Kansas Department of

Social and Rehabilitation Services

Don Jordan, Secretary

Legislative Budget Committee
November 9, 2007

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Chairperson Schwartz and members of the Committee, thank you for the opportunity to appear before you today to present testimony on Changes in the Kansas Public Mental Health System. I am Don Jordan, Secretary of Social and Rehabilitation Services.

Context & Background

Effective July 1, 2007, Kansas entered a new era for its public mental health system. Primarily in response to requirements of the Centers for Medicaid and Medicare Services (CMS), SRS worked extensively with stakeholders to shape a new system that would

- Restore our system to compliance with federal requirements, so that critical federal financial participation would continue;
- Preserve the desired features of the existing mental health system infrastructure;
- Maintain the Community Mental Health Centers (CMHCs) as the focus of responsibility for the public mental health system, while increasing the number of qualified providers ;
- Retain core system values that were co-created with stakeholders in support of consumer voice, choice and success; and
- Preserve and encourage services shown to be the most effective in successfully supporting persons with severe mental illness.

A key piece of responding to CMS involved the creation of a new Prepaid Ambulatory Health Plan (PAHP) organization to provide managed care services for all Medicaid and MediKan eligible Kansans accessing community mental health services. To implement this plan, SRS contracted with Kansas Health Solutions, a newly-formed corporation sponsored by the CMHCs. In addition, SRS took a comprehensive approach to addressing CMS concerns in the overall context of mental health services, and built solutions that would simultaneously resolve the concerns, formally fund services previously not federally funded, and retain critical services at risk of funding loss.

Core features of the solutions SRS built with system stakeholders, and which will be addressed in more detail below, include specific steps to:

- ✓ Address CMS concerns about the use of certified match for the state share of Medicaid funding.

- ✓ Address CMS objections related to some specific billing practices and the use of Targeted Case Management services.
- ✓ Enhance customer choice and service access by opening a portion of the mental health services to new Licensed Mental Health Practitioners for the delivery of traditional outpatient mental health services.
- ✓ Retain CMHCs as the public mental health safety net and as the primary providers of specialized mental health services for adults with Severe Mental Illnesses and youth with Serious Emotional Disturbances.
- ✓ Expand the array of services available through CMHCs, and access additional federal funding for services including:
    - Array of Crisis Intervention Services;
    - Peer Support services;
    - Parent Support and Training services;
    - Professional Resource Family Care (intensive stabilization services in a family-like setting);
    - Early Childhood screening and assessment services (to support preventative interventions); and
    - Inpatient/facility based service screenings and related administrative services to support successful discharge and aftercare for people returning to their communities.

As part of the PAHP program, both federally-required and state-desired system performance measures are being gathered, monitored and assessed. These measures include assessing the timeliness of screening decisions and service access for customers, promptness of claim processing and payment for providers, expansion of qualified provider network membership, availability of services statewide, and sound oversight of services to ensure instances of fraud or abuse are identified and remedied. Changes of this magnitude must be implemented and measured in phases, and the full impact of implementation cannot be seen immediately. SRS and Kansas Health Solutions are working closely together to ensure that priority issues are managed during the initial implementation and stabilization phase, that good information processes and responsiveness to customers and providers are solidified, and that the system is well poised for long-term success. Early indicators are that the implementation was sound and successful, and that stabilization efforts are moving apace – some specifics about this are included below.

Finally, it is a priority for SRS that – throughout this transition time and beyond – the CMHCs providing the backbone of the public mental health system retain or regain their strength. SRS is therefore undertaking an assessment of the financial health of each CMHC, and will be working with them and the Association of Community Mental Health Centers of Kansas (ACMHCK) to address identified concerns. It is also an SRS priority that consumers have choice among qualified service providers. SRS and KHS are closely monitoring the availability of these choices.

Additional Specifics About Elements of System Change

PAHP Performance & Implementation Activities - First Four Months

Highlights of work by Kansas Health Solutions during the first four months of implementation and stabilization include:

- responded to 4,581 customer service calls from members
- responded to 2,957 customer service calls from providers
- received and decided 16,399 requests for outpatient services requiring prior authorizations
- received and decided 4,457 requests for state hospital/acute care hospital inpatient care
- received 777 requests for admissions to Psychiatric Residential Treatment Facilities for youth (including 40 emergency exception screens); of these, 606 (or 82%) were approved for admission; 133 (18%) were diverted to community-based services suitable to meet the youth's needs; 38 requests are pending
- received and addressed 54 member grievances
- received and processed over 398,867 claims for mental health services rendered

In addition, to support successful transitions associated with the PAHP (mental health), PIHP (substance abuse), PRTF (youth psychiatric residential services) and YRC (Youth Residential Center services) programs, SRS convened a group of individuals with statewide system leadership roles to join SRS in monitoring the transitions. The group was asked to receive and share information from the many sectors of service delivery system engaged in the transitions, and to help SRS assess the progress in creating a seamless transition for people needing these critical mental health/substance abuse services. The group has represented a safeguard during the transition period in the case that policy decisions need to be made to better facilitate the transitions.

Members of the Transition Oversight Committee are:
*Representative Bob Bethel
*Senator Vicki Schmidt
* Don Jordan, SRS Secretary
*Rod Bremby, Department of Health and Environment Secretary
*Russ Jennings, Kansas Juvenile Justice Authority Commissioner
*Marci Nielsen, Kansas Health Policy Authority Executive Director
*Michael Goldberg, Kansas Health Solutions CEO
*Myron Unruh, ValueOptions-Kansas CEO
*Bruce Linhos, The Children's Alliance of Kansas Executive Director

To further support the implementation of this program, SRS and KHS jointly sponsored a series of Webinar-based stakeholder conferences from July through October, and over 1,500 stakeholders (primarily providers and consumer advocacy groups) participated. Many questions - ranging from service access criteria, to claims processing and payment issues, to

values-based system matters - were addressed in real time discussions, supplemented by follow up individualized contact to resolve unique issues.

Finally, SRS recruited and convened the State Quality Committee (SQC) for the PAHP program. The SQC members represent a cross-section of public mental health service stakeholders, and their work is to identify, monitor, evaluate and make recommendations to improve the quality of both the clinical and administrative processes for consumers receiving Medicaid and/or Medikan mental health services. The SQC held its first meeting on September 27th, where the members worked toward a final version of its charter, reporting protocol, and work plan. The committee will be meeting quarterly to analyze trends and make programmatic recommendations.

Certified Match Change:
Prior to July 1, 2007, the CMHCs were paid only the federal financial participation (Federal Share – FFP) of their Medicaid billings for services to persons who were not on the Home and Community Based Services Waiver for Children with a Serious Emotional Disturbance (SED Waiver). (In FY 2007, Medicaid payments for the SED Waiver included both the state and federal share of Medicaid.) The state share of the CMHCs' Medicaid payments was partially covered by SRS Medicaid match grants and the rest was provided by the CMHCs certifying the availability of state funds from other SRS state grants. During the 2007 Legislative session about $26 m. in other SRS state grants were moved directly to Medicaid so certified match could be eliminated in FY 2008. Those other SRS grant funds were replaced with an additional appropriation of $17 m. The net result is that the CMHCs are now paid both the state and federal share for their Medicaid funded services and they continue to receive about $40 m. in other SRS grants.

SRS expects that if a CMHC provides and bills for the same amount of Medicaid services as it did in FY 2007, the CMHC should receive at least as much in SRS revenue as was received in FY 2007, if not more. It is too early to determine if this outcome has been achieved.

Change in Medicaid Reimbursement:
CMHCs may be having some challenges in billing for Medicaid at the same level as they did in FY 2007. One reason for this is because billing through the Managed Care Organization, KHS, is slightly different from billing through the EDS Medicaid Management Information System. KHS has contacted all CMHCs and has offered to assist with the billing process as needed. Through KHS' efforts we have seen continued improvement in successful billings each month since July 1st. We expect this improvement to continue.

Another reason CMHCs may be having difficulty billing at the same level as they did in FY 2007 is that some Medicaid program and payment policies have changed in conjunction with the transition to managed care and to meet CMS requirements. First, a few of the reimbursement rates for procedure codes were changed. The following mental health procedure codes represent 85% to 90% of the CMHC Medicaid payments in recent years. Shown with each

procedure code is the reimbursement rate before July 1, 2007 and after July 1, 2007 with a short explanation for the adjustment:

Procedure Code	Before 7/1/07	After 7/1/07	Unit of Svc	Reason for the Change
Individual Psychotherapy Insight	$60.00	$60.00	40-50 min	No Change
Pharmacologic Management	$90.17	$44.00	per contact	CMS Required Change
Family Medical Psychotherapy	$65.00	$65.00	hour	No Change
Community Psychiatric Support & Treatment (CPST)	$27.50		15 min.	
CPST - Child		$31.90		Rate Increase
CPST - Adult		$31.90		Rate Increase
CPST - Dual Diagnosis		$34.70		Bonus for providing services based on best practices
CPST - Strengths Based		$33.40		Bonus for providing services based on best practices
CPST – Employment Support		$33.40		Bonus for providing services based on best practices
Psychosocial Rehabilitation Group - Youth	$10.00	$8.75	15 min.	Decreased to encourage use of individual treatment
Psychosocial Rehabilitation Group - Adult	$6.00	$4.37	15 min.	Decreased to encourage use of individual treatment
Psychosocial Rehabilitation - Individual (formerly known as Individual Community Support)	$10.00	$13.63	15 min	Increased to encourage use of individual treatment
Targeted Case Management	$25.00	$10.80	15 min.	Required Reduction to Comply with CMS Requirements
Attendant Care/Personal Care	$6.00	SED $6.00 Other $6.96	15 min.	Increased Reimbursement for Others

Of particular concern to the CMHCs is the reduction in the reimbursement rate for targeted case management. CMS required that the Kansas Health Policy Authority make this change across all service systems that provide targeted case management. SRS increased CPST, individual psychosocial rehabilitation, and personal care to, in part, off-set the reduction in the targeted case management reimbursement rate.

Another significant reduction in rates is for pharmacological management. Again, CMS required this change so that the rate did not exceed the Medicare reimbursement rate. Although it is now possible to bill other services in conjunction with this procedure code that was not allowed to be done before – and using this option results in a higher combined rate for this service. However, this requires that CMHCs change historical treatment and billing practices.

The following procedure codes have been added beginning July 1, 2007. These were added primarily to improve services to persons with mental illness. Secondarily, these new procedure codes allow CMHCs to bill for services they provided but were not previously paid for.

New Service Description	Rate	Unit of Svc
Crisis Intervention - Emergent - Attendant	$21.75	15 min.
Crisis Intervention - Ongoing - Attendant	$6.53	15 min.
Crisis Intervention - Emergent - Bachelors	$34.80	15 min.
Crisis Intervention - Ongoing - Bachelors	$13.63	15 min.
Mental Health Assessment - Early Childhood	$10.29	15 min.

Parent Support and Training - Group HCBS-SED	$3.00	15 min.
PRFC - Crisis Stabilization HCBS-SED	$138.00	per diem
Peer Support	$13.63	15 min.
Peer Support – Group	$4.37	15 min.
Crisis Intervention – LMHP	$43.50	15 min.

Expansion of Provider Network:
A key value in the structure of the PAHP program is the increase of qualified providers to meet the mental health treatment needs of Kansans, both to increase service access and to enhance customer choice. The clinical therapy procedure codes, including all individual, family, group and in-home therapy services, may be provided by any qualified, enrolled provider. Reimbursement for the therapy procedure codes remain the same as previously established, except procedure codes that include a check on the person's medication were raised to off-set the required reduction in Pharmacological Management.

During the implementation phase, Kansas Health Solutions has made it a priority to outreach to and support providers outside of the existing CMHC system, with significant results. The current provider network includes these providers – in addition to the 1,368 CMHCs and their directly connected mental health professionals:

Provider Type	Number Associated With Child Welfare Provider Agencies	Number of Independent Practitioners
ARNP	3	20
LCMFT (Licensed Clinical Marriage and Family Therapist)	24	34
LCP (Licensed Clinical Psychotherapist)	9	11
LCPC (Licensed Clinical Professional Counselor)	-	10
LMFT (Licensed Marriage and Family Therapist)	29	12
LMLP (Licensed Masters Level Psychologist)	6	-
LMSW (Licensed Masters Social Worker)	68	24
LSCSW (Licensed Specialist Clinical Social Worker)	32	120
MD	1	34
PhD Psychologist	3	85
TOTALS	175	350
COMBINED TOTALS	525	

Other System Resource Opportunities:
In the past CMHCs were paid for admission screenings done for potentially Medicaid eligible persons who were seeking admission to private in-patient hospitals for psychiatric treatment. CMHCs are now paid for similar admission screenings they do for psychiatric residential treatment facilities and state mental health hospitals. It is expected that the total amount paid for these screens each year will total at least $4.6 m. In addition, KHS has been provided $1.1 m. to pay for administrative services to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. This is a service for which the CMHCs were never directly funded in the past. These additional reimbursement opportunities will in time help stabilize SRS revenue to CMHCs.

Financial Condition of CMHCs:
SRS has been concerned for several years about the financial condition of some CMHCs. SRS' concerns have been prompted by CMHC self reports of financial difficulties, regular requests for early grant payments, and inability to repay unearned grants. Last year one CMHC failed financially and a financially stronger neighboring CMHC was selected by the County Commission to take its place.

SRS takes these concerns very seriously. Recently, I asked SRS' Chief Auditor to review CMHC independent audits from 2000 through 2006. Once the review is complete, SRS will begin working with any CMHC experiencing serious financial difficulties to develop plans to address their financial challenges that have emerged in recent years. SRS will do this in cooperation with the Association of Community Mental Health Centers of Kansas.

CMHCs are owed an amount of one-time funding for Administrative Claiming, and owe the State of Kansas for certified match overpayments previously made. SRS is working with the CMHCs and their Association to resolve these payments in a way that supports and does not jeopardize the financial condition of the CMHCs.

Conclusion

SRS has undertaken extensive public mental health system reform, in collaboration with a broad range of system stakeholders, to be responsive to CMS concerns while both preserving the core infrastructure of Kansas' public mental health system and enhancing both the service array and the number of qualified mental health providers. The implementation of these significant changes has been successful thus far; robust monitoring will continue to assess overall progress, identify and address any needed course corrections, and support long-term success.