MENTAL HEALTH TASK FORCE

Report to the Kansas Legislature

January 14, 2019

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Acknowledgments

The Mental Health Task Force is comprised of the following individuals.

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- *Note: Wes Cole, Chair, Governor's Behavioral Health Services Planning Council, was unable to participate after his appointment as Interim Superintendent of Osawatomie State Hospital in August 2018.*

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(KDADS); Angela DeRocha, Deputy Secretary and Director of Communications (KDADS); Susan Fout, Deputy Secretary (KDADS); Andy Brown, Interim Commissioner for Behavioral Health Services (KDADS); Nikki Gilliland, Special Assistant/Chief of Staff to the Secretary (KDADS); Melissa Warfield, Director of Fiscal and Program Evaluation (KDADS); Kelsee Torrez, Kansas System of Care Project Director (KDADS); Melissa Bogart-Starkey, KDADS Housing, Employment, and Benefits Program Manager (KDADS); Rick Hoffmeister, Clinical Supervisor, Policy Analyst at Division of Health Care Finance (KDHE); and David Fye, Principal Fiscal Analyst (KLRD).

Additionally, the Mental Health Task Force extends special thanks to Kari M. Bruffett, Vice President for Policy; Tatiana Y. Lin, M.A, Strategy Team Leader; Sydney McClendon, Analyst; Wen-Chieh Lin, Ph.D., Director of Research; Cheng-Chung Huang, M.P.H., Analyst; Madison Hoover, M.S., Analyst; and Jason Orr, M.P.H., Analyst; of the Kansas Health Institute for providing process facilitation, research support and report preparation under the direction of the Task Force.

About the Report

During the 2018 legislative session, the Kansas Legislature passed a proviso directing the Kansas Department for Aging and Disability Services (KDADS) to continue the Mental Health Task Force established by section 99(r) of chapter 104 of the 2017 Session Laws of Kansas.

The purpose of the Mental Health Task Force was to:

- Create a strategic plan that addresses the recommendations of the report filed on January 8, 2018.
- Ascertain the total number of psychiatric beds needed to most effectively deliver mental health services and the location where such services would be best provided in Kansas.

The Task Force was comprised of 13 behavioral health providers, advocacy organizations, citizens with lived experience and other behavioral health experts. The group met 15 times between June and December 2018 to discuss issues included in the proviso and develop the strategic plan for the recommendations included in the Mental Health Task Force Report issued on January 8, 2018. The meetings were facilitated by the Kansas Health Institute (KHI). KHI also provided research and summarized the information discussed during the meetings in the Mental Health Task Force report to the Kansas Legislature. The work of KHI was designed to supplement, not supplant, Mental Health Task Force and KDADS capacity. KHI services were provided as a form of professional consultation, and all decisions were made by the Mental Health Task Force.

The report includes seven topics informed by the January 8, 2018, report. Each section provides information about the topic, lists priority recommendations and details required actions, timing considerations, implementation timeline, budget estimates (when available) and organizations responsible for implementing the listed activities.

Executive Summary

Executive Summary

This is the second report from the Mental Health Task Force, which was established because the Legislature recognized that the behavioral health system in Kansas is in crisis. "Behavioral health" refers to mental and emotional well-being, as well as actions that affect wellness. Behavioral health problems include substance use disorders and alcohol and drug addiction, in addition to mental illnesses, serious psychological distress, and suicide. Behavioral health systems serve people with behavioral health conditions and support a wide variety of specialized services delivered in a range of care settings.

For behavioral health systems to operate effectively, they need adequate capacity, with an array of services for mental health and substance use disorder treatment, and individuals need to be able to access the appropriate service(s) for their condition(s). Capacity issues or barriers to behavioral health services significantly harm patient, societal and system-level outcomes.[1]

Figures 1A (page ES-iv) and *1B* (page ES-v) provide an illustration of the levels of care and settings that comprise the behavioral health system. Sometimes referred to as the "continuum of care," it spans from prevention and early intervention to outpatient and inpatient treatment options.

Many of the recommendations in this report are intended to address gaps in the existing system in Kansas. The Mental Health Task Force developed a strategic plan for the implementation of recommendations that will improve the behavioral health system in Kansas and align with the state and national goals of more integrated behavioral health care – more seamless care for mental illnesses, substance use disorders and addictions, and primary medical care. The recommendations and key action steps to implement each are summarized in *Figure 2*, page ES-vi.

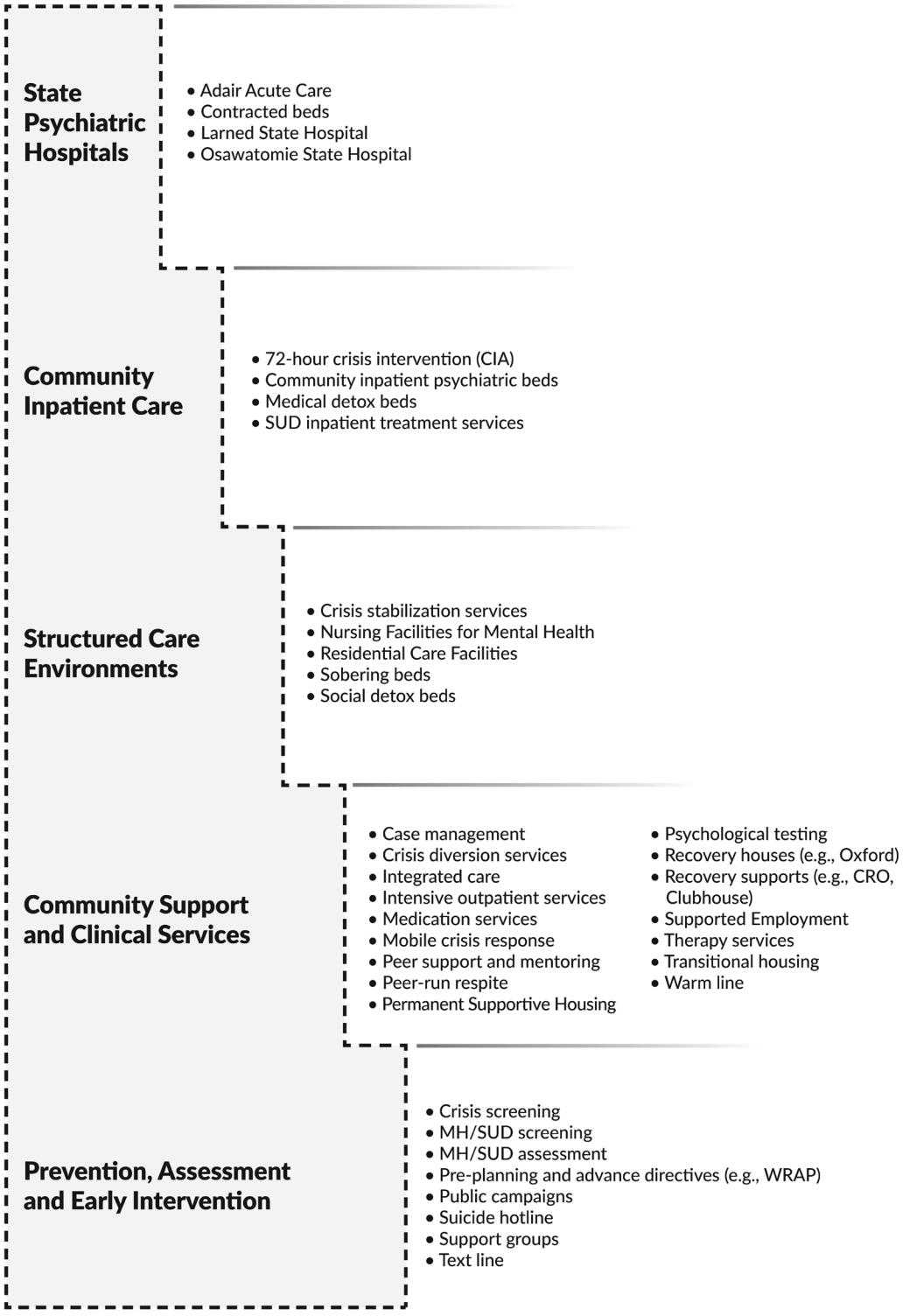
The 2018 Legislature took steps to address some of the recommendations in the January 2018 report of the Task Force, including committing funding to expand housing options through Medicaid and regional crisis stabilization programs, creating a pilot project to add mental health resources in K-12 schools, directing state agencies to create a new care management program to replace the previously halted health homes program, filling a shortfall in addiction treatment funding for the uninsured and setting a schedule to incrementally restore funding for grants to community mental health centers. It is critical that the Legislature maintain those actions as the recommendations in this plan are implemented.

Key Points

While the Task Force considers all recommendations in *Figure 2* (page ES-vi) to be priorities, there were a number of action items that emerged as essential to the implementation of the entire plan, including:

- Expanding Medicaid would undergird many of the recommendations by improving access to behavioral health services at all levels of care and allowing investment in workforce and capacity (Recommendation 2.5, page 36);
- Restoring and increasing community outpatient mental health and substance use disorder treatment, primary care, housing, employment and peer programs will improve outcomes for individuals and families (Recommendation 1.5, page 21; Recommendation 2.1, page 26; Recommendation 2.6, page 38; and Recommendation 5.1, page 60);
- Immediately increasing inpatient psychiatric capacity for voluntary and involuntary admissions (36-60 beds within 24 months) and investing in the current state hospitals will end the moratorium on admissions at Osawatomie State Hospital and begin to alleviate pressure on other systems, including hospital emergency departments and jails (Recommendation 1.1, page 5);
- Implementing a comprehensive plan to address needs at all levels and in all settings, including adding inpatient capacity up to a total of 221 new beds over five years, would stabilize the system (Recommendation 1.1, page 5);
- Investing in regional infrastructure, including crisis stabilization centers, crisis intervention centers and alternative models for rural areas, will improve access and potentially reduce demand for long-term inpatient bed capacity (Recommendation 1.2, page 13);
- Ensuring financial support for prevention, assessment, early intervention and integrated care will have long-lasting effects (Recommendation 3.1, page 42; Recommendation 3.4, page 48; and Recommendation 6.1, page 64).

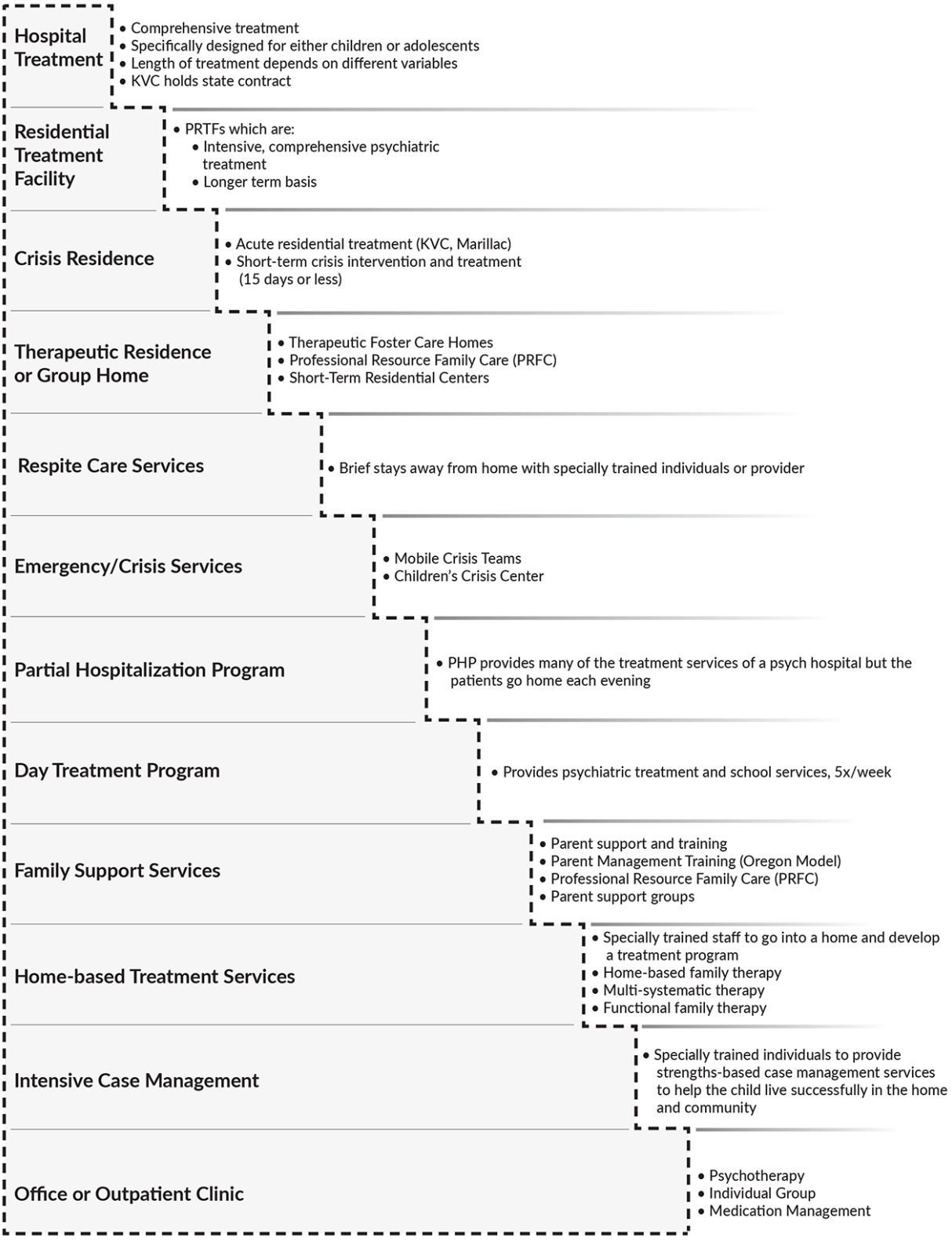
Figure 1A. **Adult Continuum of Behavioral Health Care**



Note: Services may or may not be available in all areas of the state.

Source: Adapted by the Mental Health Task Force from the Adult Continuum of Care Committee Final Report, 2015.

Figure 1B. **Children's Continuum of Behavioral Health Care**



Note: Services may or may not be available in all areas of the state.

Source: Adapted from the Kansas Children's Continuum of Care Committee report, December 2017.

Figure 2 provides an overview of recommendations developed by the Task Force and corresponding action steps to accomplish those recommendations. Some recommendations are marked to indicate action related to the recommendation. In the recommendations, one asterisk (*) indicates the Legislature has taken action related to the recommendation. Two asterisks (**) indicate a state agency has taken action related to the recommendation. Three asterisks (***) indicate action by both the Legislature and an agency.

A table that includes KDADS responses to each recommendation is included in *Appendix B*, page B-1. An implementation timeline for each recommendation and action step is included in *Appendix E*, page E-1. Individual timelines, sorted by topic, are included in the body of the report within the discussion of each topic.

Figure 2. **Mental Health Task Force Recommendations and Action Steps Grouped by Topic**

Topic 1: System Transformation	
Recommendations	**Action Steps**
Recommendation 1.1. Addressing Capacity: Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings (page 5).	1.1.a. Maintain at least the current number of beds in Osawatomie and Larned and add 36 to 60 additional regional or state hospital beds within 24 months.
	1.1.b. Within five years, add up to a total of 221 new regional or state hospital beds, including those added in the first 24 months.
	1.1.c. Stabilize staffing at state hospitals by eliminating shrinkage, updating market analyses for wages, and ensuring sufficient FTEs for quality of treatment and the number of licensed beds.
	1.1.d. End the moratorium on admissions to Osawatomie that has been in place since June 2015.
Recommendation 1.2. Regional Community Crisis Center Locations: Develop regional community crisis centers across the state including co-located or integrated Substance Use Disorder (SUD) services (page 13). *	1.2.a. Implement regulations and licensing related to the Crisis Intervention Act (CIA).
	1.2.b. Ensure consistent application of medical necessity criteria for Medicaid-covered crisis services.
	1.2.c. KDADS should issue an RFI for underserved areas where there is not a sufficient population to sustain a Rainbow Services, Inc. (RSI)-type center.
	1.2.d. KDADS should submit a plan each year to expand crisis locations.
	1.2.e. Crisis stabilization centers should be able to address SUD related needs at a defined minimum level.

Figure 2. **Mental Health Task Force Recommendations and Action Steps Grouped by Topic (continued)**

Topic 1: System Transformation	
Recommendations	**Action Steps**
Recommendation 1.3. Warm Hand-Off: Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model (page 16).**	1.3.a. Execute contracts.
	1.3.b. Develop a "warm hand-off" model to guide the 24-hour uniform hotline.
	1.3.c. Develop a mobile crisis unit for youth statewide that utilizes evidence-based practices and includes follow-up requirements.
Recommendation 1.4. Comprehensive Housing: Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness and/or substance use disorders (page 18).***	1.4.a. Implement Housing First Bridge Pilot.
	1.4.b. Add comprehensive Medicaid housing services.
	1.4.c. Provide flexible funds to support housing and ensure the supported housing fund has sufficient resources.
Recommendation 1.5. Suspension of Medicaid: Implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care (page 21).***	1.5.a. Update policies regarding termination of coverage.
	1.5.b. Provide Legislature with report on implementation progress.
Topic 2: Maximizing Federal Funding and Funding from Other Sources	
Recommendation 2.1. Reimbursement Rates: Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly (page 26).	2.1.a. Require KDADS and KDHE to establish a system that provides for regular reviews of the cost of services and reimbursement rates.
	2.1.b. Conduct a rate study for the Medicaid fee schedule and Federal Block Grant.
	2.1.c. Update Medicaid fee schedule and the Federal Block Grant based on the study results.
	2.1.d. Pursue value/outcome-based payment.
	2.1.e. Re-evaluate the use of current nursing facility case mix index and consider alternatives that appropriately assign weight for the complexity of behavioral health symptoms.

Figure 2. **Mental Health Task Force Recommendations and Action Steps Grouped by Topic (continued)**

Topic 2: Maximizing Federal Funding and Funding from Other Sources	
Recommendations	**Action Steps**
Recommendation 2.2. Care Management Program (Health Homes): Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt in to a health home to have access to activities that help coordinate their care (page 30).***	2.2.a. Select and implement a health home model with an approved state plan amendment (SPA).
	2.2.b. Establish a reimbursement mechanism.
	2.2.c. Measure outcomes on July 1, 2021, and annually after that.
Recommendation 2.3. Excellence in Mental Health: Support expansion of the federal Excellence in Mental Health Act and then pursue participation (page 32).	2.3.a. Ask Kansas congressional delegation to support expansion of the federal Excellence in Mental Health Act.
	2.3.b. Develop an application to participate in the pilot program.
Recommendation 2.4. IMD Waiver: Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule to allow federal Medicaid funds for both SUD and psychiatric inpatient treatment (page 34).**	2.4.a. Pursue SUD exemption in order to take full advantage of a new federal opportunity.
	2.4.b. Submit now and revisit no less than annually about the possibility of submission of the IMD exemption for Mental Health.
	2.4.c. Make sure that SUD exemption has been implemented with new KanCare rollout.
	2.4.d. Ensure that IT system and policy changes to not disenroll beneficiaries upon admission to an IMD are implemented.
Recommendation 2.5. Medicaid Expansion: Adopt Medicaid expansion to cover adults under the age of 65 with income up to 138 percent of the federal poverty level (FPL) to pursue solutions for serving the uninsured and underinsured, which will improve access to behavioral health services (page 36).	2.5.a. Legislature should act to repeal statutory limitations and/or pass enabling legislation.
	2.5.b. Implement Medicaid expansion by July 1, 2019.
Recommendation 2.6. Housing: Continue to empower KDADS to convene key agencies and the entities that currently provide housing programs, and to facilitate community collaborations to maximize federal funding opportunities (page 38).	2.6.a. Restore and enhance KDADS staff positions related to housing programs.
	2.6.b. Support KDADS-convened interagency commission to actively pursue federal funding opportunities.
	2.6.c. Interagency commission should convene stakeholders to bring ideas to the table and to pursue additional funding.

Figure 2. **Mental Health Task Force Recommendations and Action Steps Grouped by Topic (continued)**

Topic 3: Continuum of Care for Children and Youth	
Recommendations	**Action Steps**
Recommendation 3.1. Access to Effective Practices and Support: Deliver crisis, clinical and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community (page 42).***	3.1.a. Provide opportunities for community service organizations to increase behavioral health services in schools (e.g., the integrated primary and behavioral health care model).
	3.1.b. Review and enhance reimbursement for in-home behavioral health services.
	3.1.c. Provide and expand training for in-home services (e.g., Parent Management Training of Oregon).
	3.1.d. Develop sustainable funding to continue and expand activities funded by the Systems of Care Grant beyond the initial four grantee counties.
	3.1.e. Evaluate outcomes of intervention teams and provide the Legislature with a report on implementation of mental health intervention teams in the districts identified in 2018 Substitute for Senate Bill 423.
	3.1.f. Based on the evaluation results, expand the reach of the mental health intervention team model by including additional school districts.
	3.1.g. Fund and institute the Families First Prevention Services Act (FFPSA; 2018) in Kansas and follow the federal guidelines.
	3.1.h. Expand eligibility for parent support services to all parents of children with serious emotional disturbance (SED) or substance use disorders (SUD).
Recommendation 3.2. Intensive Outpatient Services: Expand community-based options such as intensive outpatient services (page 46).	3.2.a. Develop policy for coverage of intensive outpatient services.
Recommendation 3.3. Psychiatric Residential Treatment Facility (PRTF): Re-establish the purpose of PRTFs (page 47).	3.3.a. Establish uniform standards for PRTF evaluation, admission, discharge and length of stay.
	3.3.b. Use community mental health center (CMHC) clinicians and community-based service teams as part of the assessment, utilization review, treatment and discharge planning process.
	3.3.c. Review and assess reimbursement for CMHC participation during the admission process.

Figure 2. **Mental Health Task Force Recommendations and Action Steps Grouped by Topic (continued)**

Topic 3 Continuum of Care for Children and Youth	
Recommendations	**Action Steps**
Recommendation 3.4. Early Intervention: Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment and treatment (e.g., ABC programs) (page 48).	3.4.a. Increase awareness of current educational opportunities on adverse childhood experiences (ACES) and expand these opportunities to additional groups, including but not limited to communities, providers and hospitals, and the need for early detection of adverse events experienced by children. This may require an assessment of where the gaps are.
	3.4.b. Medicaid/CHIP and the State Employee Health Plan should recognize the use and reimbursement of the Diagnostic Classification: Age 0-5 (DC: 0-5) for diagnosis and treatment of children birth through 5 years of age.
	3.4.c. Ensure children and caregivers are screened and assessed (e.g., depression, SED) at regular intervals in early childhood programs. Based on the screening results, make appropriate referrals to community providers.
Recommendation 3.5. Transition Age Youth: Request a formal joint report to Legislature by corrections, education and health and human services agencies on programs, coordinated efforts and any collective recommendations for populations identified in SB 367 (page 51).	3.5.a. Establish a requirement for the report through a proviso or a formal letter of notification (executive order).
	3.5.b. Develop a report on existing programs and data.
Topic 4: Nursing Facilities for Mental Health	
Recommendation 4.1. Licensing Structure: Reform NFMHs to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care (page 54).	4.1.a. Seek revocation or waiver of the federal IMD exclusion rule.
	4.1.b. Review and update reimbursement rates and other payment mechanisms.
	4.1.c. Identify and deliver appropriate training curriculum for staff in NFMHs; make sure that challenges with accessing training are addressed.
	4.1.d. Connect NFMH residents to crisis services, CMHCs and community support services.
Recommendation 4.2. Presumptive Approval of Medicaid: Coordinate with KDHE and determine if a policy could be developed or revised that facilitates presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs (page 56).	4.2.a. Establish coordination of efforts between KDADS and KDHE to allow presumptive eligibility on discharge from IMD environment.

Figure 2. **Mental Health Task Force Recommendations and Action Steps Grouped by Topic (continued)**

Topic 5: Workforce	
Recommendations	**Action Steps**
Recommendation 5.1. Workforce Study: Initiate a comprehensive workforce study statewide to examine challenges experienced by employers in reaching optimal staffing levels to provide services (page 60).	5.1.a. Conduct statewide behavioral health workforce study to understand the overall shortage in the behavioral health workforce.
Recommendation 5.2. Peer Support: Encourage integration of peer support services (MH) and Kansas certified peer mentoring services (SUD) into multiple levels of service, including employment services at CMHCs, hospitalization, discharge and transition back to the community (page 60).	5.2.a. Expand training opportunities for those interested in providing peer support services (MH) and KS certified peer mentoring services (SUD).
	5.2.b. Enhance incentives to Mental Health and Substance Use Disorder providers that hire and supervise peer support and Kansas certified peer mentoring workers.
	5.2.c. Increase Medicaid reimbursement rates for peer support services.
Recommendation 5.3. State Loan Repayment Program: Require a report on increasing the number of psychiatrists and psychiatric nurses (page 62).	5.3.a. Provide Legislature with a report on the number of behavioral health professionals that have been added through the Kansas State Loan Repayment Program (SLRP).
Topic 6: Suicide Prevention	
Recommendation 6.1. Suicide Prevention: Place a focus on reversing negative suicide trends for youth and adults (page 64).	6.1.a. Create and fund a full-time state suicide prevention coordinator position who would review and recommend approaches to suicide prevention, (e.g., crisis text line, pursuing grant funding for Zero Suicide) and other evidence-based practices.
	6.1.b. Establish state suicide prevention funding to support the implementation of evidence-based strategies, including the National Suicide Prevention Lifeline in Kansas and text line.
Topic 7: Learning Across Systems	
Recommendation 7.1. Learning Across Systems: Create a position/entity to track information about adverse outcomes that occur and identify strategies for addressing them in a timely manner (page 67).	7.1.a. Convene experts and people served by the behavioral health system to identify how the learning system can be created.
	7.1.b. Review approaches used in other states and identify strategies that might work in Kansas.

Notes: One asterisk (*) indicates the Legislature has taken action related to the recommendation. Two asterisks (**) indicate a state agency has taken action related to the recommendation. Three asterisks (***) indicate action by both the Legislature and an agency.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

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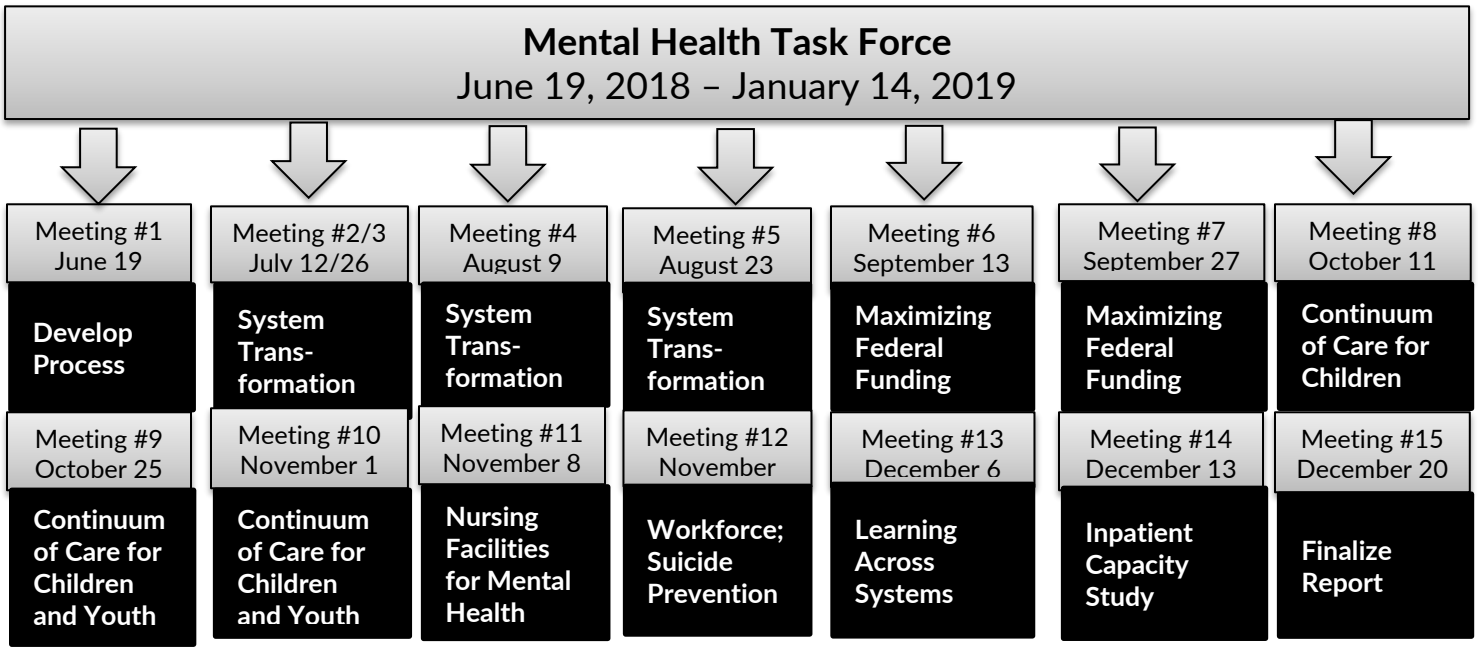
Overview of the Process and Decision-Making Procedures

Beginning June 19, 2018, the Mental Health Task Force met 15 times (*Figure 3*). In general, the meetings were held bi-weekly on Thursday from 11:30 a.m.-3:30 p.m. at the Kansas Health Institute. Thirteen of the meetings were conducted in person, while two meetings were held over the phone. The Task Force was convened by the Kansas Department for Aging and Disability Services (KDADS). The Task Force had no chair and consisted of 13 legislatively appointed members that included behavioral health providers, advocacy organizations, citizens with lived experience, and other behavioral health experts. In addition, the attendees included several KDADS staff members, a representative from the Kansas Legislative Research Department (KLRD) and the Kansas Department of Health and Environment (KDHE). The meetings were facilitated by the Kansas Health Institute (KHI). The role of KHI was to develop and provide materials in advance of the meetings, facilitate discussions, research information and ensure that the objectives of each meeting had been met.

Figure 3. **Overview of Mental Health Task Force Meetings by Dates and Topics**



Note: The Mental Health Task Force met on January 10, 2019, to ratify the report.
Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topics for the meetings were informed by the Mental Health Task Force Report issued on January 8, 2018, and were determined at the beginning of the process. During the seven-month process, the Task Force reviewed, discussed and created the implementation plan for 22 recommendations. The majority of recommendations came from the 2018 Report. To ensure that recommendations continue to be timely and relevant, the Task Force reviewed each recommendation and made updates as necessary. Some of the updates were driven by the information produced by the Governor's Substance Use Disorder Task Force, Child Welfare Task Force and the Children's Continuum of Care Task Force and/or presentations received from:

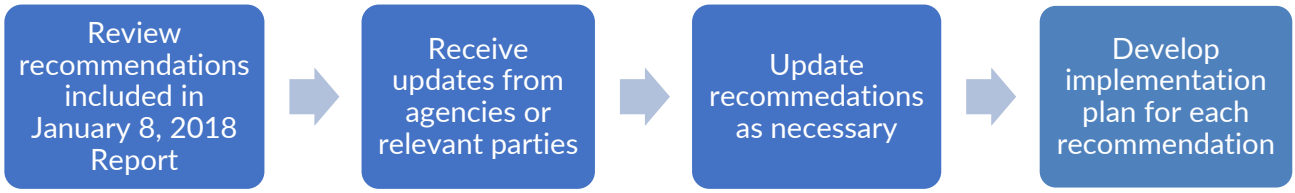
- Seth A. Seabury, U.S.C Schaeffer, Leonard D. Schaffer Center for Health Policy, *"The Cost of Mental Illness: Kansas Facts and Figures."*
- Kimberly L. Nelson, L.A.C., M.P.A., Regional Administrator, Region VII, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *"Federal Funding and Initiatives to Prevent Youth Suicide."*
- Gina Meier-Hummel, Secretary of the Kansas Department of Children and Families, *"New Initiatives for Child Welfare."*
- Andy Brown, Interim Commissioner of Behavioral Health Services, *"Suicide Prevention."*

Additionally, the Task Force was provided with regular updates from KDADS and KDHE regarding:

- Status of current initiatives related to the recommendations included in the 2018 Report.
- KDADS Request for Proposals (RFP) *"State Hospital Regional Community Bed Expansion Project."*
- Topics related to housing, Psychiatric Residential Treatment Facilities (PRTFs), suicide prevention, adverse childhood experiences (ACES), Crisis Intervention Act (CIA), Institution for Mental Disease (IMD), and transition age youth, among others.

To develop a strategic plan, the Task Force utilized the decision-making process described in *Figure 4*, page 3. All decisions were made by consensus.

Figure 4. **Decision-Making Process Used to Develop Implementation Plan**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Furthermore, the Task Force developed the implementation plan for each recommendation using the matrix illustrated in *Figure 5*.

Figure 5. **Elements of the Implementation Plan**

Recommendation	• Recommendation language.	
Rationale	• Describe potential impacts of the recommendation.	
Target Population	• Describe impacted populations.	
Action Steps	**Details**	**Considerations**
	• List specific steps to achieve the recommendation.	**Timing Consideration(s):** Select applicable considerations from the following list:* (legislative session, federal approval process, regulatory process, contracts, agency budget development, grant cycles, systems). **Timeline:** Indicate the implementation deadline. **Budget**: Indicate fiscal impact (estimates were requested from relevant agencies, derived from published documents, or based on Task Force discussion). **Responsible Parties:** Indicate agency(s) responsible for implementation. **Other Organizations:** List organizations that will be involved in the implementation.

Note: Relevant Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force Recommendations are described in *Appendix D*, page D-1. Budget estimates were not available for some recommendations (e.g., in the case of action steps that are dependent on implementation of other activities).

*Legend:

- Legislative session – Activities require legislative action.
- Federal approval process – Activities require approval by federal agencies.
- Regulatory process – Activities involve changes in agency polices or regulations.
- Agency budget development – Activities involve annual agency budget development.
- Grant cycles – Activities are related to state or federal grant making.
- Systems – Activities might impact various systems, including staffing, information systems.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 1: System Transformation

Goal of Topic: To create a system that can meet the needs of consumers and improve their behavioral health.

Introduction: Historically, mental health services were primarily administered in state and private psychiatric hospitals on an inpatient basis. In 1990, the Kansas Mental Health Reform Act fundamentally changed the system in Kansas with the goal of transitioning care from institutional services to community-based care.[2] Community Mental Health Centers became the gatekeepers for state psychiatric hospitals and community mental health services, which increased the number of patients served in the community and reduced hospital use. The number of available state hospital beds decreased from more than 1,000 beds in 1990 to 258 staffed beds in 2017 (excluding forensic beds).

However, even before the decertification of Osawatomie State Hospital in December 2015, the supply of inpatient psychiatric beds necessary to serve Kansans had been called into question. The hospital often operated well over its licensed capacity, and when it ended voluntary admissions and later reduced the number of staffed beds available, the impact was seen in the form of waiting lists and increased pressure on hospital emergency departments, community providers and jails.

In this year's report, the Task Force combined recommendations from across several topic areas from its 2018 report to place a focus on System Transformation. The Task Force developed implementation plans for five recommendations, including updating or adapting prior recommendations and incorporating a new recommendation regarding the number of adult inpatient psychiatric beds needed statewide to ensure access.

Priority Recommendations:

- **Recommendation 1.1: Addressing Capacity** (former 3.2). Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings
- **Recommendation 1.2: Regional Community Crisis Center Locations** (former 2.1). Develop regional community crisis centers across the state including co-located or integrated substance use disorder (SUD) services.

- **Recommendation 1.3: Warm Hand-Off** (former 2.5). Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model.

- **Recommendation 1.4: Comprehensive Housing** (former 2.3.). Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness and/or substance use disorders.
- **Recommendation 1.5: Suspension of Medicaid** (former 3.4). Implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care.

Figure 6. **Recommendation 1.1: Addressing Capacity (former 3.2)**

Recommendation	• Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.	
Rationale	• Increase access to services and reduce wait times. • Decrease admissions to state psychiatric hospitals if community alternatives are expanded. • Decrease emergency department use. • Reduce incarceration rates.	
Target Population	• State hospital patients. • Adults in need of voluntary or involuntary hospitalization. • State hospital staff.	
Action Steps	• **Details**	• **Considerations**
	• 1.1.a. Maintain at least the current number of beds in Osawatomie and Larned and add 36 to 60 additional regional or state hospital beds within 24 months.	**Timing Consideration(s):** Agency budget development, contracts, legislative session, licensure process. **Timeline:** 12/2020 (in process). **Budget:** Assuming full occupancy, with all-funds costs of $407 to $936 per bed per day: $5.3 million to $12.3 million a year for 36 beds, up to $8.9 million to $20.5 million for 60 beds. **Responsible Parties:** KDADS. **Other Organizations:** Governor's office, Legislature, KDHE.

Figure 6. **Recommendation 1.1: Addressing Capacity (former 3.2) (continued)**

Action Steps	Details	Considerations
	• 1.1.b. Within five years, add up to a total of 221 new regional or state hospital beds, including those added in the first 24 months.	**Timing Consideration(s):** Agency budget development, contracts, legislative session, licensure process. **Timeline:** 12/2023. **Budget**: Up to an additional $23.9 million to $55 million a year, all funds, assuming full occupancy and 60 beds added in first two years. **Responsible Parties:** KDADS. **Other Organizations:** Governor's office, Legislature, KDHE.
	• 1.1.c. Stabilize staffing at state hospitals by eliminating shrinkage, updating market analyses for wages, and ensuring sufficient FTEs for quality of treatment and the number of licensed beds.	**Timing Consideration(s):** Agency budget development, legislative session. **Timeline:** 03/2019. **Budget**: Addressing staffing, shrinkage and contract labor will cost between $10.8 million and $11.3 million a year, all funds. **Responsible Parties:** KDADS. **Other Organizations:** Department of Administration.
	• 1.1.d. End the moratorium on admissions to Osawatomie that has been in place since June 2015.	**Timing Consideration(s):** Systems (staffing) **Timeline:** As soon as possible, no later than 12/2020. **Budget**: $764 to $936 per bed per day, based on FY 2018 OSH and Adair Acute Care per diem rates. *Note: Ending moratorium may be accomplished by adding less than 36 beds, but see 1.1.a above.* **Responsible Parties:** KDADS. **Other Organizations:** Providers.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

The 2018 report of the Mental Health Task Force included a recommendation to develop a plan to add more than 300 additional hospital beds for voluntary and involuntary admissions – or to create and expand alternatives that would reduce the number of new beds needed. The estimate was based upon an ideal ratio of state hospital beds per 100,000 people, which had been identified in a 2016 report from the Treatment Advocacy Center.[3] The Task Force also called for a study to determine a Kansas-specific estimate of psychiatric inpatient beds needed for the system, and the 2018 Legislature directed KDADS to have the requested study completed.

The Task Force used the study results to develop its recommendation, which includes 1) maintaining at least all beds currently available in Larned and Osawatomie, 2) adding 36 to 60 regional or state hospital beds within two years, and 3) continuing to add regional or state hospital beds within five years to a total of up to 221 beds based on the findings of the study.

KDADS contracted with the Kansas Health Institute (KHI) to perform the study, which was designed to determine the number of inpatient psychiatric beds needed to meet current needs. The study incorporated the following data to derive an estimate of beds needed:

- Osawatomie State Hospital, Adair Acute Care, and Larned State Hospital data, calendar years (CY) 2013-2017, from KDADS;
- Hospital discharge survey data for hospitalizations for principal diagnosis of schizophrenia, bipolar disorder or major depressive disorder in general acute hospitals, CY 2013-2017, from the Kansas Hospital Association;
- Free-standing psychiatric hospital and state hospital alternative data from CY 2013-2017, from KDADS (supplemented by Prairie View Inc., with Cottonwood Springs data pending); and
- Bed counts from KDADS and the Kansas Hospital Association.

As of December 2018, the inpatient psychiatric bed rate for the adult population in Kansas is 26.2 beds per 100,000 adults (576 beds for 2,200,585 adults age 18 and over). The total includes 256 beds in two state hospitals, 120 beds in three free-standing psychiatric hospitals and 200 beds in seven adult psychiatric units in general acute care hospitals (*Figure 7*, page 8). It does not include 180 beds for older adults (63 beds in two geriatric psychiatric hospitals and 117 beds in gero-psychiatric units in nine general acute care hospitals) and 70 beds in three crisis stabilization centers (34 observation beds and 36 crisis stabilization beds).

Figure 7. **Adult Inpatient Psychiatric Beds by Facility Type in Kansas, December 2018**

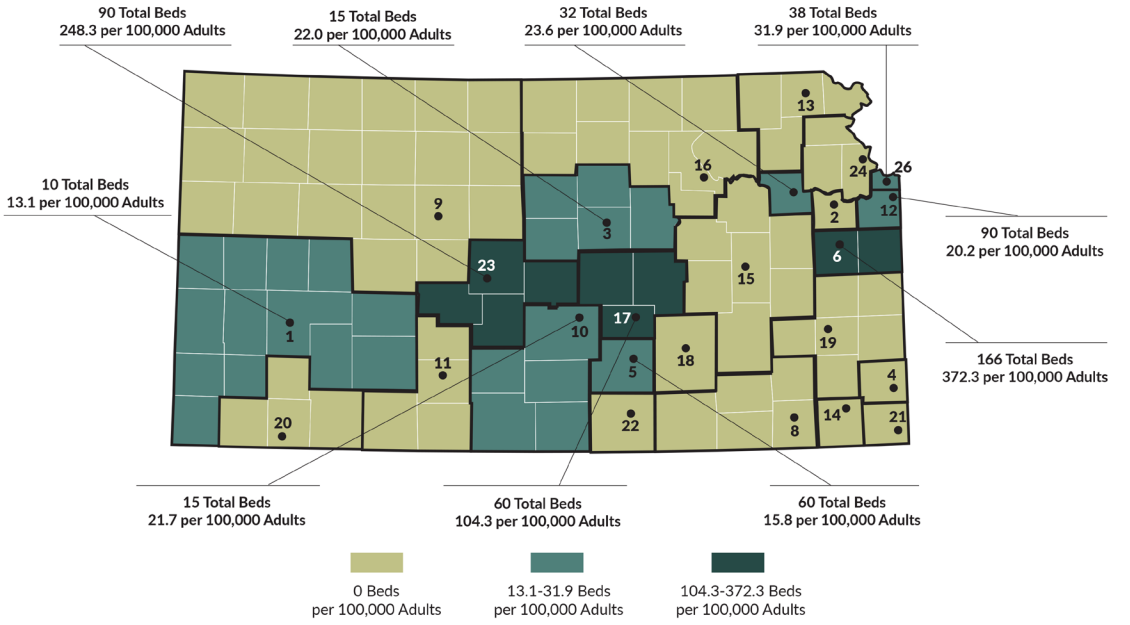
State Hospital		***General Hospital (Gero-Psychiatric Unit)***	
Larned	90	*Edwards County Hospital*	*10*
Osawatomie/Adair	166	*Fredonia Regional Hospital*	*9*
Subtotal	**256**	*Girard Medical Center*	*10*
Psychiatric Hospital		*Memorial Hospital (Abilene)*	*10*
Cottonwood Springs	48	*Mitchell County Hospital*	*10*
KVC	12	*Newton Medical Center*	*12*
Prairie View	60	*St. John Hospital (Leavenworth)*	*18*
Subtotal	**120**	*Via Christi*	*28*
General Hospital (Adult Psychiatric Unit)		*Sumner Regional Medical Center*	*10*
St. Catherine	10	***Subtotal***	***117***
Hutchinson	15	***Geriatric Psychiatric Hospital***	
KU	26	*Freedom*	*24*
Salina	15	*St. Anthony's Senior Care Hospitals*	*39*
Shawnee Mission	42	***Subtotal***	***63***
Stormont Vail	32		
Via Christi	60		
Subtotal	**200**		

Note: Only facility types in shaded areas (state hospitals, psychiatric hospitals and general hospitals with adult psychiatric units) are included in the calculation of bed supply (total 576 beds, 26.2 beds per 100,000 adults).

Source: KHI analysis of data from Kansas Department of Aging and Disability Services, the Kansas Hospital Association and personal communications with crisis stabilization centers.

The supply of inpatient psychiatric beds varies greatly across the 26 community mental health center (CMHC) catchment areas in Kansas (*Figure 8*, page 9). Fifteen out of the 26 CMHC catchment areas do not have any inpatient psychiatric beds (excluding geriatric psychiatric beds). Eight CMHC catchment areas have 13.1 to 31.9 beds per 100,000 adults. Three CMHC catchment areas that are not located in large population centers have more than 100 beds per 100,000 adults because of the presence of the two state hospitals (90 and 166 beds, respectively) and one large free-standing psychiatric hospital (60 beds).

Figure 8. **Total Inpatient Beds per 100,000 Adults, by Community Mental Health Center Area**



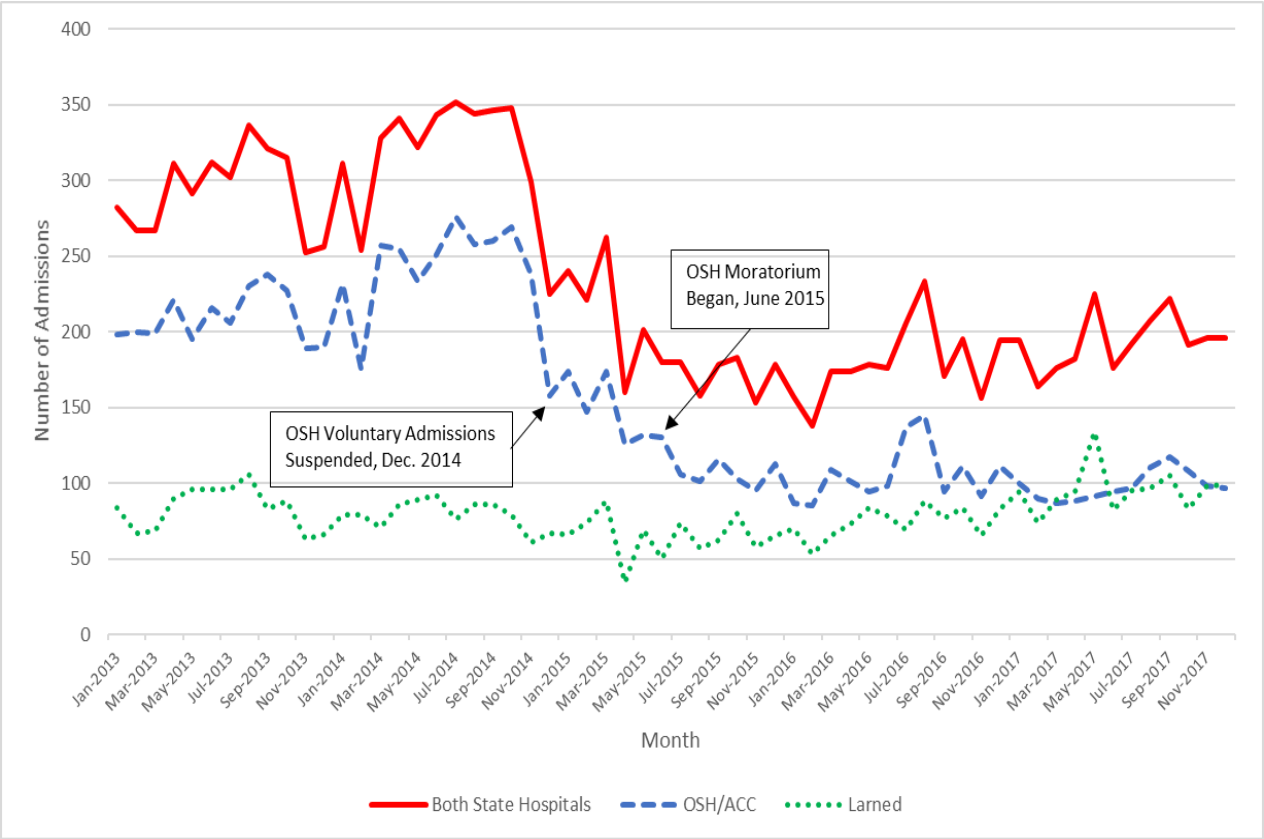
CMHC Catchment Areas

1. **Compass Behavioral Health**
   Garden City
2. **Bert Nash Community Mental Health Center Inc.**
   Lawrence
3. **Central Kansas Mental Health Center**
   Salina
4. **Community Mental Health Center of Crawford County**
   Pittsburg
5. **COMCARE of Sedgwick County**
   Wichita
6. **Elizabeth Layton Center, Inc.**
   Ottawa
7. **Family Service & Guidance Center**
   Topeka
8. **Four County Mental Health Center**
   Independence
9. **High Plains Mental Health Center**
   Hays
10. **Horizons Mental Health Center**
    Hutchinson
11. **Iroquois Center for Human Development Inc.**
    Greensburg
12. **Johnson County Mental Health Center**
    Mission
13. **Kanza Mental Health & Guidance Center**
    Hiawatha
14. **Labette Center for Mental Health Services**
    Parsons
15. **CrossWinds Counseling & Wellness**
    Emporia
16. **Pawnee Mental Health Services**
    Manhattan
17. **Prairie View, Inc.**
    Newton
18. **South Central Mental Health Counseling Center Inc.**
    Augusta
19. **Southeast Kansas Mental Health Center**
    Iola
20. **Southwest Guidance Center**
    Liberal
21. **Spring River Mental Health & Wellness**
    Riverton
22. **Sumner County Mental Health Center**
    Wellington
23. **The Center for Counseling and Consultation**
    Great Bend
24. **The Guidance Center Inc.**
    Leavenworth
25. **Valeo Behavioral Healthcare**
    Topeka
26. **Wyandot Center for Community Behavioral Health Inc.**
    Kansas City

Source: KHI analysis of data from Kansas Department of Aging and Disability Services and the Kansas Hospital Association; CHHC catchment areas adapted from Association of Community Mental Health Centers of Kansas.

The study considered the time periods before and after voluntary admissions were suspended at Osawatomie State Hospital in December 2014. While other events occurred during the 2013-2017 period (including the opening of crisis center beds and the eventual moratorium on OSH admissions in June 2015), the suspension of voluntary admissions in December 2014 coincided with the sharpest decline in the number of admissions to state hospitals during the period (*Figure 9*, page 10).

Figure 9. **State Hospital Admissions in Kansas, 2013-2017**



Source: KHI analysis of Osawatomie State Hospital (OSH), Adair Acute Care (AAC) and Larned State Hospital Psychiatric Services Program (LSH PSP) admissions from the Kansas Department for Aging and Disability Services.

The study produced a combined estimate for beds needed in the system, based upon 1) eliminating waiting for involuntary admissions in Osawatomie, and 2) comparing statewide inpatient bed demand in all settings (including but not only state hospitals) for patients with a primary diagnosis of schizophrenia, bipolar disorder or major depressive order from before and after the suspension of voluntary admissions at OSH in December 2014. Results are presented in *Figure 10*, page 11.

Adding a total of 131 to 172 beds – the average number of beds estimated needed in the combined analysis – would increase the inpatient bed supply ratio in Kansas to 32.1 to 34.0 beds per 100,000 adults age 18 and over, somewhat lower than the previous report's recommended total. Adding 221 beds – 220.6 was the high end of the range of beds projected to be needed based on the highest monthly average length of stay – would increase the ratio to 36.2 per 100,000 adults age 18 and over.

Figure 10. **Results of Combined Analysis of Inpatient Beds Needed**

Kansas		Additional Beds Needed Assuming No Discharges of Current Patients	Additional Beds Needed Assuming Discharge after Average Length of Stay
Estimate based on average length of stay in all hospital settings	Mean	141.7	**131.4**
	Median	129.8	120.9
	(Min., Max.)	(89.4, 228.6)	(77.7, 218.3)
Estimate based on average length of stay in Adair Acute Care	Mean	182.0	**171.7**
	Median	175.1	167.1
	(Min., Max.)	(130.6, 228.1)	(118.9, **220.6**)

Source: KHI analysis of data from the Kansas Department for Aging and Disability Services, the Kansas Hospital Association and Prairie View, Inc.

To supplement the addition of beds, the Task Force recommended eliminating shrinkage requirements ("shrinkage" in this usage means not filling vacant budgeted positions) at the state hospitals, keeping their market analyses up-to-date, and having enough staffing to provide care in all licensed state hospital beds to ensure the hospitals are used to their full potential. The Task Force also recommended that the moratorium on admissions at OSH – the mechanism that allows a waiting list – end as soon as possible, and no later than the addition of the first 36 to 60 new regional or state hospital beds.

The Task Force continued to support developing a regional model to provide access closer to home for more patients. The 2.9 million residents of Kansas are spread across around 82,000 square miles, in population densities ranging from frontier to urban. The state is divided into two state hospital catchment areas. The Larned State Hospital catchment area covers about two-thirds of the state, including some communities hundreds of miles from Larned, which is in west-central Kansas. The catchment area for Osawatomie State Hospital, in eastern Kansas, covers a smaller

geographic area but a larger population. Regional short-term, acute-care facilities that accept both voluntary and involuntary admissions would allow the two state hospitals to dedicate more beds to longer-term inpatients.

To have a balanced system of care that provides appropriate access to treatment, the model developed must assure more services are available locally, including access to acute care.[4] Both community and hospital services are needed, though different models may be used to provide the services.[5] Further, evidence suggests that rural psychiatric inpatient units improve access to community-based mental health services.[6]

On November 20, 2018, KDADS issued a Request for Proposals (RFP) titled *Regional Community Bed Expansion.*[7] According to the RFP, "these inpatient beds will support individuals experiencing a mental health crisis by providing a secured therapeutic environment within the individual's county of residence or adjacent county for the individual to receive inpatient treatment and assistance with transitioning back into the community." [8] Task Force members provided feedback on a draft RFP. The RFP submission deadline is January 11, 2019.

The Task Force recommended that KDADS conduct regional stakeholder engagement meetings to provide insight into local needs and said KDADS should gather input from individuals at organizations that are involved directly with providing consumers with information and directing individuals to specific services.

The Task Force added that improving inpatient capacity should not happen in a vacuum – it must be part of a comprehensive plan to ensure provision of high-quality behavioral health services at all levels and in all settings, including in the community. Inpatient capacity is integral to what many call the "continuum of care," but so is community capacity, including inpatient and outpatient community-based mental health and substance abuse disorder treatment, crisis stabilization, housing and peer programs (see *Figure 1A*, page ES-vi). The recommendations in the rest of this topic, and throughout this report, provide details about steps that can be taken to enhance the behavioral health system across the continuum.

Note: The Task Force did not provide a new recommendation in this report related to privatization of state hospitals, as the RFP for privatization of Osawatomie State Hospital has been put on hold. For background on how the Task Force previously addressed the issue of privatization, please refer to pages 35-40 of the January 8, 2018, report.

Figure 11. **Recommendation 1.2: Regional Community Crisis Center Locations (former 2.1)**

Recommendation	• Develop regional community crisis centers across the state including co-located or integrated SUD services.	
Rationale	• Provide immediate access to crisis services for people who are being admitted voluntarily and involuntarily. • Provide a supportive and more cost-effective approach to voluntary and involuntary crisis services. • People with mental illness and co-occurring disorders would be able to go through recovery in their community. • Divert costs from other state hospitals and psychiatric beds in community hospitals.	
Target Population	• Individuals/adults in crisis (18 age and above).	
Action Steps	**Details**	**Considerations**
	• 1.2.a. Implement regulations and licensing related to the Crisis Intervention Act (CIA).	**Timing Consideration(s):** Regulatory process. **Timeline:** 01/2019 (in process). **Budget:** Agency can develop regulations within existing resources. Additional licensure FTEs estimate: $60,000 to $80,000/FTE. **Responsible Parties:** KDADS. **Other Organizations:** N/A.
	• 1.2.b. Ensure consistent application of medical necessity criteria for Medicaid-covered crisis services.	**Timing Consideration(s):** Regulatory process. **Timeline:** 07/01/2019. **Budget**: Agency can develop policy within existing resources. **Responsible Parties:** KDHE/KDADS/MCOs. **Other Organizations:** Providers.

	• 1.2.c. KDADS should issue an RFI for underserved areas where there is not a sufficient population to sustain a Rainbow Services, Inc. (RSI)-type center.
	  • Develop regulations for crisis stabilization centers
	  • Create or use an existing workgroup to discuss alternative ways to meet these regulations
	  • Issue an RFI for RFP
	  • Plan for and budget necessary funding to support existing crisis centers
		Timing Consideration(s): Regulatory process, agency budget development.
		Timeline: After regulations are written (3 months for the development of regulations and RFI and 9 months for RFP).
		Budget: Part of KDADS annual budget.
		Responsible Parties: KDADS.
		Other Organizations: Stakeholders (e.g., MHTF, crisis centers).

Figure 11. **Recommendation 1.2: Regional Community Crisis Center Locations (former 2.1) (continued)**

Action Steps	Details	Considerations
	• 1.2.d. KDADS should submit a plan each year to expand crisis locations.	**Timing Consideration(s):** Agency budget development. **Timeline:** Initiate after lottery revenue is allocated (annually). **Budget**: Current agency budget requests of $4 million and $15 million (MH Grants) for crisis stabilization and community crisis beds. **Responsible Parties:** KDADS. **Other Organizations:** Groups that will be convened for the RFP discussion.
	• 1.2.e. Crisis stabilization centers should be able to address SUD related needs at a defined minimum level.	**Timing Consideration(s):** Regulatory process, agency budget development. **Timeline:** 1/2019. **Budget**: No additional estimate. **Responsible Parties:** KDADS. **Other Organizations:** Community coalitions, providers.

Note: See *Appendix D,* page D-1, for a related recommendation from the Governor's Substance Use Disorders Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Evidence suggests that increasing access to regional crisis locations can reduce wait times for emergency room treatment and decrease inpatient psychiatric admissions. Further, by increasing access to crisis services in community settings, inpatient capacity needs may be reduced.[9]

Over the years, KDADS has pursued expanded regional crisis services and recently added contracts in Salina and Manhattan. Kansas already has three non-hospital crisis stabilization centers located in Kansas City, Topeka and Wichita. For example, Rainbow Services, Inc. (RSI) in Wyandotte County provides services such as 24-hour assessment and triage for individuals experiencing a mental health crisis, crisis observation and short-term crisis stabilization for adults.[10] RSI absorbed 4,543 admissions from 2,480 individuals from the time it opened in April 2014 to August 2016. In 2015 alone, it is estimated that RSI saved about $4 million in state hospital costs, $2 million in emergency room visits, and $75,000 in jail costs.[11]

In Sedgwick County, COMCARE anticipated saving $4 million after it opened its crisis center. However, a recent report indicates a savings of $8.1 million.[12]

Crisis stabilization is a short-term service that allows a person in distress to receive services over a period of days before transitioning to community-based care. Depending on length of stay, crisis stabilization is an inpatient service, but as it is not necessarily provided in a traditional hospital setting, it can be an alternative to psychiatric hospitalization. Crisis observation, a similar service, can be provided for up to 23 hours, allowing symptoms to ease before a patient is connected to community-based follow-up services.

A key aspect to providing regional crisis stabilization services is the stable ongoing state investment to create an infrastructure that can be accessed from various areas of the state.[13] This approach can result in several benefits, including improved access, reduced utilization of the state hospitals, and decreased rates of incarceration. *Figure 12* presents a summary of services at state-funded crisis centers; the Task Force noted that there are other community-based crisis centers that are not state-funded.

Figure 12. **Regional Crisis Services**

	COMCARE	RSI	Valeo
Observation Beds	6	12	16
Crisis Stabilization Beds	10	10	16
Sobering Beds	6	10	0
Social Detox Beds	13	0	8

Source: Kansas Department for Aging and Disability Services and communication with crisis centers.

In 2017, the Legislature adopted the Crisis Intervention Act (CIA), which would allow adults to be placed in a licensed "crisis intervention center" for up to 72 hours for emergency observation and treatment, sometimes referred to as "72-hour hold." Regulations establishing licensure under the CIA have not been implemented, so there are no crisis intervention centers in operation.

Several factors can contribute to the success of any given crisis center, including stable funding, a "warm hand-off" with an appropriate level of follow-up, options to refer individuals to needed addictions treatment, community-based support services, and safe food and housing.

Creating crisis stabilization services in less populated areas of the state will require creative partnerships to have the clinical expertise on hand with some flexibility in structure. Some of the areas of Kansas that need these services might not be able to sustain the rate of utilization or number of insured patients required to fund a facility that looks like RSI in Kansas City.

The KDADS Hospital and Home Team issued a report on May 3, 2013, entitled *"Mercer Study Review and Recommendations for Alternative Use of Rainbow MHF."* This 12-page report includes recommendations for the services and functions that should be provided at state-supported crisis facilities based on the results of the Mercer actuarial analysis of hospital and community-based services in Kansas.

The Task Force also recommended that KDHE disseminate and ensure use of standardized medical necessity criteria for the reimbursement of crisis services in Medicaid, to ensure consistent application among the contracted managed care organizations.

Figure 13. **Recommendation 1.3: Warm Hand-Off (former 2.5)**

<table>
<tr><td>Recommendation</td><td colspan="2">• Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model.</td></tr>
<tr><td>Rationale</td><td colspan="2">• Improve access to care.
• Improve health outcomes.
• Avoid escalation of potentially dangerous situations.</td></tr>
<tr><td>Target Population</td><td colspan="2">• People who need to navigate the system and don't know where to start.
• Adults and children in crisis.</td></tr>
<tr><td rowspan="3">Action Steps</td><td>Details</td><td>Considerations</td></tr>
<tr><td>• 1.3.a. Execute contracts.</td><td>Timing Consideration(s): Contract, agency budget development.
Timeline: First quarter 2019.
Budget: Agency can operationalize RFP award with existing resources.
Responsible Parties: KDADS.
Other Organizations: Successful bidders.</td></tr>
<tr><td>• 1.3.b. Develop a "warm hand-off" model to guide the 24-hour uniform hotline, which should include:
  • Follow-up requirements,
  • A triage system that is clear, consistent, and uses accepted clinical standards,
  • Training standards for phone operators, and
  • Access to client history.</td><td>Timing Consideration(s): Legislative session, regulatory process, systems (e.g., I.T.).
Timeline: 06/2019.
Budget: Current agency budget request of $3 million/year of SGF, for mobile and crisis hotline.
Responsible Parties: KDADS.
Other Organizations: Contractors/bidders, community providers and law enforcement.</td></tr>
</table>

Figure 13. **Recommendation 1.3: Warm Hand-Off (former 2.5) (continued)**

Action Steps	Details	Considerations
	• 1.3.c. Develop a mobile crisis unit for youth statewide that utilizes evidence-based practices and includes follow-up requirements.	**Timing Consideration(s):** Legislative session, regulatory process, contracts, agency budget development, systems. **Timeline:** 06/2019. **Budget**: Current agency budget request of $3 million/year of SGF, for mobile and crisis hotline. **Responsible Parties:** KDADS. **Other Organizations:** Contractors/bidders, community providers, law enforcement.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

The development of a 24-hour uniform mental health hotline in Kansas could be modeled based on existing 24-hour crisis hotlines for Community Mental Health Centers.[14] Evidence from an evaluation of outcomes for crisis hotlines for non-suicidal and suicidal crisis suggests that hotlines provide a decrease in hopelessness and crisis states for non-suicidal callers and a decrease in hopelessness and psychological pain for suicidal callers, indicating hotlines can provide help to those in need of crisis intervention.[15,16]

To better implement access to care for those in crisis and establish the potential entry point for the behavioral health system, a warm hand-off for the 24-hour hotline could be based on the warm hand-off for integrated care. In the integrated care model, the patient is introduced by one provider to the next to better provide continuity of care.[17] While in the integrated care model, there is a direct introduction, often involving family or other relevant parties; the call center member would keep the caller on the line while connecting them to the appropriate provider. The Task Force also discussed the importance of having background/historical information on individuals available to all providers, so that those trying to access the system do not have to provide their information each time they encounter a different provider. The Task Force felt that the 24-hour hotline should be separate from the mobile crisis response unit, although the two may interact when implemented. Additionally, the Task Force specified that the phone operator should be trained to handle crisis situations and that there should be follow-up requirements expected of the operator/provider. Furthermore, the hotline should include a triage system that is clear, consistent and uses accepted clinical standards.

The Task Force did not modify the recommendation from the previous report. The action steps included requiring KDADS to evaluate RFP contracts, develop a "warm hand-off" model to guide the 24-hour uniform hotline and develop a mobile crisis unit for youth statewide that utilizes evidence-based practices and includes follow-up requirements.

The Task Force indicated that any contract for a mobile crisis response unit should be available statewide and signified support for allowing families to determine whether they are in crisis and therefore require services. The Task Force also discussed the importance of the mobile crisis response unit having stricter follow-up requirements, to ensure individuals continue to receive care and service coordination. Additionally, the Task Force indicated that the mobile crisis response model should be able to adapt to different regional and cultural differences based on where the individual(s) in crisis are located.

On August 23, KDADS staff provided an update about the 2018 RFP that indicates the plan for a mobile crisis unit in Kansas is to focus on serving children and families, wherever they are and whenever they define a situation as a crisis. KDADS suggested it would like the mobile crisis response unit to be a statewide resource that will create crisis plans and offer care coordination and stabilization services to families for up to eight weeks after dispatch. The RFP released by KDADS was informed by the mobile crisis response-related efforts in Oklahoma, New Jersey and Connecticut.

Figure 14. **Recommendation 1.4: Comprehensive Housing (former 2.3)**

Recommendation	• Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness and/or substance use disorders.
Rationale	• Decrease admissions to state psychiatric hospitals. • Reduce incarceration rates. • Reduce rate of individuals becoming homeless.
Target Population	Any person with a mental illness who is without housing but wants sustainable housing.

Figure 14. **Recommendation 1.4: Comprehensive Housing (former 2.3) (continued)**

Action Steps	Details	Considerations
	• 1.4.a. Implement Housing First Bridge Pilot. o Moving towards permanent housing vs. crisis housing o Provide education regarding how to access HUD o Tabulate meaningful data/outcomes and report to the Governor's Behavioral Health Services Planning Council and Legislature	**Timing Consideration(s):** Contract **Timeline:** 01/2019. **Budget:** Current agency budget request of $500,000 all funds. **Responsible Parties:** KDADS, providers. **Other Organizations:** Housing authority, contractors.
	• 1.4.b. Add comprehensive Medicaid housing services.	**Timing Consideration(s):** Federal approval process, agency budget development. **Timeline:** 06/2019. **Budget**: This is being implemented through the Medicaid policy process, not a SPA. Current fiscal impact estimate of policy change: $4.8 million/year. **Responsible Parties:** KDHE. **Other Organizations:** KDADS, housing providers.
	• 1.4.c. Provide flexible funds to support housing and ensure the supported housing fund has sufficient resources.	**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** 01/2019 (and annually). **Budget**: $1 million. **Responsible Parties:** KDADS. **Other Organizations:** Crisis stabilization centers, providers.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

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

The Governor's Behavioral Health Services Planning Council Subcommittee on Housing and Homelessness 2017 Annual Report indicated that the expansion of housing will lead to decreased admissions to state psychiatric hospitals, reduced incarceration rates, and reduced rates of individuals becoming homeless due to disability. This, in turn, will save tax dollars and help Kansans achieve recovery. If housing is not expanded, the report suggests that this may possibly force Kansans with behavioral health needs into environments not favorable to their needs, desires and well-being.[18]

Housing support allows for those in need of treatment to maintain stable housing while receiving care for medical and behavioral health needs.[19] Housing placements for homeless populations have been found to reduce emergency department (ED) usage by residents and reduce the average and total number of ED visits. Housing placement was also associated with a decreased likelihood of hospitalizations and average number of admissions.[20]

Kansas could look to neighboring Missouri, where the Department of Mental Health provides federally funded permanent supportive housing through rent assistance, rental assistance programs for those with mental illnesses and substance use disorders, and zero-cost technical assistance to help communities seeking to develop affordable or supportive housing across the state.[21]

On August 9, 2018, KDADS provided information about the Housing First program and the agency indicated that it was interested in implementing this program statewide. This approach would allow shifting the focus toward permanent housing as opposed to crisis housing. As part of the Housing First implementation, KDADS is working with the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance to CMHCs. This technical assistance would include helping individuals access Department of Housing and Urban Development (HUD) services. Furthermore, KDADS shared its work related to the Housing First Bridge Pilot program. This program focuses on providing immediate access from detox treatment to a bed, to ensure better discharge transitions. Another activity referenced by KDADS include efforts related to opening of Medicaid billing codes in order to pay for housing-related services. Moving forward, KDHE and KDADS will continue working with CMS regarding approaches for covering these services.

The Task Force did not modify the recommendation from the previous report. The action steps included requiring KDADS to implement the Housing First Bridge Pilot and provide flexible funds

to crisis stability centers to support housing and ensure the supported housing fund has sufficient resources. In addition, one of the action steps focused on requiring KDHE in collaboration with KDADS to propose a state plan amendment (SPA) to add comprehensive Medicaid housing services.

For the first action step, the Housing First Bridge Pilot, the Task Force discussed the importance evaluating outcomes of the program and reporting them to the Governor's Behavioral Health Services Planning Council and the Kansas Legislature. The Task Force also emphasized that under the pilot, there should be a focus on securing permanent housing and not just crisis housing. Additionally, the pilot should provide information on how to successfully access HUD data. Next, the Task Force discussed providing flexible funds to crisis stabilization centers to support housing and to ensure the supported housing fund has sufficient resources. Currently, the flexible funds available for housing are temporary, and the Task Force noted the importance of a more permanent, sustainable option.

The discussion about the state plan amendment (SPA) was informed by an update from KDADS. KDADS indicated that it is currently considering a state plan amendment (SPA) to cover an array of services related to housing. In considering a SPA, KDADS has been working with KDHE, HUD and CMS, although a timeframe for implementing a SPA had not been determined.

***Figure 15*. Recommendation 1.5: Suspension of Medicaid (former 3.4)**

Recommendation	• Implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care.	
Rationale	• Make it easier for a person leaving the criminal justice system or an inpatient psychiatric facility to regain health coverage. • Quicker access to mental health services, prescribed medicine and other health-related needs. • Reduce the chance of returning to prison.	
Target Population	• Medicaid recipients	
Action Steps	**Details**	**Considerations**
	• 1.5.a. Update policies regarding termination of coverage.	**Timing Consideration(s):** Regulatory process. **Timeline:** 01/2019 (in process). **Budget:** Agency can complete this action within existing resources. **Responsible Parties:** KDHE. **Other Organizations:** KDADS, KDOC.

Figure 15. **Recommendation 1.5: Suspension of Medicaid (former 3.4) (continued)**

Action Steps	Details	Considerations
	• 1.5.b. Provide Legislature with report on implementation progress.	**Timing Consideration(s):** Regulatory process. **Timeline:** 05/2019. **Budget**: Agency can complete this action within existing resources. **Responsible Parties:** KDADS. **Other Organizations:** Kansas Legislature.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

The 2018 Mental Health Task Force report included a recommendation that the state should implement policies that allow for the suspension of Medicaid benefits when beneficiaries enter an institution – for example, upon incarceration or admission to a psychiatric institution with more than 16 beds – rather than terminating their coverage entirely. The Task Force believed that suspending, rather than terminating, eligibility would improve transition planning and reduce or eliminate gaps in access to care.

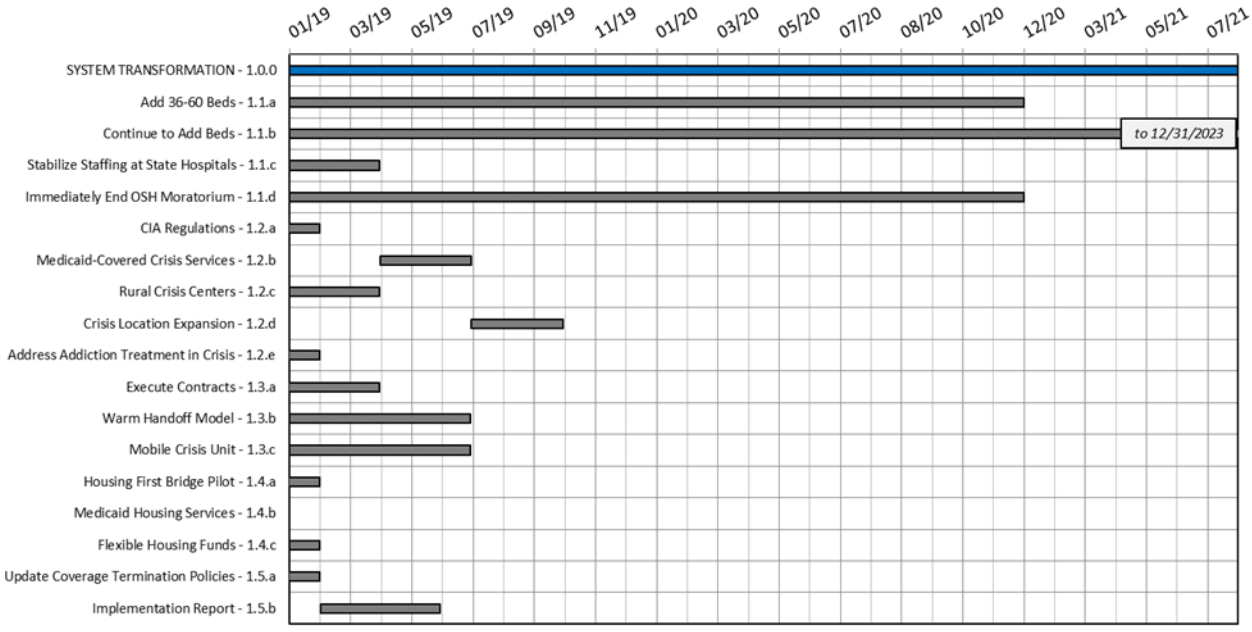
Encouraged by the 2018 Legislature to adopt a suspended eligibility status for KanCare beneficiaries entering an institution, KDHE is implementing the policy via a workaround for immediate reinstatement of coverage upon release. KDHE advised the Task Force that the workaround would be in place in early 2019. Because the Task Force is concerned the workaround may not solve all of the issues related to terminating coverage, it decided to keep the recommendation and add language indicating a solution that involved suspended eligibility would improve access to care as well as transition planning. The recommendation remains similar to recommendations in the 2015 Governor's Behavioral Health Services Planning Council Justice Involved Youth and Adults Subcommittee Report and the 2016 Nursing Facilities for Mental Health Work Group Report.[22,23] The recommendation is related to Recommendation 2.4 in this report as well.

Termination policies stem from federal rules surrounding the use of funding for populations in psychiatric hospitals and correctional facilities. For adults in a mental health institution, care cannot be provided using federal dollars due to the IMD exclusion (see Recommendation 2.4, page 34). Currently, under Kansas Medicaid regulations defined in K.A.R. 129-6-60, residence in a state

public institution in Kansas results in termination of Medicaid benefits. Adults in state psychiatric facilities cannot receive services funded through federal dollars, and in state correctional facilities, services provided in the correctional institution are not eligible for Medicaid, but inmates may be eligible for assistance for inpatient hospital services outside of the correctional institution.

While Kansas currently terminates benefits for those in public institutions, in recent years the Kansas Department of Corrections, as part of inmate release, has coordinated with KDHE to help inmates with reentry by assisting with the completion of benefits applications pre-release to allow access to disability and Medicaid resources.[24]

Figure 16. **Implementation Timeline for Topic 1: System Transformation**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 2: Maximizing Federal Funding and Funding from Other Sources

Goal of Topic: To identify opportunities for sustaining, pursuing and securing federal or other funding sources for services related to behavioral health.

Introduction: As the Task Force noted in 2018, for many years funding for behavioral health services was primarily the responsibility of states and local governments. Over time, the federal government began to take an increased role. The National Institute of Mental Health was founded in 1949, one of the first four National Institutes of Health. Community mental health centers (CMHCs) were created by law in 1963. When the Medicaid program was founded in 1965, psychiatric inpatient care expenses for adults were excluded from federal reimbursement, but even with that exclusion, Medicaid today is still the largest behavioral health services payer in the country. Federal funds for mental health and substance use disorder (SUD) treatment and rehabilitation programs became block grants in the early 1980s and now are provided in annual noncompetitive formula block grants to the states under purview of the Substance Abuse and Mental Health Services Administration (SAMHSA).

However, as treatment has moved from an institutional model to community-based services, more agencies and funding streams have become essential to behavioral health services. For example, housing programs are financed through housing departments, income support is administered by the Social Security Administration, and job training programs are available through the departments of Labor and Education.[25]

The Task Force also discussed the importance of ensuring that other funding sources for treatment are committed for their intended use. For example, funding from the Problem Gambling and Other Addictions Fund should be used for its intended purpose (including problem gambling, alcohol and drug treatment programs) rather than redirected to support other programs.

This topic area – Maximizing Federal Funding and Funding from Other Sources – includes five recommendations adapted or modified from the January 2018 Task Force report. In addition, the Task Force added an updated recommendation regarding health homes to this topic area. The Task Force then developed 19 distinct action steps needed to implement the recommendations.

Priority Recommendations:

- **Recommendation 2.1: Reimbursement Rates** (former 1.4). Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.
- **Recommendation 2.2: Care Management Program (Health Homes)** (former 7.2). Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt in to a health home to have access to activities that help coordinate their care.
- **Recommendation 2.3: Excellence in Mental Health** (former 1.5). Support expansion of the federal Excellence in Mental Health Act and then pursue participation.
- **Recommendation 2.4: IMD Waiver** (former 1.1). Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule to allow federal Medicaid funds for both substance use disorder (SUD) and psychiatric inpatient treatment.
- **Recommendation 2.5: Medicaid Expansion** (former 1.2). Adopt Medicaid expansion to cover adults under the age of 65 with income up to 138 percent of the federal poverty level (FPL) to pursue solutions for serving the uninsured and underinsured, which will improve access to behavioral health services.
- **Recommendation 2.6: Housing** (former 1.3). Continue to empower Kansas Department for Aging and Disability Services (KDADS) to convene key agencies and the entities that currently provide housing programs, and to facilitate community collaborations to maximize federal funding opportunities.

Figure 17. **Recommendation 2.1: Reimbursement Rates (former 1.4)**

Recommendation	• Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.		
Rationale	• Increase regional access to evidence-based treatment for mental illness and substance use disorders. • Increase availability of qualified practitioners. • Increase ability to retain workforce. • Increase ability of practitioners to deliver comprehensive services that meet patient needs. • Increase access to behavioral health services. • Free up resources to serve uninsured and underinsured.		
Action Steps	**Details**	**Target Population**	**Considerations**
	• 2.1.a. Require KDADS and KDHE to establish a system that provides for regular reviews of the cost of services and reimbursement rates.	• Uninsured • Medicaid beneficiaries • Direct service workers	**Timing Consideration(s):** Legislative session, regulatory process. **Timeline:** 05/2019. **Budget:** Agencies can complete this action step within existing resources. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** Legislature, providers.
	• 2.1.b. Conduct a rate study for the Medicaid fee schedule and federal block grant.		**Timing Consideration(s):** Contracts, agency budget development. **Timeline:** 12/2020. **Budget**: Agency estimates a fiscal impact of $450,000 to conduct a Medicaid and Block Grant fee rate study of fee schedules. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** Contractors, providers.

Figure 17. **Implementation of Recommendation 2.1: Reimbursement Rates (former 1.4) (continued)**

Action Steps	Details	Target Population	Considerations
	• 2.1.c. Update Medicaid fee schedule and the federal block grant based on the study results.	• Uninsured • Medicaid beneficiaries • Direct service workers (continued)	**Timing Consideration(s):** Legislative session. **Timeline:** 07/2021. **Budget**: The fiscal impact will be based on the rate study findings denoted above. **Responsible Parties:** KDHE, KDADS. **Other Organizations:** Legislature, MCOs.
	• 2.1.d. Pursue value/outcome-based payment.		**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** 01/2020. **Budget**: No additional funding required to develop or encourage value-based payment models in KanCare. **Responsible Parties:** MCOs, providers. **Other Organizations:** N/A.
	• 2.1.e. Re-evaluate the use of current nursing facility case mix index and consider alternatives that appropriately assign weight for the complexity of behavioral health symptoms.	• Nursing facilities, NFMHs providers and residents	**Timing Consideration(s):** Legislative session, agency budget development **Timeline:** 8/2019. **Budget**: Fiscal impact to be determined once specific recommendations are made to reimbursement methodology. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** Providers.

Note: See *Appendix D*, page D-1, for a related recommendation from the Governor's Substance Use Disorders Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

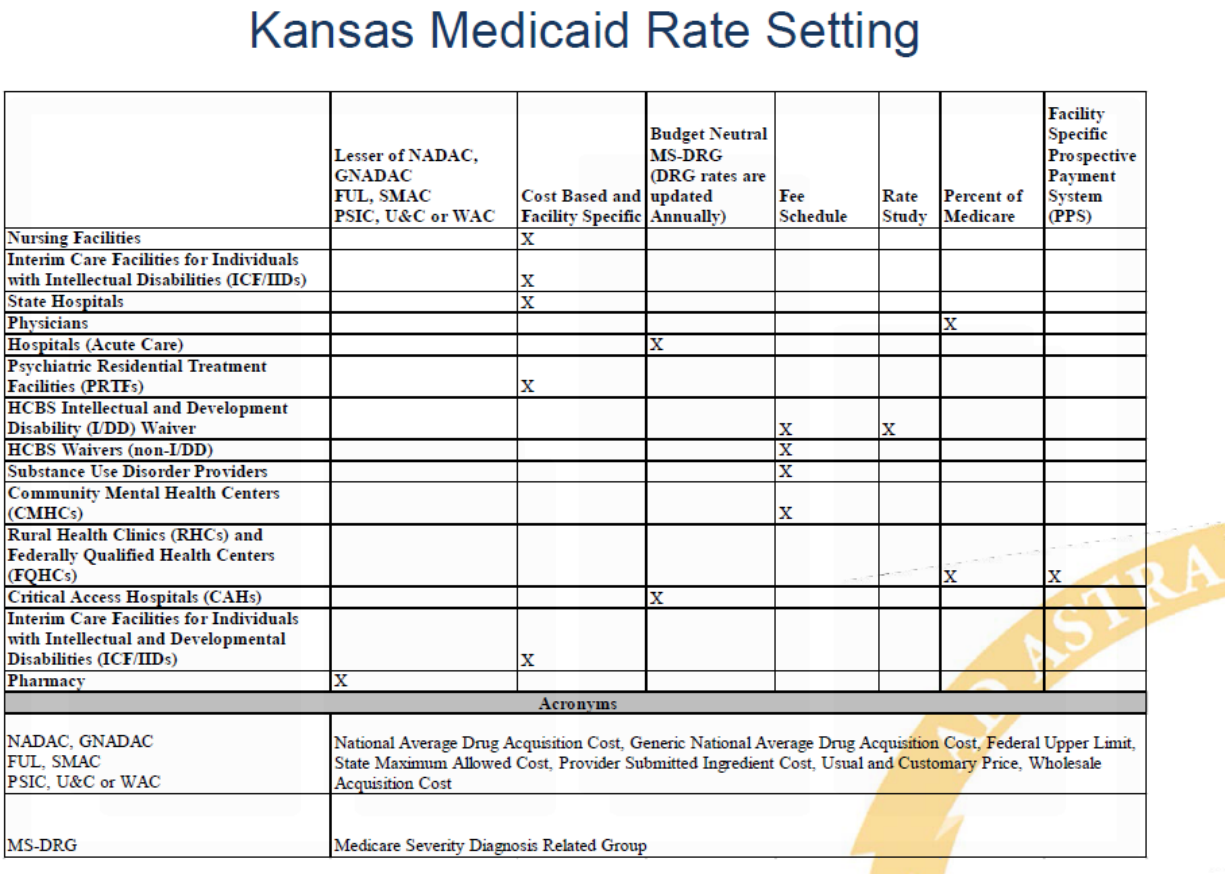
Background

Reimbursement rates influence access to behavioral health services by affecting workforce capacity and provider participation. [26] Outdated rates also can create imbalances by incentivizing some services over others. [27,28]

Regular reviews of reimbursement rates can help payers, including the Medicaid agency, ensure the sufficiency of rates, consistent quality of services and the availability of providers. A framework of policy already exists regarding rate review and adjustment. Kansas statutes, regulations and agency policies define how rates are to be calculated for certain services.

Melissa Warfield, director of fiscal and program evaluation at KDADS, presented a one-page summary of Medicaid rate-setting to the Task Force during its October 25 meeting. The document included here as *Figure 18*, page 29, highlighted seven general methods for rate-setting, including cost-based and facility-specific rates, diagnosis-related groups (DRGs), fee schedules, rate studies, percentage of Medicare, the facility-specific prospective payment system (PPS), and a distinct method for pharmacy reimbursement.

Figure 18. **Medicaid Rate-Setting Overview**



Kansas Medicaid Rate Setting

	Lesser of NADAC, GNADAC FUL, SMAC PSIC, U&C or WAC	Cost Based and Facility Specific	Budget Neutral MS-DRG (DRG rates are updated Annually)	Fee Schedule	Rate Study	Percent of Medicare	Facility Specific Prospective Payment System (PPS)
Nursing Facilities		X					
Interim Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)		X					
State Hospitals		X					
Physicians						X	
Hospitals (Acute Care)			X				
Psychiatric Residential Treatment Facilities (PRTFs)		X					
HCBS Intellectual and Development Disability (I/DD) Waiver				X	X		
HCBS Waivers (non-I/DD)				X			
Substance Use Disorder Providers				X			
Community Mental Health Centers (CMHCs)				X			
Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)						X	X
Critical Access Hospitals (CAHs)			X				
Interim Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IIDs)		X					
Pharmacy	X						
Acronyms							
NADAC, GNADAC FUL, SMAC PSIC, U&C or WAC	National Average Drug Acquisition Cost, Generic National Average Drug Acquisition Cost, Federal Upper Limit, State Maximum Allowed Cost, Provider Submitted Ingredient Cost, Usual and Customary Price, Wholesale Acquisition Cost						
MS-DRG	Medicare Severity Diagnosis Related Group						

Source: Kansas Department for Aging and Disability Services presentation to the Mental Health Task Force, October 25, 2018.

The Task Force discussed the fact that many behavioral health care rates have not been increased in Kansas Medicaid for several years. There are no current requirements to update fee schedules for behavioral health services, but the Task Force discussed the need to rebase reimbursement regularly (for example, every three to five years). Additionally, supplemental or incentive payments for acuity or outcomes could be pursued.

The Task Force was interested in the way Nursing Facilities for Mental Health (NFMH) are reimbursed relative to other nursing facilities (for more on NFMHs, see *Topic 4*, page 52). Nursing facility rates are updated based on the case mix at each facility, which is calculated and updated twice each year. The Resource Utilization Group III, Group 34, currently is used by the state to assess acuity and case mix for the nursing facilities. However, the Task Force discussed that the method does not accurately capture behavioral symptoms. RUG-IV, Group 54, is the more updated version that some states have moved to; it more accurately captures the behavioral symptoms of

residents. Subsequently, on December 7, 2018, CMS announced that it will be removing several Minimum Data Set (MDS) elements over the next few years, including elements used in RUG-III and RUG-IV, as they are no longer required for federal purposes. With the removal of those data elements, RUG-III and RUG-IV no longer will be functional. States that want to use either after October 1, 2020, will need to collect the data elements some other way.[29] The Task Force recommended that the state should consider alternatives that appropriately assign weight for the complexity of behavioral health symptoms.

The action steps for Recommendation 2.1 include requiring KDADS and KDHE to establish a system that provides for regular reviews of the cost of services and reimbursement rates, conducting a rate study to be completed by December 2020 and updating fee schedules based on the results, pursuing value- or outcome-based payments, and ensuring that behavioral symptoms are accurately captured in the methodology used to set nursing facility rates.

Figure 19. **Recommendation 2.2: Care Management Program (Health Homes) (former 7.2)**

Recommendation	• Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt in to a health home to have access to activities that help coordinate their care.	
Rationale	• Improve access and quality of care. • Improve patient experiences. • Decrease emergency department use. • Decrease inpatient admissions and readmissions.	
Target Population	• Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition.	
Action Steps	**Details**	**Considerations**
	• 2.2.a. Select and implement a health home model with an approved state plan amendment (SPA).	**Timing Consideration(s):** Federal approval process, regulatory process, agency budget development. **Timeline:** 04/2019. **Budget:** $2.5 million SGF in existing KDHE budget proviso. Up to $18 million -$25 million all funds for an inclusive program serving children, additional chronic conditions, and a broader target population. (See background for discussion of enhanced federal match rates.) **Responsible Parties:** KDHE. **Other Organizations:** MCOs, partners that are providing services, hospitals.

Figure 19. **Recommendation 2.2: Care Management Program (Health Homes) (former 7.2) (continued)**

Action Steps	Details	Considerations
	• 2.2.b. Establish a reimbursement mechanism that is appropriate to the needs of the targeted population.	**Timing Consideration(s):** Contracts, systems. **Timeline:** 04/2019. **Budget**: $100,000-$200,000 all funds to develop rates for health homes program. **Responsible Parties:** KDHE. **Other Organizations:** KDADS, providers.
	• 2.2.c. Measure outcomes on July 1, 2021, and annually after that.	**Timing Consideration(s):** Agency budget development. **Timeline:** 07/2021 (annually after). **Budget**: No estimate. **Responsible Parties:** KDHE. **Other Organizations:** Providers, MCOs.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

In its 2018 report, the Task Force recommended that Kansas retool and reinstate health homes, which had operated in a two-year pilot in Kansas from August 2014 to June 2016 for individuals with serious mental illnesses.

Health homes are activities that help coordinate care for individuals with chronic medical conditions. Health homes offer person-centered, team-based care coordination including a focus on social supports and services. Medicaid health homes can be available to those with multiple chronic conditions, a chronic condition and the risk for another, or serious mental illness.[30]

Enhanced federal matching funds (90 percent) are available for the first eight quarters of implementation for each population (or 10 quarters for health home activities targeted to beneficiaries with substance use disorders). As of the end of 2016, nearly 1.3 million Americans were enrolled in Medicaid health homes in 22 states and the District of Columbia. Chronic conditions can include mental health conditions, substance use disorder, asthma, diabetes, heart disease and being overweight (body mass index over 25).[31]

Evidence from the first 11 states to implement health homes demonstrated that using the health home state plan option allowed states to target high-cost, high-need patients, and initial results suggest potential for improvements in care utilization patterns, costs and quality.[32]

The Kansas Legislature in 2018 adopted a budget proviso directing KDHE to reinstate health homes in Fiscal Year 2019. The proviso directed that the program allow members to opt in to (rather than requiring them to opt out of) participation, limited the administrative rate that managed care organizations could hold, and required a "narrower scope of eligibility for adults than the previous program to ensure those who have a behavioral health diagnosis or chronic physical health condition are served."

The Task Force acknowledged the change to an opt-in program and encouraged the scope to include all Kansas youth and adults with a behavioral health diagnosis or chronic physical health conditions, and that reimbursement is appropriate for the needs of targeted populations.

The new program in development, OneCare Kansas, is proposed to be available for Medicaid members with two chronic conditions, one chronic condition with risk for a second, or one "serious and persistent mental health condition."[33] However, the planning committee has not finalized the target population.

The Task Force also recommended that outcomes be reported after two years and annually thereafter. Toward the end of the initial Kansas pilot health homes program, KDHE performed an actuarial analysis that found the model had reduced costs associated with emergency room utilization and inpatient admissions, but that the improvements were similar for a control group of people who had opted out of health homes. The Task Force believes that a longer timeframe will be needed to determine the effectiveness of OneCare Kansas.

Figure 20. **Recommendation 2.3: Excellence in Mental Health (former 1.5)**

Recommendation	• Support expansion of the federal Excellence in Mental Health Act and then pursue participation.
Rationale	• Improve Kansans access to integrated care. • Improve outcomes for Kansans with mental illness and/or substance use disorders. • Attract and retain qualified staff. • Increase access to mental health and substance use disorder treatment. • Expand capacity to address the opioid crisis. • Reduced rates of incarceration. • Reduced rates of homelessness.
Target Population	• Kansans with mental illness and/or substance use disorders.

Figure 20. **Recommendation 2.3: Excellence in Mental Health (former 1.5) (continued)**

Action Steps	Details	Considerations
	• 2.3.a. Ask Kansas congressional delegation to support expansion of the federal Excellence in Mental Health Act.	**Timing Consideration(s):** Legislative session. **Timeline:** 03/2019. **Budget:** No cost. **Responsible Parties:** KDADS, KDHE. **Other Organizations:** Providers.
	• 2.3.b. Develop an application to participate in the pilot program.	**Timing Consideration(s):** Federal approval process. **Timeline:** Depends on federal legislation timeline. **Budget**: Agency can complete this activity within the existing resources. **Responsible Parties:** KDADS/KDHE. **Other Organizations:** CMHCs.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

In 2014, the Excellence in Mental Health Act was implemented as a demonstration project as part of the Protecting Access to Medicare Act, providing 25 states with two-year grants of up to $2 million each, with eight states being awarded demonstration grants in 2017. Cost-based reimbursement is available for Certified Community Behavioral Health Clinics for providing: 1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization; 2) screening, assessment and diagnosis, including risk assessment; 3) patient-centered treatment planning or similar processes, including risk assessment and crisis planning; 4) outpatient mental health and substance use services; 5) outpatient clinic primary care screening and monitoring of key health indicators and health risk; 6) targeted case management; 7) psychiatric rehabilitation services; 8) peer support and counselor services and family supports; and 9) intensive, community-based mental health care for members of the armed forces and veterans. Kansas did not apply for the grants available through the demonstration.[34]

The federal Interdepartmental Serious Mental Illness Coordinating Committee in December 2017 released a report, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers.*[35] The report included a recommendation to "Expand the Certified Community Behavioral Health Clinic (CCBHC) program nationwide. The CCBHC program provides a framework to support effective services in a population health framework and

offers a sustainable payment model. Evaluate the effectiveness of the CCBHC model and, if needed, modify the model to improve the reach and quality of services and outcomes. Help interested states to move toward similar models of care delivery, even states not funded by the CCBHC program."

Federal legislation was introduced to extend the program past its 2019 expiration and expand it to 11 additional states, but as introduced it would have been available only to states that had applied for a demonstration grant in 2016 but had not been selected.

The Task Force recommended KDHE and KDADS approach the Kansas congressional delegation during the first quarter of calendar year 2019 to request support legislation that would expand the Excellence in Mental Health Act to other states, including Kansas.

Figure 21. **Recommendation 2.4: IMD Waiver (former 1.1)**

Recommendation	Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule to allow federal Medicaid funds for both SUD and psychiatric inpatient treatment.	
Rationale	• Provide stability for people admitted to mental health facilities that currently are affected by the IMD exclusion, including Larned and Osawatomie state hospitals, and a smooth transition for Medicaid beneficiaries transitioning out of inpatient settings. • Preserve continuity of care, reduce churn in the system, and keep beneficiaries covered before, during and after their treatment. • Increase access to clinically appropriate care, reduce emergency department use, reduce the total cost of care and improve health outcomes. • Allow for the expansion of community crisis residential care facilities, which now are limited to 16 beds. • KDADS estimates that a full waiver of the IMD exclusion would bring in more than $23 million in federal Medicaid funding for nearly 1,500 affected admissions at Larned and Osawatomie state hospitals alone.	
Target Population	• Medicaid recipients with SUD or mental illness. • Medicaid recipients needing hospitalization or residential treatment.	
Action Steps	**Details**	**Considerations**
	• 2.4.a. Pursue SUD exemption in order to take a full advantage of a new federal opportunity.	**Timing Consideration(s):** Federal approval process, regulatory process. **Timeline:** 01/2019 (ongoing). **Budget:** Proposal was budget neutral. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** CMS.

Figure 21. **Recommendation 2.4: IMD Waiver (former 1.1) (continued)**

Action Steps	Details	Considerations
	• 2.4.b. Submit now and revisit no less than annually about the possibility of submission of the IMD exemption for Mental Health.	**Timing Consideration(s):** Federal approval process, regulatory process. **Timeline:** 01/2019 and revisit June of each year. **Budget:** Proposal must be budget neutral. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** CMS.
	• 2.4.c. Make sure that SUD exemption has been implemented with new KanCare rollout (January 2019).	**Timing Consideration(s):** Regulatory process. **Timeline:** 01/2019 (ongoing). **Budget**: Proposal was budget neutral. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** SUD providers.
	• 2.4.d. Ensure that IT system and policy changes to not disenroll beneficiaries upon admission to an IMD are implemented.	**Timing Consideration(s):** Regulatory process, systems **Timeline:** 01/2019 (ongoing). **Budget**: Additional information may be needed to develop estimate. **Responsible Parties:** KDHE. **Other Organizations:** Contracted agencies, KEES.

Note: See Appendix D, page D-1*, for a related recommendation from the Governor's Substance Use Disorders Task Force.*
Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Federal law prohibits the use of federal Medicaid financing for care provided to most patients age 21 to 64 in mental health facilities with more than 16 beds, which in law are termed Institutions of Mental Disease (IMDs). The prohibition is referred to as the "IMD exclusion." The Managed Care Final Rule released in 2016 opened the door for individuals enrolled in managed care to not lose eligibility during inpatient hospital stays up to 15 days as long as the admissions could be considered "in lieu of" services that would offset other costs.

The KanCare demonstration renewal submitted in December 2017 sought to allow federal matching funds for members who become patients in IMDs, but according to KDHE and KDADS, the federal Centers for Medicare and Medicaid Services (CMS) indicated willingness to consider

federal funding only for members with substance use disorder diagnoses. Other states have received CMS approval to waive the exclusion for SUD, and particularly for opioid use disorder. The Kansas renewal was approved December 18, 2018, and it included approval for inpatient SUD treatment in IMDs.

However, CMS has very recently indicated willingness to consider flexibility around the use of IMDs for mental illness treatment as well. In November 2018, U.S. Health and Human Services Secretary Alex Azar, speaking at a meeting of the National Association of Medicaid Directors, encouraged states to use Section 1115 demonstrations to seek authority to pay for "short-term" stays at IMDs if states also commit to take action to ensure quality of care in those settings and to improve access to community-based services as well. On November 13, CMS issued a letter to State Medicaid Directors with more details about the opportunity.[36]

Currently, individuals admitted to Osawatomie and Larned state hospitals, or other IMDs, lose their Medicaid eligibility. A process has been put in place to have eligibility reinstated upon discharge, but some individuals leaving the hospital without benefits lack access to care.

The Task Force expressed disappointment that CMS had been slow to move forward with the KanCare application for an IMD exclusion waiver request for mental health treatment, but was encouraged by the opportunity to address it for individuals who need addiction treatment. KDHE and KDADS assured the Task Force they would continue to pursue federal matching funds for inpatient mental health treatment as well. The implementation plan includes an action step to resubmit the request right away, now that CMS has provided guidance to states.

Figure 22. **Recommendation 2.5: Medicaid Expansion (former 1.2)**

Recommendation	Adopt Medicaid expansion to cover adults under the age of 65 with income up to 138 percent FPL to pursue solutions for serving the uninsured and underinsured, which will improve access to behavioral health services.
Rationale	• Improve access to clinical care, prevention, and crisis services statewide. • Ensure that individuals have access to treatment and are covered when symptoms first occur. • Help to fill identified gaps in the continuum of care: crisis care and substance use disorder treatment. • Increase state access to available federal funds.
Target Population	• Individuals who are newly eligible and enroll (KHI has estimated expansion would add 145,000 new beneficiaries to KanCare).

Figure 22. **Recommendation 2.5: Medicaid Expansion (former 1.2) (continued)**

Action Steps	Details	Considerations
	• 2.5.a. Legislature should act to repeal statutory limitations and/or pass enabling legislation.	**Timing Consideration(s):** Legislative session, regulatory process, agency budget development. **Timeline:** 04/2019. **Budget:** See 2.5.b. **Responsible Parties:** Kansas Legislature. **Other Organizations:** KDHE/CMS.
	• 2.5.b. Implement Medicaid expansion by July 1, 2019.	**Timing Consideration(s):** Federal approval process, systems. **Timeline:** 07/2019. **Budget**: $26 million SGF in FY 2020 per 2018 fiscal note. **Responsible Parties:** KDHE. **Other Organizations:** CMS.

Note: See *Appendix D,* page D-1, for related recommendations from the Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

The Task Force included a version of this recommendation in its 2018 report. The recommendation was revised to reflect language from similar recommendations from the Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force.

The Mental Health Task Force noted that the implementation of this recommendation would serve as the foundation for many of the other recommendations in this report. For example, addressing the IMD exclusion would provide federal matching funds for inpatient psychiatric and addictions treatment only to the extent that patients are eligible for Medicaid. States that have expanded Medicaid have found that a large percentage of new enrollees have behavioral health diagnoses. A Government Accountability Office analysis of four states that expanded in 2014 (Iowa, New York, Washington and Virginia) found that 17 percent to 25 percent of enrollees covered by expansion had behavioral health diagnoses.[37] Other state-specific results related to behavioral health services for expansion enrollees, including in Ohio, Indiana, Arkansas and Iowa, were reviewed by the Task Force and are included in *Appendix C*, page C-1 Medicaid Expansion and Behavioral Health.

Expanded Medicaid eligibility also has the potential to address workforce and program capacity, particularly among providers who see a large proportion of currently uninsured patients.

With the passage of the Patient Protection and Affordable Care Act (ACA), Medicaid eligibility was expanded to all adults under the age of 65 with incomes up to 138 percent of the Federal Poverty Level, the equivalent of $34,638 for a four-person household in 2018. In June 2012, the Supreme Court ruled that states could not be required to expand their Medicaid programs, making the expansion optional for states.[38] The Kansas Legislature passed a bill to expand Medicaid in 2017, but it was vetoed by then-Governor Sam Brownback.

As of November 2018, 36 states and the District of Columbia have expanded Medicaid. Of that group, most had expanded Medicaid eligibility under traditional rules with no waivers, while eight had expanded using waivers.

The Task Force recommends that the Legislature act during the 2019 session to enable expansion of KanCare by July 1, 2019. The 2018 fiscal note for legislation considered in 2018 estimated net state general fund costs of $26 million in Fiscal Year 2020 if Medicaid were expanded.

Figure 23. **Recommendation 2.6: Housing (former 1.3)**

Recommendation	• Continue to empower KDADS to convene key agencies and the entities that currently provide housing programs, and to facilitate community collaborations to maximize federal funding opportunities.	
Rationale	• Increase state access to available federal funds. • Additional federal funding will allow expanded housing options for people with behavioral health issues. • The expansion of housing will lead to decreased admissions to state psychiatric hospitals, reduced rates of incarceration, and will prevent people becoming homeless in the first place.	
Target Population	• Youth and adults who have unmet housing needs.	
Action Steps	**Details**	**Considerations**
	2.6.a. Restore and enhance KDADS staff positions related to housing programs.	**Timing Consideration(s):** Legislative session, regulatory process, agency budget development. **Timeline:** 04/2019. **Budget:** Included in agency's $500,000 supplemental request, see 1.4.a. **Responsible Parties:** Kansas Legislature. **Other Organizations:** KDADS.

Figure 23. **Recommendation 2.6: Housing (former 1.3) (continued)**

Action Steps	Details	Considerations
	• 2.6.b. Support KDADS-convened interagency commission to actively pursue federal funding opportunities.	**Timing Consideration(s):** Systems. **Timeline:** 03/2019 (ongoing). **Budget:** Part of agency operations. **Responsible Parties:** KDADS. **Other Organizations:** KHRC, DOC, DCF.
	• 2.6.c. Interagency commission should convene stakeholders to bring ideas to the table and to pursue additional funding.	**Timing Consideration(s):** Systems. **Timeline:** 07/2019. **Budget:** Part of agency operations. **Responsible Parties:** Commission and its members. **Other Organizations:** Local community members.

Note: See *Appendix D*, page D-1, for a related recommendation from the Child Welfare System Task Force.
Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

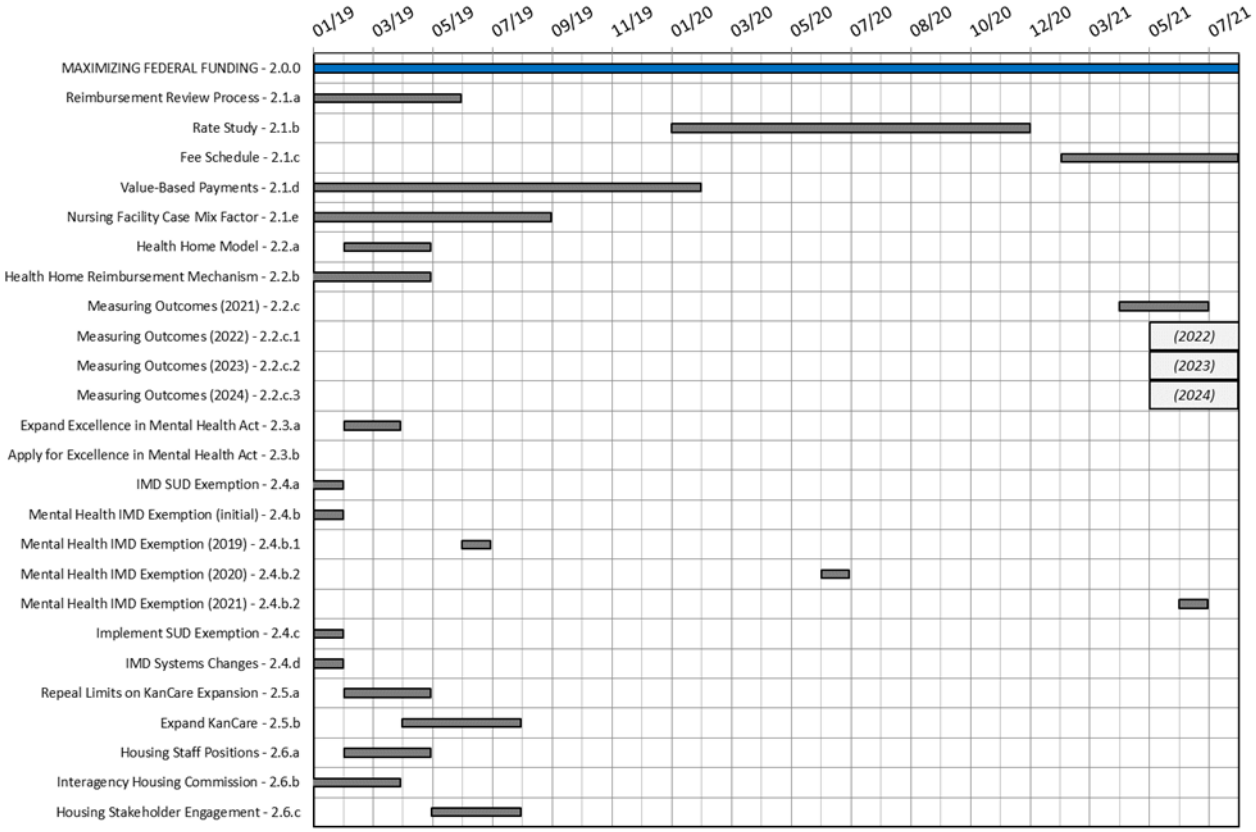
Background

Services that support a community-based model of behavioral health care are not all administered within a single agency, whether at the state or federal level. Because funding opportunities may come from a patchwork of federal agencies and programs, collaboration and integration are required to ensure that opportunities are recognized. States that more actively coordinate housing efforts across agencies may be more successful in obtaining funding to support housing programs.

The Task Force recommended restoring and enhancing dedicated housing program positions at KDADS. The agency previously had a position focused on solely on housing but ran out of funding to continue the position. The activity would require funding allocated by the Legislature, and the new KDADS position(s) would focus broadly on housing programs.

The Task Force appreciated that KDADS had created an interagency commission (which had been recommended by the Task Force in its 2018 report), but wanted to ensure that the commission would continue. The Task Force also recommended that the Interagency Commission engage with non-governmental stakeholders as well, some of whom may be aware of federal or other funding opportunities for housing programs. Additionally, some stakeholder groups may be eligible to apply for funding for which state agencies are ineligible.

Figure 24. **Implementation Timeline for Topic 2: Maximizing Federal Funding and Funding from Other Sources**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 3: Continuum of Care for Children and Youth

Goal: To enhance the array of community-based services available to children and youth with behavioral health needs.

Introduction: The Task Force reviewed its recommendations from 2018 and made updates based on recent reports, including the 2017 Children's Continuum of Care Task Force Report and the 2018 Working Groups Report to the Child Welfare System Task Force, and updates from KDADS and DCF.

The updated recommendations related to the continuum of care for children and youth prioritized by the Task Force included one which focused on access to effective practices and supports, one focused on expanding intensive outpatient services, one that focused on decreasing the use of PRTFs for crisis stabilization services, one focused on early childhood intervention and the recognition of adverse childhood experiences (ACEs), and one recommending a joint agency report on reforms for transition age youth.

Priority Recommendations:

Recommendation 3.1: Access to Effective Practices and Support (former 2.2). Deliver crisis, clinical and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.

Recommendation 3.2: Intensive Outpatient Services (former 6.2). Expand community-based options such as intensive outpatient services.

Recommendation 3.3: Psychiatric Residential Treatment Facility (PRTF). Re-establish the purpose of PRTFs**.** (former 6.3)

Recommendation 3.4: Early Intervention (former 6.4). Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment and treatment (e.g., ABC programs).

Recommendation 3.5. Transition Age Youth (new): Request a formal joint report to Legislature by corrections, education and health and human services agencies on programs, coordinated efforts and any collective recommendations for populations identified in SB 367.

Figure 25. **Recommendation 3.1: Access to Effective Practices and Support (former 2.2)**

<table>
<tr><td>Recommendation</td><td colspan="3">• Deliver crisis, clinical and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.</td></tr>
<tr><td>Rationale</td><td colspan="3">• Improve the physical and psychological safety of students and schools, as well as academic performance and problem-solving skills.
• Prevent suicides.
• Reduce child welfare caseloads.
• Keep children in their homes.
• Reduce foster placements.</td></tr>
<tr><td rowspan="3">Action Steps</td><td>Details</td><td>Population</td><td>Considerations</td></tr>
<tr><td>• 3.1.a. Provide opportunities for community service organizations to increase behavioral health services in schools (e.g., the integrated primary and behavioral health care model).</td><td rowspan="2">• Children, youth and families.</td><td>Timing Consideration(s): Agency budget development, grant cycles.
Timeline: 03/2019.
Budget: No estimate.
Responsible Parties: KDHE/DHCF (Medicaid), KDHE (KDHE grants), KSDE (KSDE pilot).
Other Organizations: Schools, school districts, FQHCs, CMHCs, Association of School Boards.</td></tr>
<tr><td>• 3.1.b. Review and enhance reimbursement for in-home behavioral health services.</td><td>Timing Consideration(s): Agency budget development, systems.
Timeline: 02/2019.
Budget: Cost would be based on rate review (current rate for 90847HK has been $110 since 2007).
Responsible Parties: KDHE/KDADS.
Other Organizations: MCOs, in-home behavioral health providers.</td></tr>
</table>

Figure 25. **Recommendation 3.1: Access to Effective Practices and Support (former 2.2) (continued)**

Action Steps	Details	Population	Considerations
	• 3.1.c. Provide and expand training for in-home services (e.g., Parent Management Training of Oregon).	• Children, youth and families (continued).	**Timing Consideration(s):** Agency budget. development, grant cycles **Timeline:** 03/2019. **Budget:** No estimate. **Responsible Parties:** KDHE/DHCF (Medicaid), KDHE (KDHE grants), KSDE (KSDE pilot). **Other Organizations:** Schools, school districts, FQHCs, CMHCs, Association of School Boards.
	• 3.1.d. Develop sustainable funding to continue and expand activities funded by the Systems of Care Grant beyond the initial four grantee counties.	• Population age 16-23	**Timing Consideration(s):** Agency budget development, systems. **Timeline:** 02/2019. **Budget:** $2.5 million a year to continue at current levels. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** MCOs, in-home behavioral health providers.
	• 3.1.e. Evaluate outcomes of intervention teams and provide the Legislature with a report on implementation of mental health intervention teams in the districts identified in 2018 Substitute for Senate Bill 423.	• School-age children	**Timing Consideration(s):** Legislative session, agency budget development, systems. **Timeline:** 04/2019. **Budget:** No estimate. **Responsible Parties:** KSDE. **Other Organizations:** School districts.

Figure 25. **Recommendation 3.1: Access to Effective Practices and Support (former 2.2) (continued)**

Action Steps	Details	Population	Considerations
	• 3.1.f. Based on the evaluation results, expand the reach of the mental health intervention team model by including additional school districts.	• School-age children (continued)	**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** This step will be implemented based on the results of the previous step. **Budget:** TBD based on results of 3.1.e. **Responsible Parties:** KSDE. **Other Organizations:** School districts.
	• 3.1.g. Fund and institute the Families First Prevention Services Act (FFPSA; 2018) in Kansas and follow the federal guidelines.	• Families in which members have SUD • Foster families • Kids at risk of out-of-home placement • Parents that need behavioral health treatments	**Timing Consideration(s):** Legislative session, federal approval process, agency budget development. **Timeline:** 04/2019. **Budget:** DCF supplemental budget request includes SGF of $600,000 in FY 2018, $2.1 million in FY 2019, and $2.5 million in FY 2020. **Responsible Parties:** DCF/Kansas Legislature. **Other Organizations:** Provider organizations.
	• 3.1.h. Expand eligibility for parent support services to all parents of children with serious emotional disturbance (SED) or substance use disorders (SUD).	• Parents who have children with SED/SUD	**Timing Consideration(s):** Legislative session, federal approval process, regulatory process, contracts, agency budget development. **Timeline:** 01/2020. **Budget:** Agency estimates additional cost of $9.5 million all-funds, assuming parents of nearly 62,000 KanCare-enrolled children would use service at same rate and frequency as parents of children on the SED waiver (current cost on the waiver is $292 per year per beneficiary using the service, or; current cost of about $733,000 per year. **Responsible Parties:** KDADS/KDHE. **Other Organizations:** CMS, providers that need to be trained.

Note: See *Appendix D*, page D-1, for related recommendations from the Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

The Task Force believes that providing crisis intervention and prevention services to children and families in a natural setting such as school, home or community is necessary to effectively treat children and promote healthy development. The Substance Abuse and Mental Health Services Administration (SAMHSA) echoes this sentiment, listing provision of services in the least restrictive manner as an essential value for crisis intervention practice.[39] The same report stresses that least-restrictive emergency interventions both avoid coercion and preserve the individual's connectedness with their world.[40]

For prevention services, there is also evidence of improved outcomes from interventions in a more natural setting. Some examples of these effects are found with school-based interventions and functional family therapy. School-based interventions have been shown to alleviate symptoms and increase positive coping skills for children at risk for behavioral and emotional problems. School-based interventions also have been shown to reduce the risk of conduct problems.[41] Further, some evidence suggests that community-based treatments with environmental interventions (e.g., physical, social, or cultural impacts) and environmental interventions alone had a positive impact on mental health outcomes.[42] Functional family therapies have also been found to be effective in mental health prevention and outcomes, including for disruptive behaviors and substance use disorders.[43]

Steps are being taken to expand access to effective practices in natural settings across Kansas. One example is the Mental Health Intervention Team pilot program, which was created by the Kansas Legislature in 2018. The pilot program will partner school districts with CMHCs to create intervention teams—comprised of school district employees, CMHC clinical therapists and case managers—to provide access to services for students. Other examples are the System of Care (SOC) grants, which were awarded to four Kansas counties to implement programs that are youth-guided, family-focused, and community-based. Kansas federally qualified health centers (FQHCs) also provide community-based behavioral health services, within their clinics and within schools. In 2018, five centers provided behavioral health services in schools, serving almost 1,200 students.[44]

While access has increased in some areas, the Task Force also felt that access to other services had decreased, such as access to in-home care. Increasing access to effective practices and prevention services in more settings and communities, in addition to integrating care across providers, will provide more support for children, youth and families across the continuum of care.

Figure 26. **Recommendation 3.2: Intensive Outpatient Services (former 6.2)**

Recommendation	• Expand community-based options such as intensive outpatient services.	
Rationale	• Improve access to care. • Decrease emergency department use. • Improve health outcomes.	
Target Population	• Children/youth under 21.	
Action Steps	**Details**	**Considerations**

	• 3.2.a. Develop policy for coverage of intensive outpatient services.
	  ○ Ensure that settings (place of service) are clinically appropriate for target population.
	  ○ Ensure transportation to intensive day programs is provided.
		Timing Consideration(s): Legislative session, regulatory process, agency budget development.
		Timeline: 07/2019.
		Budget: No total estimate. Services are covered currently for SUD but not mental health. MCOs cover code S9480 for mental health as an "in lieu of" service at between $150-160 per diem.
		Responsible Parties: KDADS/KDHE.
		Other Organizations: Legislature, MCOs, Providers.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Kansas Medicaid home and community-based services for children and adolescents with serious emotional disturbances include wraparound facilitators, parent support and training, independent living skills, attendant care, professional resource family care (crisis), and short-term respite care. [45]

However, the Task Force said the range of options available was limited, restricting the continuum of care. Members also felt that other services such as intensive outpatient services could be provided to expand the array of resources available to Kansas children. These could include approaches such as Extended Day Treatment programs which provide after-school style programs with behavioral health treatment.[46] Additional services that could be utilized to provide behavioral health care to youth include person-plus-environment interventions and environment-only interventions, such as trained home visitors and home visitation programs and one-on-one mentoring, and after-school or other community interventions.[47]

The Task Force stated that increasing intensive outpatient services may reduce PRTF admissions by providing alternative service options. In addition to expanding the available options for intensive outpatient services, resources to ensure that individuals can access intensive outpatient

services (e.g., through transportation services) may be necessary. In conversations with the Task Force, KDADS also indicated that they plan to develop additional intensive options moving forward.

Figure 27. **Recommendation 3.3: Psychiatric Residential Treatment Facility (PRTF) (former 6.3)**

Recommendation	• Re-establish the purpose of PRTFs.	
Rationale	• PRTFs provide a necessary level of care not provided in community or acute settings. • Currently there is insufficient coordination with managed care organizations.	
Target Population	• Children and youth under age 21 needing out of home care for behavioral health and SUD.	
Action Steps	**Details**	**Considerations**
	• 3.3.a. Establish uniform standards for PRTF evaluation, admission, discharge and length of stay.	**Timing Consideration(s):** Contracts. **Timeline:** 01/2019. **Budget:** Part of agency operations. **Responsible Parties:** KDHE/KDADS/PRTF workgroup. **Other Organizations:** Child welfare providers, PRTF operators, Association of Mental Health, MCOs, parent advocacy.
	• 3.3.b. Use community mental health center (CMHC) clinicians and community-based service teams as part of the assessment, utilization review, treatment and discharge planning process.	**Timing Consideration(s):** Contracts **Timeline:** 07/2019. **Budget:** No additional state cost. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** Child welfare providers, PRTF operators, Association of Mental Health, MCOs, parent advocacy.
Action Steps	• 3.3.c. Review and assess reimbursement for CMHC participation during the admission process.	**Timing Consideration(s):** Contracts **Timeline:** 07/2019. **Budget:** No additional cost to review and assess. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** Child welfare providers, PRTF operators, Association of Mental Health, MCOs, parent advocacy.

Note: See *Appendix D*, page D-1, for a related recommendation from the Child Welfare System Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Evidence suggests that lengths of stay in PRTFs have dropped in Kansas. According to testimony presented to the Kansas Child Welfare Task Force in October 2017, the average length of stay for foster youth in psychiatric residential facilities declined from 120 days in 2013 to 45 days in 2017. Related to this is a decline in the number of initial authorized days, down from 90 in 2013 to 14 in 2017, and a decline in renewal days, from 60 in 2013 to 7 in 2017. At the same time, the percentage of children discharged to a family-like setting also has declined, decreasing from 80 percent in 2013 to 20 percent by 2017.[48]

The Task Force reviewed the 2017 Children's Continuum of Care Task Force report and recommendations, which were released after completion of the 2018 Mental Health Task Force Report. The Children's Continuum of Care Task Force report documented current concerns with PRTFs, namely that PRTFs are providing crisis stabilization services when they were intended to provide care for chronic behavioral health conditions; the report cited decreasing lengths of stay as evidence of the focus on crisis stabilization.

The Children's Continuum of Care Task Force also recommended use of CMHC clinicians and community-based service teams (CBST) in planning admission to and discharge from a PRTF, due to a current lack of care coordination between MCOs and CMHCs. Citing similar concerns, the Task Force adopted recommendation language from the Children's Continuum of Care Task Force report. The Task Force supports standard practices and criteria for care in PRTFs and increased coordination between MCOs and CMHCs.

Figure 28. **Recommendation 3.4: Early Intervention (former 6.4)**

Recommendation	• Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment and treatment (e.g., ABC programs).
Rationale	• Earlier identification of behavioral health symptoms. • Potential for earlier intervention. • Better outcomes when treatment is received when symptoms appear.

Figure 28. **Recommendation 3.4: Early Intervention (former 6.4) (continued)**

Action Steps	Details	Target Population	Considerations
	• 3.4.a. Increase awareness of current educational opportunities on adverse childhood experiences (ACES) and expand these opportunities to additional groups, including but not limited to communities, providers and hospitals, and the need for early detection of adverse events experienced by children. This may require an assessment of where the gaps are.	• Children 0-3	**Timing Consideration(s):** Agency budget development, grant cycles. **Timeline:** 01/2020. **Budget:** Evaluation can be conducted using current resources. **Responsible Parties:** KDADS/KDHE. **Other Organizations:** MH Providers, hospitals, MHC, DCF.
	• 3.4.b. Medicaid/CHIP and the State Employee Health Plan should recognize the use and reimbursement of the Diagnostic Classification: Age 0-5 (DC: 0-5) for diagnosis and treatment of children birth through 5 years of age.	• Children age 0-5 • Primary caregivers	**Timing Consideration(s):** Legislative session, contracts, agency budget development, systems. **Timeline:** 01/2020 (12 months). **Budget:** Estimate requires further analysis. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** CMS, Providers, MCOs.
	• 3.4.c. Ensure children and caregivers are screened and assessed (e.g., depression, SED) at regular intervals in early childhood programs. Based on the screening results, make appropriate referrals to community providers.	• Children age 0-5 • Primary caregivers • Children's mental health providers	**Timing Consideration(s):** Regulatory process. **Timeline:** 01/2020. **Budget:** No estimate. **Responsible Parties:** KDADS/KDHE **Other Organizations:** Local medical society, providers, general public awareness.

Note: See *Appendix D*, page D-1, for related recommendations from the Governor's Substance Use Disorders Task Force and the Child Welfare System Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Traumatic events in childhood can have an adverse effect on functioning, including disruption of development and long-term consequences.[49] These adverse childhood experiences (ACEs) include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, mother treated violently, substance misuse within household, household mental illness, parental separation or divorce, and incarcerated household member. Higher cumulative ACEs are associated with health, social and behavior problems including substance use disorders. ACEs are also often co-occurring.[50]

These adverse experiences, if not addressed, can lead to physiological stress that becomes toxic. Toxic stress can then impact behavior, as the individual undergoing toxic stress attempts to counter the stress response. Such behaviors can include smoking, overeating, promiscuity and substance abuse. These behaviors can moderate the stress response but lead to maladaptive behaviors and chronic health issues or mortality.[51]

To improve outcomes, it is important to educate a variety of sectors — including providers —about ACEs. Some trainings for ACEs already exist in Kansas. KDADS offers two online modules that provide information on ACES, in addition to offering more intensive in-person trainings. The in-person trainings are currently limited to two locations (Wichita and Lawrence), however, and may not be accessible for those in other parts of the state. Increased access to training on ACEs where needed, in addition to encouraging providers to screen young children at earlier intervals, increases the likelihood that children receive needed services early on.

Figure 29. **Recommendation 3.5: Transition Age Youth (new)**

Recommendation	• Request a formal joint report to Legislature by corrections, education and health and human services agencies on programs, coordinated efforts and any collective recommendations for populations identified in SB 367.	
Rationale	• Improve rehabilitation programs for youth. • Reduce racial and ethnic disparities in the youth justice system.	
Target Population	• Transition Age Youth.	
Action Steps	**Details**	**Considerations**
	• 3.5.a. Establish a requirement for the report through a proviso or a formal letter of notification (executive order).	**Timing Consideration(s):** Legislative session. **Timeline:** 01/2020. **Budget:** No additional cost. **Responsible Parties:** KDADS, KSDE, KS DOC, DCF. **Other Organizations:** N/A.
	• 3.5.b. Develop a report on existing programs and data.	**Timing Consideration(s):** Legislative session. **Timeline:** 01/2020. **Budget:** Agency can develop report with existing resources. **Responsible Parties:** KDADS, KSDE, KS DOC, DCF. **Other Organizations:** N/A.

Note: See *Appendix D*, page D-1, for a related recommendation from the Child Welfare System Task Force.
Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

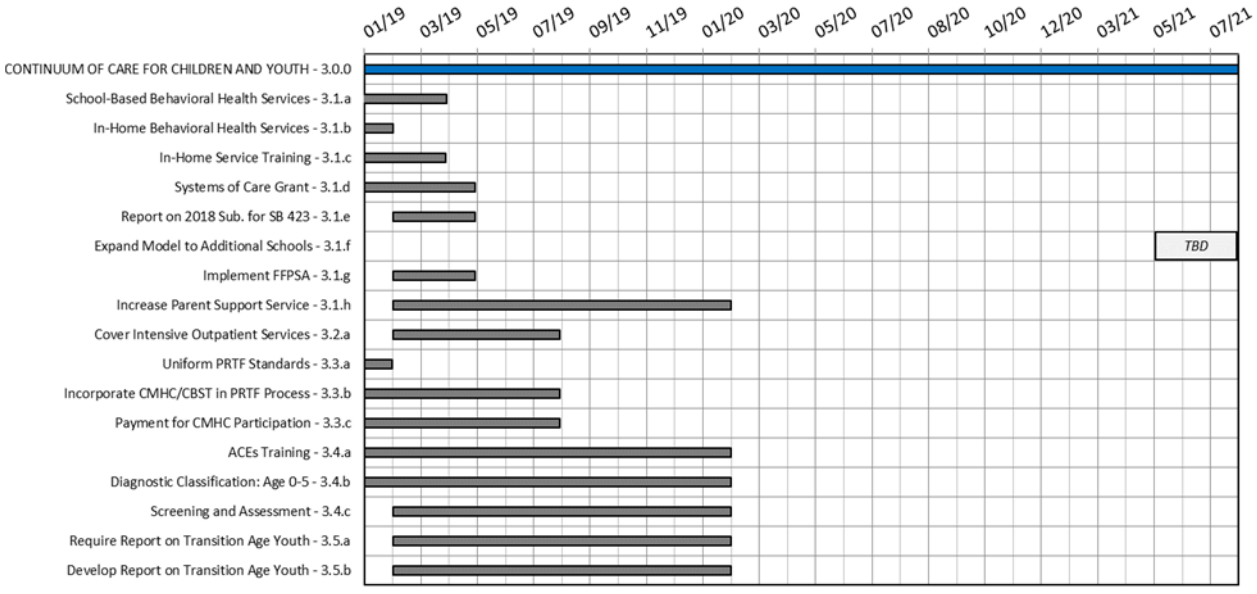
Background

Studies estimate that between 65 percent and 70 percent of juvenile justice offenders could be diagnosed with a mental health or substance use disorder. Overlap in incarcerated juveniles and those with behavioral health issues is in part due to a lack of services available to treat behavioral health issues. "Transition age youth," meaning individuals between age 18 and 26, are particularly vulnerable to entering the justice system. Many of these individuals lose access to Medicaid behavioral health services once they reach age 18, due to differing eligibility requirements for children and adults. Increased access to behavioral health services may decrease criminalization of this population.

Juvenile justice system reform, passed via Senate Bill 367 in 2016, was intended to decrease the number of youth in the juvenile justice system by creating community-based alternatives to detention centers. The Task Force heard via testimony in 2018 that community-based alternatives have not been robust enough to serve all juvenile offenders released back into their communities, and the lack of community-based alternatives has led to an increase of children into the Kansas child welfare system. Lack of coordination between the behavioral health system and juvenile justice system also has exacerbated this issue.

Multiple state agencies have created strategies to increase access to behavioral health services for transition age youth, to decrease the number of individuals in the juvenile justice system. While these reform efforts are important, the Task Force believes that the ultimate success of any reform is contingent on collaboration and coordination across agencies.

Figure 30. **Implementation Timeline for Topic 3: Continuum of Care for Children and Youth**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 4: Nursing Facilities for Mental Health

Goal: To ensure that nursing facilities for mental health are integrated into the behavioral health continuum of care.

Introduction: The Task Force reviewed its three previous recommendations related to Nursing Facilities for Mental Health (NFMHs), focusing on how the facilities can be better integrated into the behavioral health continuum of care. During this review process, the Task Force combined two of its previous recommendations into one recommendation (now Recommendation 4.1). This change integrated the Task Force's recommendation related to active treatment and necessary rehabilitative services with its recommendation related to crisis services, to create one recommendation spanning the different services provided within NFMHs.

To be eligible for admission to an NFMH, adults must be screened, using the Preadmission Screening and Resident Review (PASRR) process conducted by an Aging and Disability Resource Center.[52] After initial admission, annual assessments are completed by screeners from Community Mental Health Centers to determine whether the level of care remains appropriate. Kansas has 10 such facilities as of December 2018, per the Kansas Department for Aging and Disability Services online directory.

Priority Recommendations:

Recommendation 4.1: Licensing Structure (former 5.1). Reform NFMHs to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care.

Recommendation 4.2: Presumptive Approval of Medicaid (former 5.2). Coordinate with KDHE and determine if a policy could be developed or revised that facilitates presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs.

Figure 31. **Recommendation 4.1: Licensing Structure (former 5.1)**

<table>
<tr><td>Recommendation</td><td colspan="3">• Reform NFMHs to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care.</td></tr>
<tr><td>Rationale</td><td colspan="3">• Decrease use of state-only funds to pay for psychiatric services in NFMHs.
• Improve quality of care.
• Improve process of discharge into community services.</td></tr>
<tr><td rowspan="3">Action Steps</td><td>Details</td><td>Target Population</td><td>Considerations</td></tr>
<tr><td>• 4.1.a. Seek revocation or waiver of the federal IMD exclusion rule.</td><td rowspan="2">• Age 21-64
• Individuals that reside in NFMH</td><td>Timing Consideration(s): Federal approval process, regulatory process, agency budget development.
Timeline: 6/2019 (annually thereafter).
Budget: Proposal must be budget neutral.
Responsible Parties: KDHE/KDADS.
Other Organizations: CMS, KHCA.</td></tr>
<tr><td>• 4.1.b. Review and update reimbursement rates and other payment mechanisms.</td><td>Timing Consideration(s): Legislative session, regulatory process, agency budget development.
Timeline: 07/2019.
Budget: Fiscal impact can be determined once specific recommendations are made to reimbursement methodology.
Responsible Parties: KDHE/KDADS.
Other Organizations: NFMHs, Legislature Gov. Behavioral Health Service Planning Council.</td></tr>
</table>

Figure 31. **Recommendation 4.1: Licensing Structure (former 5.1) (continued)**

Action Steps	Details	Target Population	Considerations
	• 4.1.c. Identify and deliver appropriate training curriculum for staff in NFMHs; make sure that challenges with accessing training are addressed.	• Facility directors • KDADS licensing	**Timing Consideration(s):** Contracts, agency budget development, systems. **Timeline:** 03/2019. **Budget:** No estimate. **Responsible Parties:** KDADS. **Other Organizations:** KS Association of CMHCs, KHCA.
	4.1.d. Connect NFMH residents to crisis services, CMHCs and community support services.	• Age 21-64 • Individuals that reside in NFMH	**Timing Consideration(s):** Legislative session, federal approval, agency budget development. **Timeline:** 07/2019. **Budget:** No estimate. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** CMHCs, NFMHs, providers.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

NFMHs provide residential care and rehabilitation treatment for persons with serious mental illness with 24-hour supervision and care.[53] While NFMHs are a structure unique to Kansas, acting as a nursing facility with some mental health services provision and care, the federal government considers NFMHs to be IMDs.[54] The IMD classification is currently a barrier to care, preventing the state from accessing federal matching funding for care for adults age 21-64.[55] However, this barrier could be removed with a successful IMD exclusion waiver, which CMS recently indicated support for (see Recommendation 2.4, page 34).

In addition to a lack of federal funding for NFMH residents, the Task Force identified concerns with the current state payment system for NFMHs. The Task Force received a presentation on rate setting from KDADS, which included an overview of how Nursing Facility (NF) and NFMH rates are set (for more on this presentation, see Recommendation 2.1, page 26). As with other nursing facilities, NFMH rates are based on the case mix of their patients, which is assessed via the

Resource Utilization Group, version III (RUG-III), Group 34. The Task Force discussed the need to update the tool used to assess case mix, as the RUG-III, Group 34 may not adequately capture behavioral health needs. Other payment mechanisms (e.g., value-based payments) may provide additional options for updating the payment systems for NFMHs. According to KDADS, NF and NFMHs already receive some incentive payments, including payments for reducing staff turnover.

The NFMH Workgroup identified multiple areas that could be improved within NFMHs, including connecting residents of NFMHs to crisis services and training and education within NFMHs. Regarding crisis services, the NFMH Workgroup identified a lack of services for veterans, inconsistent services across CMHCs (e.g., some sites have mobile services available while others do not), and lack of crisis services onsite. NFMHs could explore models involving partnerships with other service providers to increase access to crisis services, including informal partnerships or formal consortia.

The NFMH Workgroup also discussed needed improvements for training and education programs for NFMHs, specifically training for staff. Barriers addressed by the workgroup included cost barriers to providing training, most NFMH staff having medical — not behavioral — health certification, and a lack of awareness of currently available training. The Task Force noted that staffing coverage could also be a barrier. The Task Force felt that developing standardized training for NFMH staff, combined with incentives for participation, could improve outcomes for residents and help in retention of the NFMH workforce.

Figure 32. **Recommendation 4.2: Presumptive Approval of Medicaid (former 5.2)**

Recommendation	• Coordinate with KDHE and determine if a policy could be developed or revised that facilitates presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs.
Rationale	• Improve access to care. • Improve discharge into community services. • Decrease emergency department use. • Improve health outcomes.
Target Population	• Age 21-64. • Individuals that reside in NFMH.

Figure 32. **Recommendation 4.2: Presumptive Approval of Medicaid (former 5.2) (continued)**

Action Steps	Details	Considerations
	• 4.2.a. Establish coordination of efforts between KDADS and KDHE to allow presumptive eligibility on discharge from IMD environment.	**Timing Consideration(s):** Federal approval process, regulatory process, agency budget development, systems. **Timeline:** 2020. **Budget:** Coordination can be achieved using current resources. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** CMHCs, NFMHs.

Note: See *Appendix D,* page D-1, for a related recommendation from the Child Welfare System Task Force.
Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Although some patients with mental illness have Medicaid coverage prior to admission to public institutions, most states have policies that require Medicaid coverage to be terminated. This termination is because states cannot receive federal financial participation (FFP) for individuals age 21-64 in an Institution of Mental Disease (IMD). Most states interpret the rules as meaning individuals entering into IMDs are ineligible for Medicaid.[56]

For states, terminating eligibility or allowing it to lapse after entry into an institution provides an unambiguous designation and avoids the potential for (1) erroneous payment for non-FFP Medicaid services for which the state would be fully responsible, or (2) erroneously billing the federal government for Medicaid services provided to individuals who were not eligible for federal matching payments at the time of the service.[57]

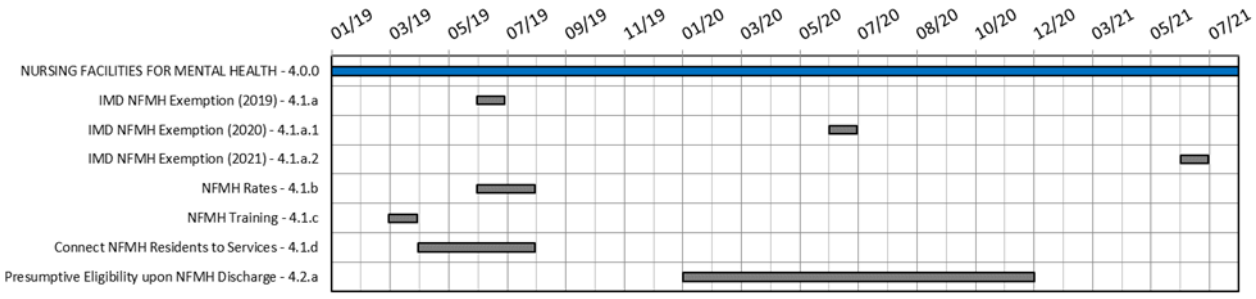
To allow for more seamless re-entry into the Medicaid program upon release from an IMD, states can facilitate the Medicaid application process for those potentially eligible (e.g., those eligible upon entry or who appear to meet eligibility criteria on discharge). Through presumptive eligibility, applicants can begin to receive services before conclusive determination of eligibility, allowing for more seamless integration of care for those in need of medical treatment.

Although federal funding is not available for residents of an NFMH between the ages of 21 and 64, Kansas provides medical assistance using all state funds. Eligibility criteria and process mirror that of other Medicaid institutional determinations, including income, resources and non-financial criteria. Eligible persons are enrolled in a Title XIX benefit package. The fiscal agent separates

funding source based on the age and long-term care coding. The only difference, other funding source, between an NFMH and a skilled nursing facility is enrollment in KanCare. NFMH residents are fee-for-service.

Persons leaving an NFMH retain medical coverage upon discharge until eligibility can be adjusted, but persons are redetermined following discharge. If eligibility is retained, they are enrolled with an MCO (these include Supplemental Security Income recipients and Medically Needy). Persons who are not eligible will lose coverage but always are allowed to keep the medical coverage until the end of the month of discharge (at a minimum).

Figure 33. **Implementation Timeline for Topic 4: Nursing Facilities for Mental Health**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 5: Workforce

Goal: To encourage the availability of behavioral health professionals and peer workers to support individuals in the behavioral health system.

Introduction: Access to high-quality behavioral health services demands a qualified workforce with sufficient capacity to serve the needs of people across the state. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) notes that the need for an educated and seasoned workforce stems not only from demand, but high turnover rates, a shortage of professionals, aging workers, and low compensation.[58] The Task Force noted that workforce issues are broad in behavioral health and extend beyond the recommendations in this report. As a result, the Task Force recommended a comprehensive study of behavioral health workforce needs to identify additional steps to address the shortage of clinical workers.

The Task Force reviewed its 2018 recommendation related to Workforce and maintained its support for peer workers, individuals with lived experience of a behavioral health condition that support others with behavioral health conditions in their recovery process. Peer workers, including peer specialists and certified peer mentors, have been found to improve outcomes and are one way to increase the behavioral health workforce in Kansas. The Task Force also added a new recommendation to require a report on how inclusion in the state loan repayment program for medical professionals has affected the number of behavioral health professionals serving in Kansas.

Priority Recommendations:

Recommendation 5.1: Workforce Study (new). Initiate a comprehensive workforce study statewide to examine challenges experienced by employers in reaching optimal staffing levels to provide services.

Recommendation 5.2: Peer Support (former 7.1). Encourage integration of peer support services (MH) and Kansas certified peer mentoring services (SUD) into multiple levels of service, including employment services at CMHCs, hospitalization, discharge and transition back to the community.

Recommendation 5.3: State Loan Repayment Program (new). Require a report on increasing the number of psychiatrists and psychiatric nurses.

Figure 34. **Recommendation 5.1: Workforce Study (new)**

Recommendation	• Initiate a comprehensive workforce study statewide to examine challenges experienced by employers in reaching optimal staffing levels to provide services.	
Rationale	• Improve access. • Improve health outcomes.	
Target Population	• Individuals who have a mental illness or substance use disorder.	
Action Steps	**Details**	**Considerations**
	• 5.1.a. Conduct statewide behavioral health workforce study to understand the overall shortage of clinical workforce.	**Timing Consideration(s):** Contracts, agency budget development, federal technical assistance. **Timeline:** Throughout FY 2019 with report by 1/2020. **Budget:** $150,000 to conduct surveys, stakeholder focus groups, training needs and gaps analysis. **Responsible Parties:** KDADS. **Other Organizations:** SAMHSA Mental Health Technology Transfer Center.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Workforce shortages and turnover issues are common in many behavioral health care settings in Kansas. A comprehensive workforce study will help identify gaps in academic programs in Kansas and explore workforce shortages by professional discipline and behavioral health sector. Survey results will help identify contributing factors for employee turnover and more effective retention strategies.

Improved employee retention and recruitment will help reduce workforce shortages and improve access to care and positive treatment outcomes for persons served by the behavioral health system of care.

Figure 35. **Recommendation 5.2: Peer Support (former 7.1)**

Recommendation	• Encourage integration of peer support services (MH) and Kansas certified peer mentoring services (SUD) into multiple levels of service, including employment services at CMHCs, hospitalization, discharge and transition back to the community.
Rationale	• Improve employment outcomes. • Improve health outcomes.
Target Population	• Mental Health and Substance Use Disorder consumers (Medicaid recipients).

Figure 35. **Recommendation 5.2: Peer Support (former 7.1) (continued)**

Action Steps	Details	Considerations
	• 5.2.a. Expand training opportunities for those interested in providing peer support services (MH) and KS certified peer mentoring services (SUD).	**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** 12/2019 (annually thereafter). **Budget:** Current agency contract with WSU is $139,000. Expansion of training would require additional agency resources. **Responsible Parties:** KDADS, WSU, SUD contractor (Kansas certification for peer mentoring). **Other Organizations:** N/A.
	• 5.2.b. Enhance incentives to Mental Health and Substance Use Disorder providers that hire and supervise peer support and Kansas certified peer mentoring workers.	**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** 07/2019. **Budget:** No estimate. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** N/A.
	• 5.2.c. Increase Medicaid reimbursement rates for peer support services.	**Timing Consideration(s):** Regulatory process, agency budget. **Timeline:** 07/2019. **Budget:** Increasing peer support reimbursement 6 percent-10 percent for both MH and SUD will cost an estimated $146,599-$244,332 a year. **Responsible Parties:** KDHE/KDADS. **Other Organizations:** MCOs.

Note: See *Appendix D*, page D-1, for a related recommendation from the Governor's Substance Use Disorders Task Force.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Peer specialists are individuals with a lived experience of mental illness or substance use disorder who can serve as models for successful recovery after receiving treatment and progressing to a stage where they can manage their conditions. Evidence suggests that peers with similar lived experiences are associated with improved outcomes, including reduced inpatient service use, improved relationships with providers, better engagement with care, higher levels of empowerment, higher levels of patient activation, and higher levels of hopefulness for recovery.[59]

In Kansas, there are two types of Peer Workers that support individuals in the behavioral health system: Peer Specialists support individuals with mental health conditions, while Kansas Certified Peer Mentors (KCPM) support individuals with SUD.

Training opportunities to prepare a peer workforce exist in Kansas. For example, Behavioral Health Services provides training for individuals to become KCPMs. To be eligible as a KCPM, individuals must: be age 18 or older, have established one year in stable recovery and completed the BHS-administered Certified Peer Mentor training seminar. Certified Peer Specialist Training was previously provided at Wichita State University in the Community Engagement Institute. Qualifications for the program included: self-identifying as having direct, first-hand experience of living with a psychiatric diagnosis, being hired in a Medicaid system such as a CMHC or other qualifying state agency, and being over age 18 with a GED or high school diploma.[60] The Task Force received updates from KDADS regarding training for Peer Specialists in Kansas, who indicated that at the time this report was drafted, contracts with Wichita State University were being finalized to again offer Certified Peer Specialist Training.

Figure 36. **Recommendation 5.3: State Loan Repayment Program (new).**

Recommendation	Require a report on increasing the number of psychiatrists and psychiatric nurses.	
Rationale	• Improve access. • Improve health outcomes. • Measure effectiveness of state policy.	
Target Population	• Individuals who have a mental illness or substance use disorder.	
Action Steps	**Details**	**Considerations**
	5.3.a. Provide Legislature with a report on the number of behavioral health professionals that have been added through the Kansas State Loan Repayment Program (SLRP).	**Timing Consideration(s):** Legislative session. **Timeline:** 1/2020 (annually thereafter). **Budget:** No estimate. **Responsible Parties:** KDHE. **Other Organizations:** N/A.

Background

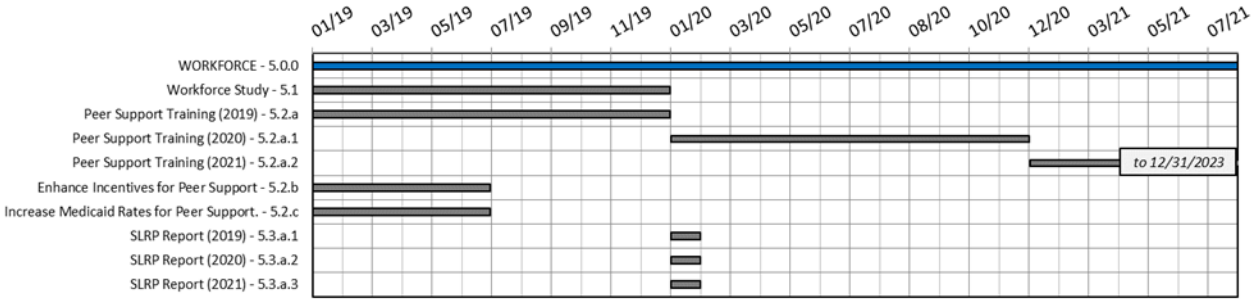
Administered by the KDHE Bureau of Community Health Systems, the State Loan Repayment Program (SLRP) helps eligible health care professionals repay qualifying educational loans in exchange for a minimum two-year service commitment at an eligible practice site in a federally designated Health Professional Shortage Area (HPSA). Continuation awards also are available to

professionals who want to continue beyond their original two-year commitment, for up to three additional years. The number of awards granted each year varies, as the program is competitive.

The 2017 Legislature amended the Medical Student Loan Act to add general and child psychiatry to eligible programs and allows loan recipients to satisfy their obligations by performing at least 100 hours per month of on-site mental health care at a medical facility, a community mental health center, Larned State Hospital (LSH), Osawatomie State Hospital (OSH), or any facility that provides mental health services and is operated by a state agency. The bill required, subject to appropriations, the University of Kansas Medical Center to enter into medical student loan agreements with six individuals who commit to satisfying their loan obligations by practicing or teaching general or child psychiatry.

The 2017 Legislature also amended the Nursing Service Scholarship Program to give priority to qualified nursing students who are sponsored by a behavioral health facility.

Figure 37. **Implementation Timeline for Topic 5: Workforce**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 6: Suicide Prevention

Goal: To create a statewide support structure targeted at decreasing the rate of youth and adult suicides.

Introduction: While not included in its 2018 report, the Task Force decided to develop a new recommendation related to suicide prevention given that rates of suicide in Kansas and across the United States are increasing. Nationally, the U.S. suicide rate rose 25.4 percent between 1999 and 2016; in Kansas it rose 45.0 percent.[61]

In 2017, suicide was the eighth leading cause of death for Kansans, and more than 500 individuals died by suicide. Risk of suicide is higher for certain populations, including white men over 60 and veterans. Youth suicide rates also have increased in recent years, leading to the development of the Attorney General's Youth Suicide Prevention Task Force, which convened in 2018. A report and recommendations from the Attorney General's Youth Suicide Prevention Task Force were due at the end of 2018 and were not available at the time that this report was drafted.

Figure 38. **Recommendation 6.1: Suicide Prevention (new)**

Recommendation	• Place a focus on reversing negative suicide trends for youth and adults.	
Rationale	• In 2016, 5,723 of the 44,965 Americans who died by suicide were between the ages of 15-24. • An additional 436 were between the ages of 10-14. • Suicide is the second leading cause of death between ages 10-24.	
Target Population	• Youth, white male over 60 and veterans.	
Action Steps	**Details**	**Considerations**
	• 6.1.a. Create and fund a full-time state suicide prevention coordinator position who would review and recommend approaches to suicide prevention, (e.g., crisis text line, pursuing grant funding for Zero Suicide) and other evidence-based practices.	**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** 7/2019. **Budget:** $60,000-$80,000/FTE. **Responsible Parties:** KDADS, Kansas Legislature. **Other Organizations:** KSDE, DCF, KDHE, law enforcement.

Figure 38. **Recommendation 6.1: Suicide Prevention (new) (continued)**

Action Steps	Details	Considerations
	6.1.b. Establish state suicide prevention funding to support the implementation of evidence-based strategies, including the National Suicide Prevention Lifeline in Kansas and text line.	**Timing Consideration(s):** Legislative session, agency budget development. **Timeline:** 7/2019. **Budget:** $700,000-$1.4 million. **Responsible Parties:** KDADS, Kansas Legislature. **Other Organizations:** KSDE, DCF, KDHE, law enforcement.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

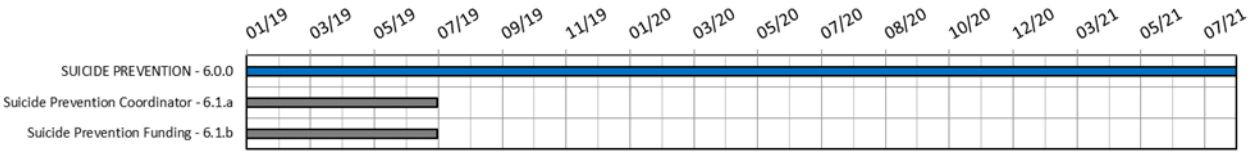
Background

Suicide prevention requires a comprehensive approach that touches individuals, families and communities, as well as affects the broader social environment. The National Suicide Prevention Line (NSPL) is a free hotline available 24/7 that offers support to individuals in crisis across the United States. Calls are answered by a combination of local and national call centers, and states that answer a percentage of calls locally are eligible to apply for grant funding to put toward other suicide prevention programs. In addition to the NSPL, a separate crisis text line is available that pairs individuals in crisis with a crisis counselor.

Evidence-based programs, such as Zero Suicide, also exist to prevent suicide. Zero Suicide is a framework targeted at health and behavioral care systems to engage in suicide prevention. Elements of Zero Suicide include training, comprehensive screenings, treatment and transition planning. Numerous additional examples for evidence-based strategies are found in The Centers for Disease Control and Prevention Technical Package of policy, programs and practices for preventing suicide.[62] KDADS, with input from stakeholders, can examine suicide data and determine the best evidence-based strategies to fund.

Kansas has taken specific steps in recent years to decrease suicide rates. In 2016, Kansas passed The Jason Flatt Act (SB 323), which required school district employees across the state to complete suicide prevention training. While a step in the right direction, the Task Force believes additional steps need to be taken to counter youth suicide rates, and suicide rates overall. Kansas also accepted a Governor's challenge from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018 that will focus on suicide prevention for veterans, service families and their kids. The challenge will run through the end of the summer of 2019.

Figure 39. **Implementation Timeline for Topic 6: Suicide Prevention**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Topic 7: Learning Across Systems

Goal: To develop a learning system that tracks adverse outcomes across the entire behavioral health system to allow the system to learn from past failures and successes.

Introduction: Throughout the duration of the Task Force, there was continued interest in developing a mechanism through which failures and successes in the behavioral health system are acknowledged and addressed.

The original intent for the recommendation was to encourage collaboration between providers to focus on decreasing youth suicides. In subsequent discussions, the Task Force broadened the recommendation to understand outcomes across the behavioral health system to see where improvements could be made.

Figure 40. **Recommendation 7.1: Learning Across Systems (new):**

Recommendation	• Create a position/entity to track information about adverse outcomes that occur and identify strategies for addressing them in a timely manner.	
Rationale	• Increase transparency. • Build a culture of learning. • Patient-centered care.	
Target Population	• Individuals that interact with the behavioral health system.	
Action Steps	**Details**	**Considerations**
	• 7.1.a. Convene experts and people served by the behavioral health system to identify how the learning system can be created.	**Timing Consideration(s):** Agency budget development. **Timeline:** 1/2020. **Budget:** No estimate. **Responsible Parties:** KDADS. **Other Organizations:** Providers, Law enforcement, Family members/consumers (individuals with lived experience), NAMI, CROs, Consumer Advisory Council.
	• 7.1.b. Review approaches used in other states and identify strategies that might work in Kansas.	

Note: See *Appendix D,* page D-1, for a related recommendation from the Child Welfare System Task Force.
Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Background

Learning systems already exist for medical care systems that could be adapted for behavioral health systems.[63] Many of these existing systems utilize health data compiled from multiple

settings and sectors. The National Academies have developed characteristics of a continuously learning health care system, which includes:[64]

Figure 41. **Characteristics of a Continuously Learning Health Care System**

Science and Informatics

- **Real-time access to knowledge**—A learning health care system continuously and reliably captures, curates, and delivers the best available evidence to guide, support, tailor, and improve clinical decision making and care safety and quality.
- **Digital capture of the care experience**—A learning health care system captures the care experience on digital platforms for real-time generation and application of knowledge for care improvement.

Patient-Clinician Relationships

- **Engaged, empowered patients**—A learning health care system is anchored on patient needs and perspectives and promotes the inclusion of patients, families, and other caregivers as vital members of the continuously learning care team.

Incentives

- **Incentives aligned for value**—In a learning health care system, incentives are actively aligned to encourage continuous improvement, identify and reduce waste, and reward high-value care.
- **Full transparency**—A learning health care system systematically monitors the safety, quality, processes, prices, costs, and outcomes of care, and makes information available for care improvement and informed choices and decision making by clinicians, patients, and their families.

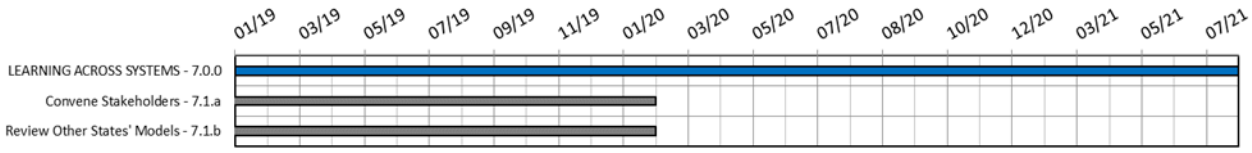
Culture

- **Leadership-instilled culture of learning**—A learning health care system is stewarded by leadership committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core aim.
- **Supportive system competencies**—In a learning health care system, complex care operations and processes are constantly refined through ongoing team training and skill building, systems analysis and information development, and creation of the feedback loops for continuous learning and system improvement.

Source: National Academies, Health and Medicine Division

While learning systems are more common in physical health care settings, some behavioral health learning systems already exist. One system was created by The Center for Health Care Services and integrated health care data from multiple hospitals in San Antonio to track utilization and expenditures of "super utilizers." Super utilizers were individuals that were part of the safety net population (e.g., Medicaid, uninsured/underinsured individuals) and had high utilization of inpatient discharges or emergency department visits. [65] In addition to their physical health conditions, this group was also targeted due to frequent co-occurring behavioral health conditions. Using the integrated data as a baseline, The Center for Health Care Services developed Integrated Care Teams — composed of Licensed Professional Counselors (LPC), Licensed Chemical Dependency Counselors (LCDC), Certified Peer Specialists and others — to address gaps in the system that lead to the utilization patterns of super utilizers.[66] A similar effort to integrate data across providers and track super utilizers is currently underway in Sedgwick County and may be one model for assessing outcomes in the Kansas behavioral health system.

Figure 42. **Implementation Timeline for Topic 7: Learning Across Systems**



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

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Appendix A: Key Acronyms

Figure A-1. **Key Acronyms**

Acronym	Meaning
ACA	Affordable Care Act
ACES	Adverse Childhood Experiences
CBST	Community-Based Service Teams
CCBHC	Certified Community Behavioral Health Clinic
CIA	Crisis Intervention Act
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CRO	Consumer-Run Organization
CWSTF	Child Welfare System Task Force
DCF	Kansas Department for Children and Families
DHCF	Division of Health Care Finance
DRG	Diagnosis-Related Groups
FFPSA	Families First Prevention Services Act
FQHC	Federally Qualified Health Center
HUD	Department of Housing and Urban Development
IMD	Institution for Mental Diseases
KCPM	Kansas Certified Peer Mentors
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KEES	Kansas Eligibility Enforcement System
KHI	Kansas Health Institute
KLRD	Kansas Legislative Research Department
KS DOC	Kansas Department of Corrections
KSDE	Kansas Department of Education
LSH	Larned State Hospital
MAT	Medication-Assisted Treatment
MDS	Minimum Data Set
MH	Mental Health
MHA	Mental Health America
MHTF	Mental Health Task Force
NAMI	National Alliance on Mental Illness
NFMH	Nursing Facility for Mental Health
NSPL	National Suicide Prevention Line
OSH	Osawatomie State Hospital
PDPM	Patient-Driven Payment Model
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility

Figure A-1. **Key Acronyms (continued)**

Acronym	Meaning
PSP	Psychiatric Services Program
RFI	Request for Information
RFP	Request for Proposal
RSI	Rainbow Services, Inc.
RUG	Resource Utilization Group
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening Brief Intervention and Referral to Treatment
SED	Serious Emotional Disturbance
SGF	State General Fund
SOC	Systems of Care
SPA	State Plan Amendment
SPMI	Severe and Persistent Mental Illness
SUD	Substance Use Disorder
WSU	Wichita State University

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Appendix B: Implementation Status of Previous Recommendations

Figure B-1 developed by the Kansas Department for Aging and Disability Services (KDADS), provides a summary of the implementation status of recommendations included in this report. The figure is organized by topic areas that have been discussed by the Mental Health Task Force throughout the report.

Figure B-1. **Status of Mental Health Recommendations**

Topic 1: System Transformation		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 1.1. Addressing Capacity (former 3.2): Implement and fund a comprehensive plan to address voluntary and involuntary hospital inpatient capacity needs while providing all levels of care across all settings.	1.1.a. Maintain at least the current number of beds in Osawatomie and Larned and add 36 to 60 additional regional or state hospital beds within 24 months.	
	1.1.b. Within five years, add up to a total of 221 new regional or state hospital beds, including those added in the first 24 months.	
	1.1.c. Stabilize staffing at state hospitals by eliminating shrinkage, updating market analyses for wages, and ensuring sufficient FTEs for quality of treatment and the number of licensed beds.	
	1.1.d. End the moratorium on admissions to Osawatomie that has been in place since June 2015.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 1: System Transformation		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 1.2. Regional Community Crisis Center Locations (former 2.1): Develop regional community crisis centers across the state including co-located or integrated SUD services.	1.2.a. Implement regulations and licensing related to the Crisis Intervention Act (CIA).	KDADS is currently drafting regulations.
	1.2.b. Ensure consistent application of medical necessity criteria for Medicaid-covered crisis services.	
	1.2.c. KDADS should issue an RFI for underserved areas where there is not a sufficient population to sustain a Rainbow Services, Inc. (RSI)-type center.	KDADS will consult with the new Administration, once in place, to facilitate a review of underserved areas.
	1.2.d. KDADS should submit a plan each year to expand crisis locations.	KDADS BHS will work with KDADS Budget and providers to examine feasibility of expanding crisis locations.
	1.2.e. Crisis stabilization centers should be able to address SUD related needs at a defined minimum level.	KDADS will review current crisis center contracts and explore opportunities to define minimum levels of SUD related services. It is the expectation of the agency that any new proposal will include co-located services.
Recommendation 1.3. Warm Hand-Off (former 2.5): Establish a 24-hour uniform hotline and implement a warm hand-off based on the 911 model.	1.3.a. Execute contracts.	
	1.3.b. Develop a "warm hand-off" model to guide the 24-hour uniform hotline.	KDADS has an RFP to address a 24/7 crisis hotline that uses a warm hand-off approach.
	1.3.c. Develop a mobile crisis unit for youth statewide that utilizes evidence-based practices and includes follow-up requirements.	KDADS has an RFP for mobile crisis response that utilizes EBPs with follow-up requirements. KDADS will follow up with the new administration.

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 1: System Transformation		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 1.4. Comprehensive Housing (former 2.3.): Expand an array of housing that would include a range of options from residential care facilities, long-term and transitional supported housing, and independent housing units following evidence-based practices and principles, such as permanent supportive housing and home ownership. Include state contracts and Medicaid funding and ensure that housing serves people with disabilities, mental illness and/or substance use disorders.	1.4.a. Implement Housing First Bridge Pilot.	KDADS issued four contracts in 2018 under the Housing First Bridge Pilot. Those are: Valeo, Kim Wilson, MHA, and Miracles – SUD.
	1.4.b. Add comprehensive Medicaid housing services.	KDADS continues to work with KDHE to finalize Medicaid Operation Community Integration (OCI) policies and the agencies are currently negotiating rates between the MCOs and CMHCs.
	1.4.c. Provide flexible funds to support housing and ensure the supported housing fund has sufficient resources.	
Recommendation 1.5. Suspension of Medicaid (former 3.4): The state should implement policies that allow for the suspension of Medicaid benefits when persons enter an institution rather than terminating their coverage entirely, to improve transition planning and access to care.	1.5.a. Update policies regarding termination of coverage.	This is a KDHE function. Individuals discharging from state hospitals currently receive priority support from the KanCare Clearinghouse through an assigned liaison to KDADS. KDADS is working with SOAR Coordinators across the state to help facilitate discharge transitions.
	1.5.b. Provide Legislature with report on implementation progress.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 2: Maximizing Federal Funding and Funding from Other Sources		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 2.1. Reimbursement Rates (former 1.4): Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.	2.1.a. Require KDADS and KDHE to establish a system that provides for regular reviews of the cost of services and reimbursement rates.	
	2.1.b. Conduct a rate study for the Medicaid fee schedule and Federal Block Grant.	
	2.1.c. Update Medicaid fee schedule and the Federal Block Grant based on the study results.	
	2.1.d. Pursue value/outcome-based payment.	
	2.1.e. Re-evaluate the use of current nursing facility case mix index and consider alternatives that appropriately assign weight for the complexity of behavioral health symptoms.	
Recommendation 2.2. Care Management Program (Health Homes) (former 7.2): Take steps to ensure that all Kansas youth and adults with a behavioral health diagnosis or chronic physical health condition are eligible to opt in to a health home to have access to activities that help coordinate their care.	2.2.a. Select and implement a health home model with an approved state plan amendment (SPA).	
	2.2.b. Establish a reimbursement mechanism.	
	2.2.c. Measure outcomes on July 1, 2021, and annually after that.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 2: Maximizing Federal Funding and Funding from Other Sources		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 2.3. Excellence in Mental Health (former 1.5): Support expansion of the federal Excellence in Mental Health Act and then pursue participation.	2.3.a. Ask Kansas congressional delegation to support expansion of the federal Excellence in Mental Health Act.	KDADS supports the Excellence in Mental Health Act and will explore with the new administration. There currently is not an opportunity for Kansas to participate.
	2.3.b. Develop an application to participate in the pilot program.	
Recommendation 2.4. IMD Waiver (former 1.1): Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule to allow federal Medicaid funds for both SUD and psychiatric inpatient treatment.	2.4.a. Pursue SUD exemption in order to take a full advantage of a new federal opportunity.	CMS approved KanCare Section 1115 demonstration extension, including the ability to provide SUD services to beneficiaries in an IMD setting, on Dec. 18, 2018.
	2.4.b. Submit now and revisit no less than annually about the possibility of submission of the IMD exemption for Mental Health.	KDADS BHS has had conversations with NASDAD and SAMHSA about the IMD exemption for Mental Health and is waiting for additional instructions for next steps.
	2.4.c. Make sure that SUD exemption has been implemented with new KanCare rollout (Jan. 1, 2019).	
	2.4.d. Ensure that IT system and policy changes to not disenroll beneficiaries upon admission to an IMD are implemented.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 2: Maximizing Federal Funding and Funding from Other Sources		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 2.5. Medicaid Expansion (former 1.2): Adopt Medicaid expansion to cover adults under the age of 65 with income up to 138 percent FPL to pursue solutions for serving the uninsured and underinsured, which will improve access to behavioral health services.	2.5.a. Legislature should act to repeal statutory limitations and/or pass enabling legislation.	
	2.5.b. Implement Medicaid expansion by July 1, 2019.	
Recommendation 2.6. Housing (former 1.3): Continue to empower KDADS to convene key agencies and the entities that currently provide housing programs, and to facilitate community collaborations to maximize federal funding opportunities.	2.6.a. Restore and enhance KDADS staff positions related to housing programs.	KDADS recognizes the need for additional housing staff.
	2.6.b. Support KDADS-convened interagency commission to actively pursue federal funding opportunities.	KDADS supports the idea of establishing an interagency commission.
	2.6.c. Interagency commission should convene stakeholders to bring ideas to the table and to pursue additional funding.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 3: Continuum of Care for Children and Youth		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 3.1. Access to Effective Practices and Support (former 2.2): Deliver crisis, clinical and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.	3.1.a. Interagency commission agency should convene stakeholders to bring ideas to the table and to pursue additional funding. Provide opportunities for community service organizations to increase behavioral health services in schools (e.g., the integrated primary and behavioral health care model).	
	3.1.b. Review and enhance reimbursement for in-home behavioral health services.	
	3.1.c. Provide and expand training for in-home services (e.g., Parent Management Training of Oregon).	
	3.1.d. Develop sustainable funding to continue and expand activities funded by the Systems of Care Grant beyond the initial four grantee counties.	KDADS is working with federal program officers and TA providers to address sustainability.
	3.1.e. Evaluate outcomes of intervention teams and provide the Legislature with a report on implementation of mental health intervention teams in the districts identified in 2018 Substitute for Senate Bill 423.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 3: Continuum of Care for Children and Youth		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 3.1. (continued) Access to Effective Practices and Support (former 2.2): Deliver crisis, clinical and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.	3.1.f. Based on the evaluation results, expand the reach of the mental health intervention team model by including additional school districts.	
	3.1.g. Fund and institute the Families First Prevention Services Act (FFPSA; 2018) in Kansas and follow the federal guidelines.	
	3.1.h. Expand eligibility for parent support services to all parents of children with serious emotional disturbance (SED) or substance use disorders (SUD).	KDADS has increased funding for parent support services through the Systems of Care Grant.
Recommendation 3.2. Intensive Outpatient Services (former 6.2): Expand community-based options such as intensive outpatient services.	3.2.a. Develop policy for coverage of intensive outpatient services.	KDADS believes expanding IOP is important and will bring this to the attention of new administration.
Recommendation 3.3. Psychiatric Residential Treatment Facility (PRTF). Re-establish the purpose of PRTFs**.** (former 6.3):	3.3.a. Establish uniform standards for PRTF evaluation, admission, discharge and length of stay.	KDADS is exploring establishing uniformed standards for PRTFs in collaboration with the MCOs.
	3.3.b. Use CMHC clinicians and community-based service teams as part of the assessment, utilization review and treatment and discharge planning process.	
	3.3.c. Review and assess reimbursement for CMHC participation during the admission process.	KDADS will conduct a cost study to identify appropriate levels of reimbursement.

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 3: Continuum of Care for Children and Youth		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 3.4. Early Intervention (former 6.4): Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment and treatment (e.g., ABC programs).	3.4.a. Increase awareness of current educational opportunities on adverse childhood experiences (ACES) and expand these opportunities to additional groups, including but not limited to communities, providers and hospitals, and the need for early detection of adverse events experienced by children. This may require an assessment of where the gaps are.	KDADS will conduct a needs/gap assessment in collaboration with KDHE.
	3.4.b. Medicaid/CHIP and the State Employee Health Plan should recognize the use and reimbursement of the Diagnostic Classification: Age 0-5 (DC: 0-5) for diagnosis and treatment of children birth through 5 years of age.	
	3.4.c. Ensure children and caregivers are screened and assessed (e.g., depression, SED) at regular intervals in early childhood programs. Based on the screening results, make appropriate referrals to community providers.	
Recommendation 3.5. Transition Age Youth (new)**:** Request a formal joint report to Legislature by corrections, education and health and human services agencies on programs, coordinated efforts and any collective recommendations for populations identified in SB 367.	3.5.a. Establish a requirement for the report through a proviso or a formal letter of notification (executive order).	
	3.5.b. Develop a report on existing programs and data.	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Recommendations	Action Steps	Status (KDADS)
Topic 4: Nursing Facilities for Mental Health		
Recommendation 4.1. Licensing Structure (former 5.1): Reform NFMHs to allow for the provision of active treatment and necessary rehabilitative services and crisis services in NFMHs and inclusion within continuum of care.	4.1.a. Seek revocation or waiver of the federal IMD exclusion rule.	See response to Recommendation 2.4 IMD Exemption.
	4.1.b. Review and update reimbursement rates and other payment mechanisms.	
	4.1.c. Identify and deliver appropriate training curriculum for staff in NFMHs; make sure that challenges with accessing training are addressed.	KDADS currently provides funding for mental health first aid training in NFMHs. KDADS is working to address barriers related to attendance and staffing requirements.
	4.1.d. Connect NFMH residents to crisis services, CMHCs and community support services.	
Recommendation 4.2. Presumptive Approval of Medicaid (former 5.2)**:** Coordinate with KDHE and determine if a policy could be developed or revised that facilitates presumptive approval upon discharge for anyone leaving an IMD environment, including NFMHs**.**	4.2.a. Establish coordination of efforts between KDADS and KDHE to allow presumptive eligibility on discharge from IMD environment.	KDADS will initiate communications with KDHE regarding the granting of presumptive eligibility for patients discharging from an IMD environment.

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 5: Workforce		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 5.1. Workforce Study (new): Initiate a comprehensive workforce study statewide to examine challenges experienced by employers in reaching optimal staffing levels to provide services.	5.1.a. Conduct statewide behavioral health workforce study to understand the overall shortage in the behavioral health workforce.	KDADS has begun preparation for this study by engaging the MHTTC and BHS program staff in forming a team and scheduling an initial technical assistance meeting to outline the goals and objectives of the study, draft a proposal with timelines and required resources to conduct the study, and identify key stakeholders for the process.
Recommendation 5.2. Peer Support (former 7.1): Encourage integration of peer support services (MH) and Kansas certified peer mentoring services (SUD) into multiple levels of service, including employment services at CMHCs, hospitalization, discharge and transition back to the community.	5.2.a. Expand training opportunities for those interested in providing peer support services (MH) and KS certified peer mentoring services (SUD).	KDADS supports increased peer support services and certified peer mentoring and will address with the new administration.
	5.2.b. Enhance incentives to Mental Health and Substance Use Disorder providers that hire and supervise peer support and Kansas certified peer mentoring workers.	
	5.2.c. Increase Medicaid reimbursement rates for peer support services.	
Recommendation 5.3. State Loan Repayment Program (new): Require a report on increasing the number of psychiatrists and psychiatric nurses.	5.3.a. Provide Legislature with a report on the number of behavioral health professionals that have been added through the Kansas State Loan Repayment Program (SLRP).	

Figure B-1. **Status of Mental Health Recommendations (continued)**

Topic 6: Suicide Prevention		
Recommendations	**Action Steps**	**Status (KDADS)**
Recommendation 6.1. Suicide Prevention (new)**:** Place a focus on reversing negative suicide trends for youth and adults.	6.1.a. Create and fund a full-time state suicide prevention coordinator position who would review and recommend approaches to suicide prevention, (e.g., crisis text line, pursuing grant funding for Zero Suicide) and other evidence-based practices.	KDADS is in support of the creation of this position and would need to seek approval from the Governor's office to request additional funding to establish the position.
	6.1.b. Establish state suicide prevention funding to support the implementation of evidence-based strategies, including the National Suicide Prevention Lifeline in Kansas and text line.	
Topic 7: Learning Across Systems		
Recommendation 7.1. Learning Across Systems (new)**:** Create a position/entity to track information about adverse outcomes that occur and identify strategies for addressing them in a timely manner.	7.1.a. Convene experts and people served by the behavioral health system to identify how the learning system can be created.	
	7.1.b. Review approaches used in other states and identify strategies that might work in Kansas.	

Source: The Kansas Department for Aging and Disability Services, 2018

Appendix C: Medicaid Expansion and Behavioral Health

This document provides information from annual reports/evaluations for select states that have expanded Medicaid. We have included information from those reports on the impact of Medicaid expansion on access and use of behavioral health services. Where available, we have also included information on behavioral health outcomes. The report also includes links to national reports on the effect of Medicaid expansion on behavioral health.

Ohio:

Below are bullet points from the 2018 Ohio Medicaid Group VIII Assessment. Group VIII enrollees refer to the new adult eligibility group added via Medicaid expansion (adults age 19-64, with incomes at or below 138% of FPL).

Mental Health

- Continuous Group VIII were 3.4 times as likely to report that their mental health had improved since enrolling on Medicaid, compared to those reporting that it had worsened.
- Around 1 in 4 (24.6%) individuals in the Continuous Group VIII, Churn, and Non-Group VIII Medicaid groups screened positive for depression, while the Unenrolled Group had lower rates (17.4%).
- Continuous Group VIII enrollees who met screening criteria for depression and anxiety were significantly less likely to report being employed (26.9% versus 60.7%).
- More than half (51.2%) of Unenrolled Group VIII who met screening criteria for anxiety or depression reported difficulties obtaining needed prescriptions, compared to less than one-fourth (22.1%) of the Continuous Group VIII who met such screening criteria.
- The majority of Continuous Group VIII enrollees with depression or anxiety (84.3%) reported that access to mental health treatment was “not a problem.”

Health Risk Behaviors

- More than one third (37.0%) of Group VIII enrollees who quit smoking in the last two years said that Medicaid helped them to quit. This translates to approximately 26,000 Ohioans.

- One in ten (9.8%) Group VIII enrollees received a primary diagnosis for any substance use disorder and 7.9% received a primary diagnosis for opioid use disorder in 2017. The majority (64.1%) of those diagnosed with OUD filled at least one prescription for medication-assisted treatment, and 85.8% received psychosocial treatment.
- Obtaining behavioral health care made a significant difference in the lives of many enrollees with substance use disorder. In the words of one respondent: "[Medicaid] means a lot, it means I can get help with my addiction, gets me the counseling I need. If I didn't have it I would probably end up back in jail."
- A small percentage (7.4%) of Continuous Group VIII reported having misused pain medications in the past, although the majority of those who did (60.0%) said that such misuse had occurred more than one year ago. (Note that misuse is not necessarily abused, defined as the habitual taking of addictive or illegal drugs.)
- About one in five (18.2%) Continuous Group VIII reported that they drank more than four alcoholic beverages in a single day in the last thirty days (compared to 15.5% for Non-Group VIII Medicaid, 19.7% for Churn, and 23.8% for Unenrolled; the differences between these groups are not significant).

Indiana:

The table below is from the Healthy Indiana Plan Demonstration, Section 1115 Annual Report. It provides information on one of eight quality initiatives outlined by the Indiana Office of Medicaid Policy and Planning (OMPP). Other quality initiatives related to Medicaid expansion in Indiana included: access to care, ER admissions per 1,000 member months, and smoking cessation for pregnant women.

Figure C-1. **Improvement in Behavioral Health**

Objective	Methodology	Goal
Percentage of members who received follow-up within seven days of discharge from hospitalization for mental health disorders.	OMPP is using HEDIS measures for tracking the percentages of members receiving follow-up.	Achieve at or below 90th percentile for members who receive follow-up within seven days of discharge from hospitalization for mental health disorders (HEDIS).
2017 Results		
One of the four MCEs achieved the 2017 OMPP pay-for-outcome metrics set for the HEDIS seven-day follow-up after hospitalization measure by increasing the percentage of their members who received these visits. Two of the MCEs experienced increased rates over the year during 2017. OMPP analyzed quarterly HIP reporting submitted by the MCEs that documented each plan's rate of follow-up within seven days of discharge from hospitalization for members with mental health disorders, and feedback was provided verbally and via dashboard reviews. OMPP will continue these monitoring efforts in 2018.		

Note: Managed Care Entity (MCE), Office of Medicaid Policy and Planning (OMPP), Healthcare Effectiveness Data and Information Set (HEDIS).

Source: Healthy Indiana Plan Section 1115 Demonstration Annual Report.

Arkansas:

Annual reports on the Arkansas Works Program (formerly the Health Care Independence Program) have included little about behavioral health service utilization. A three-year review of the program was due to CMS in July 2018 but has not been released publicly; this three-year review may include information on behavioral health service utilization. A proposed evaluation plan (submitted to CMS in February 2017) for the Arkansas Works Program includes a quality measure focused on follow-up after hospitalization for mental illness.

Iowa:

Iowa's 2016 Interim Evaluation on expansion removed measures examining behavioral health service use because most individuals in Iowa with mental illnesses were not included in the report. Individuals with mental illnesses were instead grouped under the medically frail program or the Integrated Health Home program.

Links to reports:

- 2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment (August 2018). Retrieved from

http://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

- Arkansas Works Program Proposed Evaluation for Section 1115 Demonstration Waiver (February 2017). Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-draft-eval-dsgn-2017-2021.pdf

- Healthy Indiana Plan Demonstration: SECTION 1115 ANNUAL REPORT (April 2018). Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2018-043018.pdf

- Iowa Health and Wellness Plan Evaluation: Interim Report (December 2016). Retrieved from http://ppc.uiowa.edu/sites/default/files/ihawp_interim_report.pdf

National studies on expansion and behavioral health:

- National Council for Behavioral Health. (2017, May). A*mericans with Mental Health and Substance Use Disorders: The Single Largest Beneficiaries of the Medicaid Expansion.* Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2017/04/Medicaid-Expansion-Behavioral-Health-UPDATED-5-1-17.pdf
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Appendix D: Crosswalk Between Mental Health Task Force Recommendations and Governor's Substance Use Disorders (SUD) Task Force Recommendations and Child Welfare System Task Force Recommendations

Figure D-1 provides an overview of recommendations relevant to recommendations issued by the Mental Health Task Force. The recommendations included in the crosswalk from other Task Forces were developed by three Working Groups of the Child Welfare System Task Force (CWSTF)[67] and the Governor's Substance Use Disorders (SUD) Task Force[68]. Overall, the crosswalk includes six out of 22 Mental Health Task Force recommendations that fall within three topic areas: System Transformation, Maximizing Federal Funding and Funding from Other Sources and Continuum of Care for Children and Youth.

Figure D-1. **Crosswalk Between Mental Health Task Force Recommendations and Other Task Forces**

Mental Health Task Force Recommendations	Governor's Substance Use Disorders (SUD) Task Force Recommendations	Child Welfare System Task Force Recommendations
Topic 1. System Transformation		
Recommendation 1.2. Regional Community Crisis Center Locations (former 2.1): Develop regional community crisis centers across the state including co-located or integrated SUD services.	**TR 4. Needs Assessment.** Conduct a statewide needs assessment to identify gaps in funding, access to substance use disorder (SUD) treatment providers and identify specific policies to effectively utilize and integrate existing SUD treatment resources.	No relevant recommendations.

Figure D-1. **Crosswalk Between Mental Health Task Force Recommendations and Other Task Forces (continued)**

Mental Health Task Force Recommendations	Governor's Substance Use Disorders (SUD) Task Force Recommendations	Child Welfare System Task Force Recommendations
Topic 2. Maximizing Federal Funding and Funding from Other Sources		
Recommendation 2.1. Reimbursement Rates (former 1.4): Facilitate a detailed review of the costs and reimbursement rates for behavioral health services, including mental health and substance use disorder treatment, and update rates accordingly.	**TR6. Service Integration.** Adopt coding practices that allow for the integration of services across the continuum of care domains (e.g., primary care, substance use disorder and mental health) to provide more integrative services to clients with co-occurring conditions. **TR8. Payment Reform.** Support substance use disorder payment reform targeted to improve population health. **TR9. Peer Support Reimbursement.** Expand access to peer support services and increase Medicaid reimbursement rates for the services.	No relevant recommendations.
Recommendation 2.4. IMD Waiver (former 1.1): Seek revocation or waiver of the federal Institution for Mental Disease (IMD) exclusion rule to allow federal Medicaid funds for both SUD and psychiatric inpatient treatment.	**TR11. IMD Waivers.** Explore waiver of IMD exclusion for mental health and substance use disorder treatment and support current IMD exclusion waiver for residential services for substance use treatment.	No relevant recommendations.

Figure D-1. **Crosswalk Between Mental Health Task Force Recommendations and Other Task Forces (continued)**

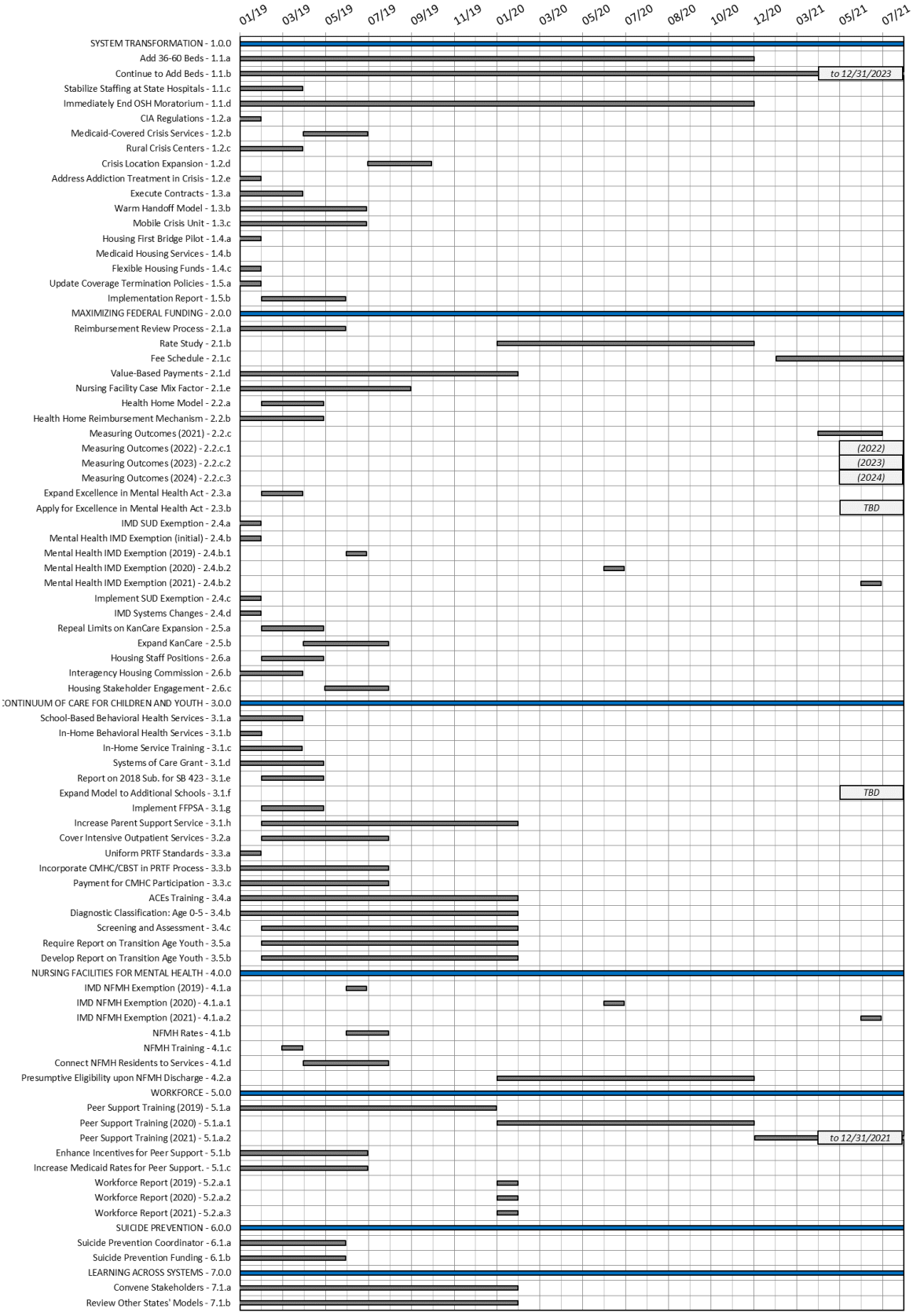
Mental Health Task Force Recommendations	Governor's Substance Use Disorders (SUD) Task Force Recommendations	Child Welfare System Task Force Recommendations
Topic 2. Maximizing Federal Funding and Funding from Other Sources		
Recommendation 2.5. Medicaid Expansion (former 1.2): Adopt Medicaid expansion to cover adults under the age of 65 with income up to 138 percent FPL to pursue solutions for serving the uninsured and underinsured, which will improve access to behavioral health services.	**TR 13. KanCare.** Recommend a full expansion of Medicaid in order to increase access to healthcare for uninsured, low-income Kansans. Expansion will improve access to needed healthcare services, including substance use disorder treatment, and reduce more costly treatment sought in hospital emergency departments. Data clearly show that states that have expanded Medicaid have improved access to all healthcare services, including SUD treatment; individuals stay in treatment longer, and chronic disease management and outcomes are improved.	**B7.5.** The State of Kansas and the Legislature shall fund and expand KanCare.

Figure D-1. **Crosswalk Between Mental Health Task Force Recommendations and Other Task Forces (continued)**

Mental Health Task Force Recommendations	Governor's Substance Use Disorders (SUD) Task Force Recommendations	Child Welfare System Task Force Recommendations
Topic 3. Continuum of Care for Children and Youth		
Recommendation 3.1. Access to Effective Practices and Support (former 2.2): Deliver crisis, clinical and prevention services for children and youth and families in natural settings (e.g., homes, schools, primary care offices) in the community.	**PREV6. Fund Prevention.** Establish and sustain permanent funding sources for primary, secondary and tertiary prevention associated with prescription drugs, opioids, alcohol, methamphetamines and other drug misuse for all ages. **TR1. Expand Medication-Assisted Treatment.** Expand access and utilization of Medication-assisted treatment (MAT).	**C3: Service Setting**. The State of Kansas shall prioritize delivering services for children and youth in natural settings such as, but not limited to, homes, schools and primary care offices in the child's community when possible. The needs of the child and family should be the most important factor when determining the settings where services are delivered.
Recommendation 3.4. Early Intervention (former 6.4): Increase access to early childhood mental health services by including language in state Medicaid behavioral health plans to explicitly cover early childhood mental health screening, assessment and treatment (e.g., ABC programs).	**TR7. SBIRT.** Increase access to and utilization of Screening, Brief Intervention and Referral to Treatment (SBIRT) across health care provider disciplines by reimbursing appropriately trained and licensed professionals to provide this service across locations. **Prev5. Data**. Collect, analyze, use and disseminate surveillance data to inform prevention efforts and monitor trends in at-risk populations.	**C3: Service Setting**. The State of Kansas shall prioritize delivering services for children and youth in natural settings such as, but not limited to, homes, schools and primary care offices in the child's community when possible. The needs of the child and family should be the most important factor when determining the settings where services are delivered.

Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

Appendix E: Implementation Timeline



Source: Mental Health Task Force Report to the Kansas Legislature, January 14, 2019.

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