. The following are just a few examples:

- (Supported Employment) My patient had a very difficult past and was coming from a rough situation while seeking employment. She worked hard on all her goals and was able to find employment at a local homeless shelter. She did such a great job she was promoted to a lead position. After the shelter closed, she was able to obtain employment at a local Mental Health facility where she now works as a Peer Support. She was also appointed by the Governor to the Peer Subcommittee. My patient now plans to start college in the fall to pursue a degree in social work or psychology.
- (Supported Employment) Patient was referred to us in July 2023 with very little work history. She had been living with her guardian and wanted to explore her independence, which included getting a job and getting her own apartment. She is not a very verbal person and is generally quiet. We provided career exploration with patient while job searching to find what she was most interested in. My patient started her job in February as a housekeeper working three days per week. She has also moved into her own apartment. This past spring, my patient was hospitalized for mental health symptoms for two weeks, Our staff was able to advocate for the patient with her employer and saved her job. My patient was able to return to work and continues to work there three days per week.
- (Crisis Response) Our crisis co-responder and her community policing partner teamed up with Hope House, ECKAN, and Lawrence First Church of the Nazarene to begin working with a family in the transitional housing program. After a year of living in their car and/or hotel, the family was approved for housing and moved in April. Both adult residents attained employment (with one attaining two jobs) and both youths were transitioned and enrolled in school. One parent enrolled in mental health services and has actively attended and participated in appointments. The family has attended weekly case management and is setting financial goals to obtain permanent housing.
- (ACT) Our ACT team worked with a veteran who had contact only in crisis. After a recent

hospitalization, he was able to come in for an intake and met with ACT the same day. The ACT team worked to help him re-establish utilities, phone services, food and medications. He has been able to find some work, and the team is now helping him to find a refrigerator for his home.

- (ACT) Our Assertive Community Treatment (ACT) team has made a significant impact on individuals with the highest needs and has been very successful in assisting with maintaining individuals in the community setting. We tracked a small group of high acuity individuals that had been receiving intensive services the year prior to us starting our ACT team. In the year prior to ACT, those individuals had been admitted to the state hospital 45 times that year. After starting an ACT program, that same group of individuals served by the ACT team went to the state hospital just 9 times the following year.

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[1] Substance Abuse and Mental Health Services Administration. (2023). *Certified Community Behavioral Health Clinic (CCBHC): Certification criteria*. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf