LEGISLATIVE RESEARCH COMMISSION

PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Kentucky's Community Mental Health System Is Expanding And Would Benefit From Better Planning And Reporting: An Update

Research Report No. 423

Prepared By

Cindy Upton, Lora Littleton, and Jean Ann Myatt

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Cindy Upton
Lora Littleton
Jean Ann Myatt

Greg Hager, PhD
Committee Staff Administrator

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lrc.ky.gov

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Abstract

This is an update of a report the committee adopted in June 2007. The 2007 report covered fiscal years 2001 to 2005. This update covers FY 2006 to FY 2010 and provides data for the full 10 years. Over the last decade, the community mental health centers have provided 45 percent more services to 27 percent more people, with an increase in revenue of less than 19 percent. The centers are required to provide services regardless of a person's ability to pay. The regional boards' financial health varies greatly. The system appears to be stable statewide in terms of providing current services to current populations. The system's capacity to expand services or serve larger populations is questionable, particularly in some regions. The potential impact on the regions of implementing Medicaid managed care for some behavioral health services is unknown.

Foreword

Program Review staff thank officials and staff of the 14 regional mental health-mental retardation boards and the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities for their assistance in preparing this report.

Bobby Sherman
Director

Legislative Research Commission
Frankfort, Kentucky
January 23, 2012

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Summary

This report updates the Program Review and Investigations Committee report *Kentucky's Community Mental Health System Is Expanding and Would Benefit From Better Planning and Reporting*. That report, adopted in June 2007, covered fiscal years 2001 to 2005. This update covers FY 2006 to FY 2010 and provides data for the full 10 years.

System Structure And Planning

Federal law created the community mental health and mental retardation system in 1963. According to state law, a combination of cities and counties may establish a regional community mental health and mental retardation services program, which may be administered by a board. Kentucky has 14 regional boards. The regions correspond approximately with the area development districts. The Pathways region encompasses two area development districts. Services are provided through community mental health centers in the 14 regions.

Source: Created by Program Review staff using information from the website of the Dept. for Behavioral Health, Development and Intellectual Disabilities.

The secretary of the Cabinet for Health and Family Services has statutory authority for oversight of board operations and certain funding decisions. That authority is exercised by the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Federal laws and regulations affect planning, service delivery, and measurement of outcomes. The Community Mental Health Services block grant is an example of a federal program passed through the department to the boards.

Federal and state laws require that planning for mental health, substance abuse, and intellectual or other developmental disabilities services take place at statewide and regional levels.

At the state level, the plan and budget for community services is developed by the department and is incorporated in the budget request of the cabinet. The department's budget submission is prepared within federal and state funding restrictions, including the amount of available funding and priority populations and services.

Among other entities, two commissions are statutorily required to be involved in planning for behavioral health services. The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (843 Commission) is required by state law to assess statewide needs and develop a state plan for program development, funding, and efficient use of state funds for persons with mental illness, substance use disorders, and dual diagnoses (both mental illness and substance abuse). The 843 Commission has not met since 2007. The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (144 Commission) is required by state law to assess state needs and develop a state plan for program development, funding, and efficient use of state funds for persons with intellectual and other developmental disabilities. The 144 Commission continues to meet.

At the regional level, the boards are the major statutory planning authorities for community mental health, substance abuse, and intellectual and developmental disabilities services for their populations.

In practice, the budgetary process does not incorporate long-term planning. The regional plans and budgets are developed in concert with the department. The department estimates the total funds that will be available for distribution to the regional boards during the upcoming fiscal year. Each board is notified of the amount the region may receive from each funding source passed through the department. Each board then develops an annual plan and budget based on the anticipated funding levels and other expected sources, which include Medicaid. Each board presents its plan and budget to the department for review and approval. Once the department's budget is enacted, the approved programs, services, and funding levels are incorporated into the contract between the department and each regional board.

The following recommendations from the 2007 are repeated in this updated report. To date, neither recommendation has been implemented.

Recommendation 1.1
If it is the intent of the General Assembly that the 843 Commission and the 144 Commission develop comprehensive plans for needed services and funding, then the General Assembly may wish to direct the commissions to present a plan to the governor and the Legislative Research Commission in sufficient time before each biennium so that the plan could be useful in the budgetary process. The plan should include specific population and service targets, funding needs, and measurable outcomes.

Recommendation 1.2
The General Assembly may consider merging the 843 Commission and the 144 Commission to identify needs, prepare a plan for services and associated funding, and identify expected outcomes for individuals with mental illness, substance use disorders, intellectual and other developmental disabilities, and dual diagnoses. The General Assembly may consider requiring the combined commission to have a legislator and the secretary of the Cabinet for Health and Family Services as co-chairs.

The 2007 report also contained a recommendation regarding strategic planning.

Recommendation 1.3
Each regional board should develop a strategic plan that describes clearly set objectives, strategies and a timetable to implement them, and cost estimates. The board's plan should include expected outcomes and measurable indicators. The plans should be an integral part of statewide planning decisions.

This recommendation is still relevant. However, it does not describe a method by which the boards' strategic plans could become part of statewide planning. In this update, Program Review staff concluded that the boards' strategic plans should be shared with local government officials who could discuss relevant issues with their senators and representatives in the General Assembly. In that way, the plans can become an integral part of statewide planning decisions through individual legislators.

Consumers And Services

People who receive services from the centers include those with mental illness, substance use disorders, intellectual and other developmental disabilities, and other disorders, such as acquired brain injuries.

The number of people receiving services from the centers and the number of services they receive are increasing. In FY 2010, the centers served almost 178,000 unique individuals statewide. This is an increase of nearly 38,000 persons—27 percent—from 10 years before. The services provided to these individuals increased by almost 45 percent over the same period, an increase from about 14 million services in FY 2001 to almost 21 million services in FY 2010.

On average, mental health services were 40 percent of total services, intellectual and other developmental disabilities services were 36 percent, substance abuse services were 6 percent, and other services were 18 percent.

On average, persons with a mental health diagnosis were almost 78 percent of the service population. Persons with a diagnosis of substance abuse were approximately 13 percent, persons with a primary diagnosis of intellectual or other developmental disabilities were 2 percent, and persons with other diagnoses, such as acquired brain injuries or dual diagnoses, were 7 percent of the service population.

Personal referrals for community services, which are self-referrals, averaged 43 percent of consumers. More than 17 percent of referrals were made by agencies, and 13 percent were made by the judicial system. The remainder were referrals from all other sources.

In an average year over the period from FY 2001 to FY 2010, approximately 4 percent of Kentuckians received services at one of the centers. The percentages receiving services varied significantly by region. In the Kentucky River region, nearly 8 percent of residents received services. In three other regions in eastern Kentucky, more than 6 percent of residents received services. In general, a higher regional poverty rate and a higher rate of uninsured individuals correlate to a larger share of the population accessing community services.

Funding

Total revenue and support, adjusted for inflation to be in 2001 dollars, increased by 18.7 percent, from $324 million in FY 2002 to $385 million in FY 2010.

From FY 2002 to FY 2010, on average, 54 percent of revenue came from the federal government; 32 percent came from the state. Other revenue sources included local matching and charges to patients.

On average, Medicaid provided nearly 82 percent of federal funding. State revenue from the department represented 82 percent of state funding in FY 2002 and 61 percent in FY 2010.

Statute requires the centers to provide services regardless of a person's ability to pay. The charity allowance is the amount an indigent person is not required to pay and is determined on an income-related sliding fee schedule unique to each region. Adjusted for inflation, the statewide community care support allocation for FY 2010 was $4.5 million less than for FY 2001. This should not be interpreted to mean that an additional $4.5 million in community care support funding is needed, because the regions have not in the past defined and reported charity allowances consistently. For that reason, the 2007 report contained the following recommendation, which has been partially implemented by the department.

Recommendation 3.1
The Department for Behavioral Health, Developmental and Intellectual Disabilities should develop a standardized method to calculate charity allowances. The department should require the boards to use that method and report annually, in conjunction with their annual financial statement audit, a separate schedule of charity allowances. The boards' independent auditors should be required to certify that the charity allowances are reported in accordance with the department's instructions.

The department has instructed the regional boards on how to calculate the charity allowances but has not required them to include the calculation in a schedule in their financial statements or to have their auditors certify that the calculation has been properly reported. Most regions do not report an amount for charity care in their financial statements. Thus, the amount of charity care may be calculated but is not being reported in publicly available financial statements.

The regions' financial health varies greatly. In general, the system appears to be stable statewide in terms of providing current services to current populations. The system's capacity to expand services or serve larger populations is questionable, particularly in some regions. This relative financial stability could be changed by the state's move to Medicaid managed care for some behavioral health services in all regions except Seven Counties and Communicare. To continue to provide the affected services to existing and new clients, the boards are required to contract with one or more managed care organizations chosen by the state. This requirement will add to the boards' administrative burden. In addition, it is unknown whether the managed care organizations will choose to lower their reimbursement rates for Medicaid services in the future.

Consumer Outcomes And Other Performance Measures

Assessing consumer outcomes is difficult, in part because of a lack of consensus on what performance should be measured and how it should be measured. Of the outcomes that are measured, Kentucky's vary from those of other reporting states. For example, for the mental health outcome "increased/retained employment," Kentucky reported 16.4 percent of adult consumers as employed in 2010, compared to 19 percent in all reporting states. On the outcome "stability in housing," Kentucky reported that 90.2 percent of consumers live in a private residence, compared to 82.7 percent in all reporting states.

Chapter 1

Kentucky's Regional And State Structure

This report updates the Program Review and Investigations Committee report *Kentucky's Community Mental Health System Is Expanding and Would Benefit From Better Planning and Reporting*, which was adopted in June 2007.

Conclusions

This report has two major conclusions.

- Kentucky has a comprehensive system for planning services but is not taking advantage of the work of all partners. State and regional groups develop cost estimates to satisfy the demand for services, but the estimates are not used in developing the budget.

- The number of persons served by the centers and the number of services have increased more than has inflation-adjusted revenue. Regions vary in financial strength. Although the system appears to be stable statewide in terms of providing current services to current populations, its capacity to expand services or serve larger populations is questionable in some regions.

Regional Board Structure Is Established In Statute

Kentucky has 14 regional mental health and mental retardation boards. The regions approximate the area development districts.

As shown in Figure 1.A, Kentucky has 14 regional mental health and mental retardation boards. The 14 regions approximate the area development districts. The Pathways region encompasses two area development districts. The only region that does not border another state is Bluegrass, which borders eight other regions.

KRS 210.430 authorizes each board to apply for financial assistance by submitting its plan, budget, and board membership for the next fiscal year annually to the secretary of the Cabinet for Health and Family Services. Eligibility for a state grant or other fund allocation from the cabinet depends on approval by the secretary. The board's composition must reasonably represent the groups listed in KRS 210.380.

Figure 1.A
Mental Health And Mental Retardation Regions

Source: Created by Program Review staff using information from the website of the Department for Behavioral Health, Development and Intellectual Disabilities.

Federal law created the community mental health and mental retardation system in 1963.

Kentucky's community mental health and mental retardation system was created in large part by the US Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. The law funded the construction of facilities for treatment of persons with mental illness and intellectual disabilities and established a commitment for services to be provided in local communities. Subsequent federal legislation provided staffing grants for the regional centers. Although much of the original legislation has been amended or superseded, it established the regional basis for community services.

In 1964, Governor Edward T. Breathitt established the Kentucky Mental Health Planning Commission, which presented *Pattern for Change in Kentucky Mental Health Programs and Services* to the governor and General Assembly in 1966. The report incorporated recommendations from the Kentucky Mental Retardation Planning Commission, which performed a similar study under a grant from the US Public Health Service. The central recommendation of the mental health planning commission report was for the state to implement a program to stimulate greater responsibility of Kentucky's citizens at the community level for mental health and intellectual disabilities services through the creation of regional boards of citizens.

KRS 210.370 describes how regional mental health and mental retardation boards can be established. A combination of cities and counties may establish a regional services program.

This recommendation was adopted in KRS Chapter 210. KRS 210.370 describes how regional mental health and mental retardation boards can be established. A combination of cities and counties may establish a regional services program. The program may be administered by a community mental health and mental retardation board.

In this report, the term *board* refers to the nonprofit corporation and/or the members of the board of directors of the individual nonprofit corporations. The term *center* refers to the administration and staff employed by the boards and the programs they administer.

KRS 210.380 ensures the creation of local boards of citizens. Board membership is required to be representative of the elected chief executives of county governments; local health departments; medical societies; county welfare boards; hospital boards; lay associations concerned with mental health and mental retardation; labor, business, and civic groups; and the general public.

According to KRS 210.400, the duties of the board are to

- review and evaluate mental health and intellectual disabilities services provided pursuant to KRS 210.370 to 210.460 and report thereon to the cabinet secretary, the administrator of the program, and, when indicated, the public, with recommendations for additional services and facilities;
- recruit and promote local financial support for the program from private sources such as community chests, business, industrial and private foundations, voluntary agencies, and other lawful sources, and promote public support for municipal and county appropriations;
- promote, arrange, and implement working agreements with other social service agencies, both public and private, and with other educational and judicial agencies;
- adopt and implement policies to stimulate effective community relations;
- be responsible for the development and approval of an annual plan and budget;
- act as the administrative authority of the community mental health and intellectual disability program; and
- oversee and be responsible for the management of the program in accordance with the plan and budget adopted by the board and the policies and regulations issued under KRS 210.370 to 210.480 by the cabinet secretary.

The Cabinet For Health And Family Services Oversees Funding And Program Services

The Department for Behavioral Health, Developmental and Intellectual Disabilities has authority for oversight of board operations.

The statutory authority for oversight of board operations and certain funding decisions rests with the secretary of the Cabinet for Health and Family Services. That authority is exercised by the Department for Behavioral Health, Developmental and Intellectual Disabilities.[a] KRS 210.410 authorizes the secretary to make state grants and other fund allocations from the cabinet to help the boards provide at least the following services: inpatient, outpatient, partial hospitalization or psychosocial rehabilitation, emergency, consultation and education, and intellectual disability.

The state formula for paying the boards for services is introduced in KRS 210.440. At the beginning of each fiscal year, the secretary is required to allocate available funds to the boards in accordance with their approved plans and budgets. The secretary must review operations, budgets, and expenditures of the centers and may reallocate or withdraw funds from centers based on the results of the review. KRS 210.440 is implemented in 908 KAR 2:050.

KRS 210.450 describes additional duties of the secretary that include but are not limited to the following:

- Promulgate policies and regulations governing eligibility of centers to receive state grants and other fund allocations from the cabinet.
- Govern eligibility for service so that no person is denied service on the basis of race, color, creed, or inability to pay.
- Provide for establishment of fee schedules based on ability to pay.
- Regulate fees without regard to ability to pay for diagnostic services for anyone referred by the courts, schools, or public and private health and welfare agencies.
- Govern financial record keeping.
- Provide for financial and program reporting requirements.

The regional boards are required to provide services to all persons regardless of their ability to pay.

The requirement for the regional boards to provide services regardless of a person's ability to pay is referred to in this report as the "safety net." State safety net funding, adjusted for inflation, has decreased over the past 10 years.

Federal program laws and regulations affect the planning, service delivery, and outcomes measurement of the state and the centers.

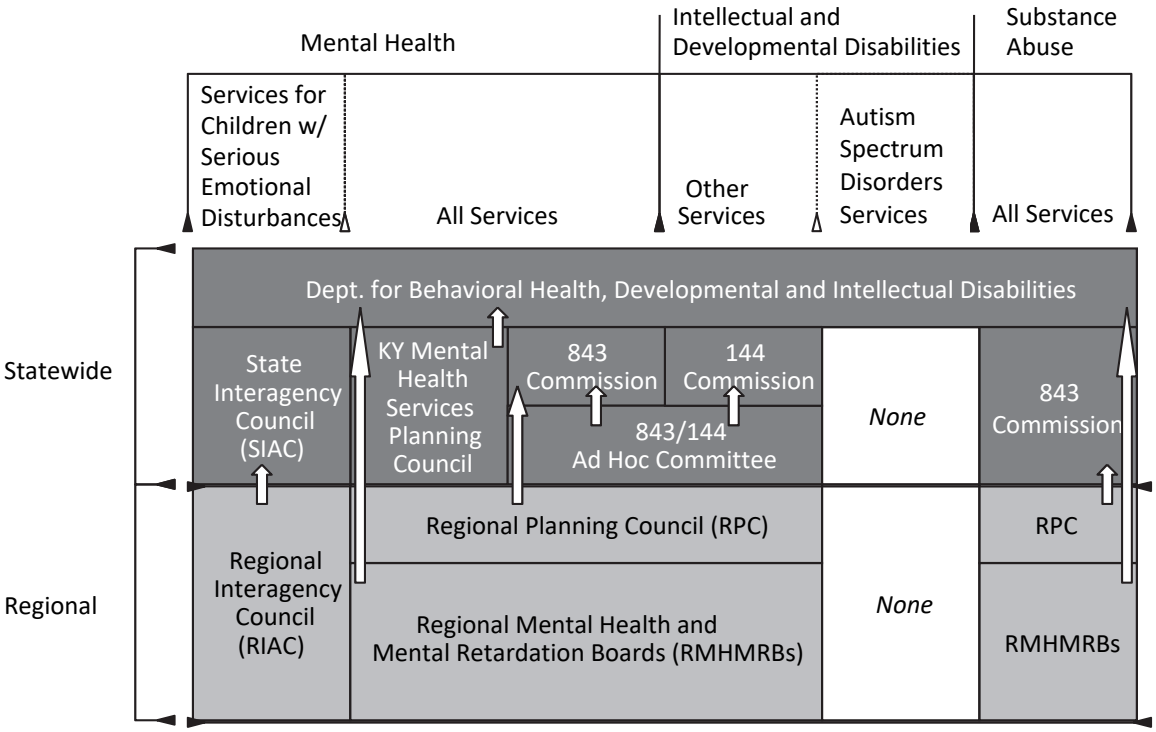
[a] It was formerly known as the Department for Mental Health and Mental Retardation Services.

An example of a federal program passed through the department to the centers is the Community Mental Health Services block grant. It authorizes centers to provide mental health services to adults with severe mental illness and children with serious emotional disturbance, including programs on child mental health, psychosocial rehabilitation, peer support, and consumer-directed programs. Illnesses covered by the grant include schizophrenia, bipolar disorder, and severe depression. The Substance Abuse Prevention and Treatment block grant is another example. It authorizes centers to provide prevention, treatment, and rehabilitation services to persons with alcohol and drug use disorders. At least 20 percent of the grant funds must be spent for educational activities. At least 10 percent of base expenditures from 1994 must be spent on services to pregnant women and women with dependent children.

Many Groups Are Involved In Planning For Services

Federal and state laws require that planning for mental health, substance abuse, and intellectual and other developmental disabilities services take place at both the statewide and regional levels. Figure 1.B shows the program planning relationships required by state statute.

Figure 1.B
Statutory Planning Entities By Level Of Planning, Organizational Hierarchy, And Program Area Of Responsibility



Source: Developed by Program Review staff from requirements in Kentucky Revised Statutes.

The state plan and budget for community services is part of the executive branch budget request.

At the state level, the plan and budget for community services is developed by the department and is incorporated in the budget request of the cabinet. The department's budget submission is prepared within federal and state funding restrictions, including the amount of available funding and priority populations and services. The department's plan and budget for mental health services incorporates the Kentucky Mental Health Services Planning Council's recommendations for use of the Community Mental Health Services block grant. The grant's provisions require that the council be established and provide input on services funded by the grant.

The department has authority over planning, funding, and service delivery for mental health, substance abuse, and intellectual disabilities services The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (843 Commission) is required by state law to assess statewide needs and develop a state plan for program development, funding, and efficient use of state funds for persons with mental illness, substance use disorders, and dual diagnoses (both mental illness and substance abuse). The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (144 Commission) is required by state law to assess state needs and develop a state plan for program development, funding, and efficient use of state and federal funds for persons with intellectual and other developmental disabilities.

Other statutory groups at the statewide level are involved in planning for behavioral health services but have a less formal impact on the department's budget request. These groups include the State Interagency Council for Services to Children with Emotional Disabilities; the Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities; and the Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses. Regional board staff participate in these groups. Each statewide statutory planning authority is discussed below in terms of the scope of its planning responsibilities.

- The department exercises the authority for planning, funding, and service delivery for mental health, substance abuse, and intellectual disabilities services. The department's responsibility includes community services as well as inpatient and other residential care at the state-owned and state-contracted psychiatric hospitals, nursing facilities, substance abuse treatment facilities, and intermediate care facilities for persons with intellectual and other developmental disabilities.
- The Kentucky Commission on Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (also known as the 843 Commission) is required by KRS Chapter 210 to assess statewide needs and develop a state plan for program development, funding, and efficient use of state funds for persons with mental illness, substance use disorders, and dual diagnoses (both mental illness and substance abuse). The commission's responsibility includes community services and inpatient and residential care and encompasses coordination of services and funding across agencies and funding sources.
- The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities (also known as the 144 Commission) is required by state law to assess state needs and develop a state plan for program development, funding, and efficient use of state and federal funds for persons with intellectual and other developmental disabilities. The commission's responsibility includes community services and residential care in intermediate care facilities. Inherent in this responsibility is coordination of services and funding across agencies and funding sources.
- The State Interagency Council is a statewide group composed of officers of state agencies that offer services to children and their parents. The council's efforts are limited to services for children with serious emotional disturbance.
- The Mental Health Services Planning Council is required by federal law for any state that receives Community Mental

Health Services block grant funds. Council members include consumers, family members, consumer organizations, providers, and state agencies. The council is responsible for reviewing plans for allocation of mental health services statewide and recommending modification of such plans; monitoring, reviewing, and evaluating the allocation and adequacy of mental health services in the state; and playing a role in improving mental health services in the state.

The regional boards are the statutory planning authorities for community services.

At the regional level, the boards are the major statutory planning authorities for community mental health, substance abuse, intellectual disability, and other services for their populations. Other entities are involved in both community and inpatient or other residential care services for specific populations. The requirements imposed on the boards and their programs result in significant statutory administrative burdens not imposed on private providers. Each regional statutory planning authority is briefly described below in terms of the scope of its planning responsibilities.

- The regional boards are the only entities in the state with the sole statutory responsibility for providing services in the community. The boards and their programs, implemented by the centers, are responsible for community services to persons with mental illness, substance use disorders, and intellectual and other developmental disabilities. They are required by statute to present to the department an annual plan and budget for community services.
- The regional boards are required to convene regional planning councils to assess regional needs and recommend a regional strategic plan. The councils' scope includes community and inpatient and other residential care needs for persons with mental illness, substance use disorders, and dual diagnoses. Regional planning councils report directly to the 843 Commission. Regional board staff are active participants in these councils.
- The regional interagency councils provide for regional participation in the planning and service coordination among agencies that serve children with serious emotional disturbance. Councils are required by statute to be established in each region of the state and to be chaired by a representative of the Department for Community Based Services. The regional councils' responsibilities include reviewing case histories of children and identifying and providing appropriate services. The regional councils report their results to the state council. Regional board staff are active participants in these councils.

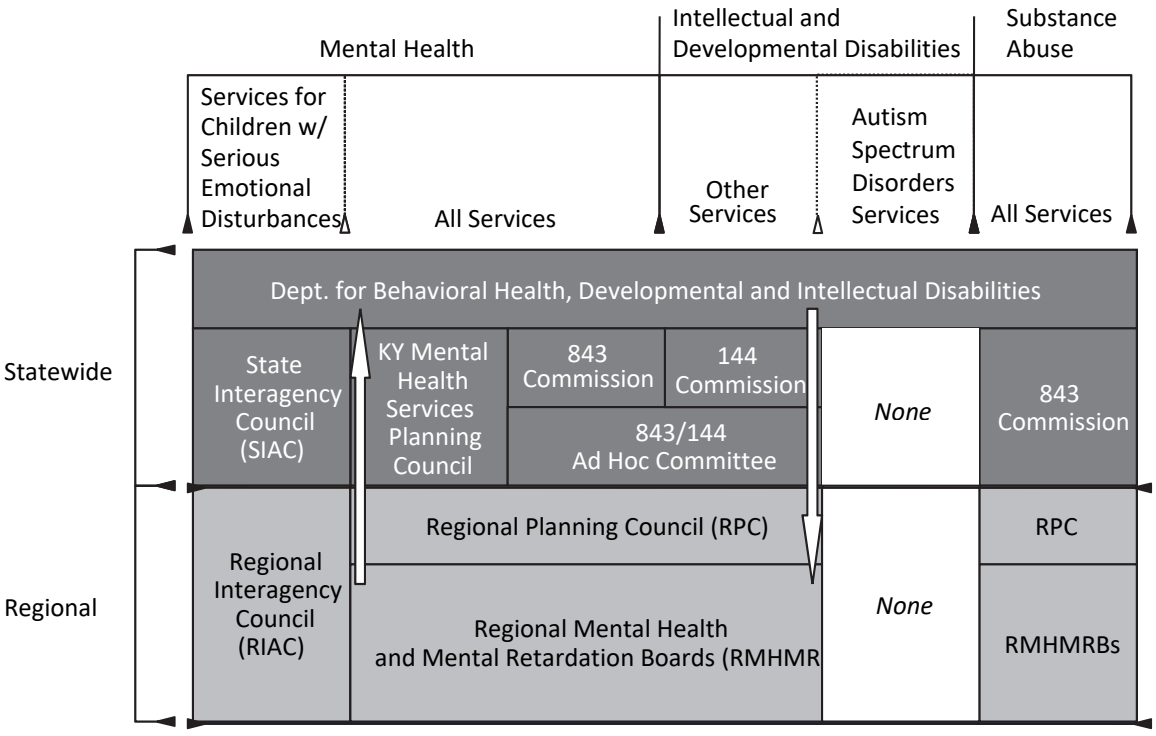
Budgetary Processes Do Not Incorporate Long-Term Planning

The state budgetary process does not provide sufficient opportunity for addressing regional funding needs.

Figure 1.B showed entities at the state and regional levels with statutory planning duties related to specific populations who receive mental health, substance abuse, and intellectual and other developmental disabilities services from the centers. Although these entities were created to plan programs and services for consumers, the related plans cannot be implemented without adequate funding. The duties associated with these entities indicate that most of them are required to identify funding needs and develop funding strategies. However, the executive branch budgetary process does not provide sufficient opportunity for the identified regional funding needs to be addressed.

Figure 1.C shows that the only planning entities directly involved in the budgetary process for community services are the regional boards and the department.

Figure 1.C
Statutory Planning Entities By Level Of Planning And Budget Responsibility



Source: Developed by Program Review staff from requirements in Kentucky Revised Statutes.

The regional plans and budgets are developed in concert with the department. Early in each calendar year, the department estimates the total funds that will be available for distribution to the regional

boards during the upcoming fiscal year. Department staff send a letter to each board specifying the amount the region may receive from each funding source passed through the department. The regional boards then develop an annual plan and budget based on these funding levels and other expected sources, which include Medicaid. Each board presents its plan and budget to the department for review and approval. Once the department's budget is enacted, the department sends a second letter to the boards outlining their approved funding levels and any new fiscal or programmatic requirements. The approved programs, services, and funding levels are incorporated into the contract between the department and each regional board.

The statutory planning authorities of the different entities are designed to produce plans and identify funding needs for various purposes. For example, the 843 Commission is required to identify funding needs and develop a comprehensive state plan to guide funding and the use of state resources for all services to persons with mental illness, substance use disorders, and dual diagnoses, including inpatient and residential care. Table 1.1 shows the members of the 843 Commission and the stakeholders they represent.

The 843 Commission's membership is heavily weighted toward executive branch agencies. Additional members represent consumers, legislators, and others involved in services and supports for the affected populations. The co-chairs of the commission are a member of the General Assembly and the cabinet secretary, as required by KRS 210.502(2).

The 843 Commission has not met since 2007.

Table 1.1
Members Of The 843 Commission And Their Representation

Statutorily Required Member	Stakeholder Representation
• Secretary of the Cabinet for Health and Family Services • Secretary of the Justice and Public Safety Cabinet • Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities • Commissioner of the Department for Medicaid Services • Commissioner of the Department of Corrections • Commissioner of the Department of Juvenile Justice • Commissioner of the Department of Education • Executive director of the Office of Vocational Rehabilitation • Commissioner of the Department for Aging and Independent Living • Director of Protection and Advocacy Division of the Department of Public Advocacy • Director of the Division of Family Resource and Youth Services Centers • Executive director of the Office of Transportation Delivery of the Transportation Cabinet • Commissioner of the Department for Public Health • Executive director of the Office of Drug Control Policy	Executive branch
• Three members of the House of Representatives • Three members of the Senate	Legislative branch
• Director of the Administrative Office of the Courts	Judicial branch
• Chief executive officer of the Kentucky Housing Corporation	Outside stakeholder
• Chair of a regional planning council • Consumer of mental health or substance abuse services • Adult family member of a consumer of mental health or substance abuse services	Outside stakeholder appointed by executive branch

Source: Compiled by Program Review staff from KRS 210.502.

The 144 Commission has similar representation and responsibilities for persons with intellectual disability and other developmental disabilities. However, the 144 Commission is chaired by the cabinet secretary without a legislative co-chair. Table 1.2 shows the members of the 144 Commission and the stakeholders they represent.

Table 1.2
Members Of The 144 Commission And Their Representation

Statutorily Required Member	Stakeholder Representation
• Secretary of the Cabinet for Health and Family Services • Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities • Commissioner of the Department for Medicaid Services • Executive director of the Office of Vocational Rehabilitation • Director of the Kentucky Council on Developmental Disabilities	Executive branch
• Two members of the House of Representatives • Two members of the Senate	Legislative branch
• Director of the University Affiliated Program at the Interdisciplinary Human Development Institute at the University of Kentucky • Five family members • Three persons with intellectual or other developmental disabilities • Two business leaders • Three direct service providers • One representative of a statewide advocacy group	Outside stakeholder appointed by executive branch

Source: Compiled by Program Review staff from KRS 210.575.

The two state commissions' identification of needs is designed to show gaps in services and funding and how the gaps could be closed, regardless of budgetary constraints.

The planning processes of the regional boards and the two commissions are designed to accomplish different purposes and operate independently of each other. The boards are required to participate in the department's annual plan and budget process to result in a contract with the department. The top-down approach is necessitated by the executive branch budget submission process and the state budgetary constraints. The commissions' identification of funding needs does not result in a state budget obligation. The identification of needs is designed to show gaps in services and funding and to recommend how the gaps could be closed.

The 843 Commission addresses the needs of persons with mental illness, substance use disorders, and dual diagnoses involving mental illness and substance abuse. The 144 Commission addresses the needs of persons with intellectual and other developmental disabilities, who also may have dual diagnoses, such as intellectual disability and mental illness or intellectual disability and a substance use disorder. In addition to the centers, entities such as schools, hospitals, the courts, local jails, and state correctional facilities also are likely to have contact with all such persons. Combining the two commissions could facilitate the development of a state plan to address the needs of all persons in Kentucky.

Although the 843 Commission has not met since 2007, the following recommendations from the 2007 Program Review report remain relevant and are repeated in this updated report.

Recommendation 1.1 (2.1 in 2007 report)

Recommendation 1.1

If it is the intent of the General Assembly that the 843 Commission and the 144 Commission develop comprehensive plans for needed services and funding, then the General Assembly may wish to direct the commissions to present a plan to the governor and the Legislative Research Commission in sufficient time before each biennium so that the plan could be useful in the budgetary process. The plan should include specific population and service targets, funding needs, and measurable outcomes.

Recommendation 1.2 (2.2 in 2007 report)

Recommendation 1.2

The General Assembly may consider merging the 843 Commission and the 144 Commission to identify needs, prepare a plan for services and associated funding, and identify expected outcomes for individuals with mental illness, substance use disorders, intellectual and other developmental disabilities, and dual diagnoses. The General Assembly may consider requiring the combined commission to have a legislator and the secretary of the Cabinet for Health and Family Services as co-chairs.

If the commissions are merged, then recommendation 1.1 would apply to the combined commission.

The 2007 report also contained the following recommendation.

Recommendation 1.3 (2.3 in 2007 report)

Recommendation 1.3

Each regional board should develop a strategic plan that describes clearly set objectives, strategies and a timetable to implement them, and cost estimates. The board's plan should include expected outcomes and measurable indicators. The plans should be an integral part of statewide planning decisions.

This recommendation is still relevant. However, it does not describe a method by which the boards' strategic plans could become part of statewide planning. In this updated report, Program Review staff concluded that the boards' strategic plans should be

shared with local government officials who could discuss relevant issues with their senators and representatives in the General Assembly. In that way, the plans could become an integral part of statewide planning decisions through communication with state legislators.

Chapter 2

Consumers And Services

People who receive services from community centers include those with mental illness, substance abuse disorders, and intellectual and other developmental disabilities.

Community mental health centers serve individuals with mental illness, substance use disorders, intellectual and other developmental disabilities, and other disorders, such as acquired brain injuries. Nationally, the need for services for individuals with these diagnoses has been studied and reported by numerous agencies and organizations. According to the Substance Abuse and Mental Health Services Administration, in 2008, 30 million adults (13.4 percent of the population 18 years or older) in the United States received treatment for a mental health issue during the past 12 months.[1] The same group also noted that, in 2010, an estimated 22.1 million individuals (8.7 percent of the population aged 12 or older) had substance dependence or abuse in the past year.[2]

Sources Of Information On Consumers And Services

Consumer information for this report was obtained from client data submitted by the regions to the Department for Behavioral Health, Developmental and Intellectual Disabilities. The client data sets are the only source of reliable information on consumers. Information on services for this report was obtained from regional cost reports submitted to the department. The cost reports are required to contain all services provided to all persons served by the centers. In the 2007 report, Program Review staff worked with the regional centers and the department to aggregate statistics on persons and services into broad groups based on a person's primary diagnosis and the type of service received: mental illness, substance abuse, intellectual or other developmental disabilities, and other. The "other" category of consumers consists of a variety of persons, including

- those receiving services for acquired brain injury;
- those whose primary diagnosis was deferred, meaning that the person discontinued services before the clinician could determine a primary diagnosis; and
- those whose primary diagnosis could not be determined from the data because of information system problems.

This category also includes services provided to groups of persons with various diagnoses, such as persons with mental illness and intellectual disabilities who attend the same work habilitation program.

For this update, Program Review staff obtained client data and regional cost reports from the department for FY 2006 to FY 2010. Staff categorized services in the cost reports in the same manner as in the 2007 report. For data available for all 10 years, the update compares data from fiscal years 2001 to 2010.

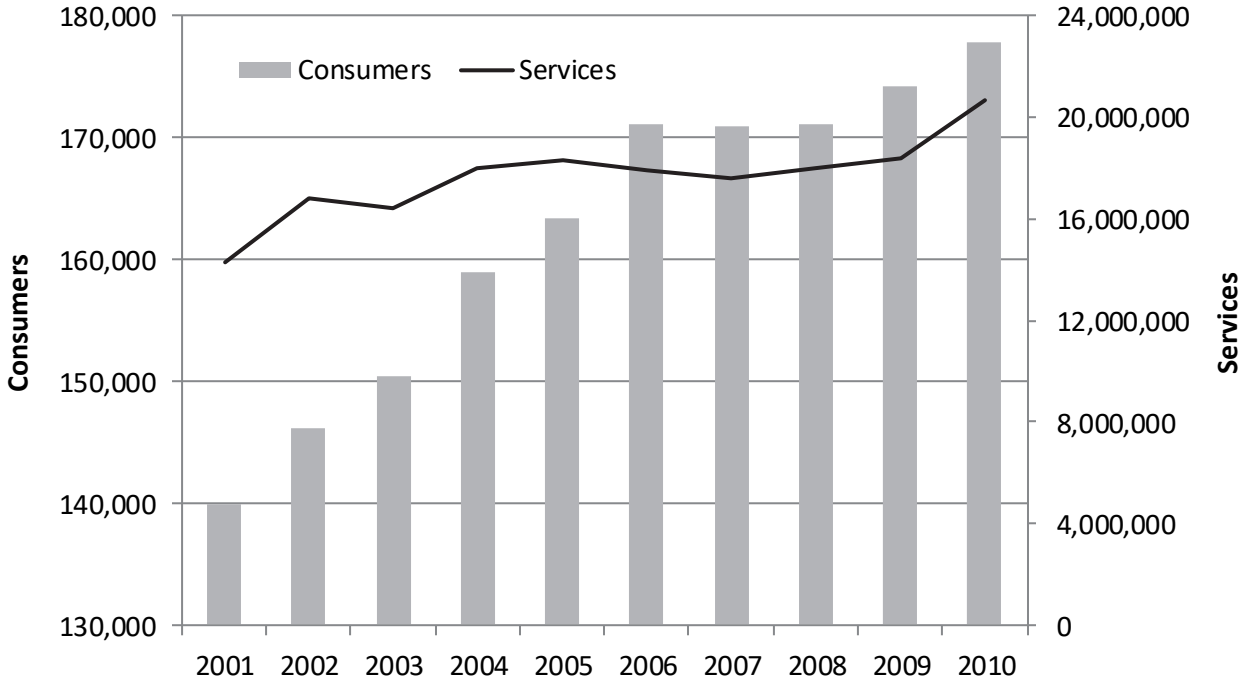
The Numbers Of Consumers And Services Are Increasing

The number of people receiving services from the centers and the number of services they receive are increasing. Figure 2.A shows the increase in the number of people served and total services provided to them by the centers statewide from FY 2001 to FY 2010.

In FY 2010, the centers provided nearly 21 million services to nearly 178,000 people. Compared to FY 2001, this represents a 27 percent increase in people served and a 44 percent increase in services provided.

In FY 2001, the centers served nearly 140,000 individuals. By FY 2010, that number had risen to nearly 178,000, representing a 27.1 percent increase. The services provided to these individuals increased by 44.8 percent, from just over 14 million services in 2001 to nearly 21 million in 2010.

Figure 2.A
Increase In Consumers And Services
Fiscal Year 2001 To Fiscal Year 2010



Source: Compiled by Program Review staff from information provided by the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Table 2.1 shows the proportion of consumers by primary diagnosis from FY 2001 to FY 2010. On average, individuals with a mental health diagnosis were 77.8 percent of the service population during the 10-year period. Over the same period, 13.3 percent of the service population had a primary diagnosis of substance abuse; 1.9 percent had a primary diagnosis of intellectual and other developmental disabilities. Persons with a primary diagnosis of "other" were 6.9 percent.

Table 2.1
Percentage Of Statewide Consumers By Primary Diagnosis
Fiscal Year 2001 To Fiscal Year 2010

Primary Diagnosis	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Mental health	75.6	77.3	78.2	78.9	79.1	74.6	76.8	78.9	78.9	79.7
Substance abuse	15.6	15.2	14.7	14.5	13.9	12.3	12.8	12.4	11.9	11.1
Intellectual and other developmental disabilities	2.0	2.0	2.4	2.3	2.1	1.8	1.6	1.6	1.7	1.8
Other	6.8	5.5	4.7	4.3	4.9	11.2	8.7	7.1	7.5	7.4

Note: Percentages shown may not total to 100.0 because of rounding.
Source: Compiled by Program Review staff from information obtained from the Department for Behavioral Health, Developmental and Intellectual Disabilities

Table 2.2 provides regional details on population, consumers, and percentage served. A lower percentage of state consumer population served does not necessarily mean that a region has better mental health or a lesser prevalence of substance abuse or intellectual disabilities. Regional alternatives for care are also a factor. Persons with health insurance or more disposable income may choose to obtain services from private providers.

Table 2.2
Population And Consumer Service Rates By Region
Averages For Fiscal Year 2001 To Fiscal Year 2010

Region	Population	% Of State Population	Consumer Population	% Of State Consumer Population	% Of Regional Population Served
Four Rivers	203,857	4.9%	7,989	4.9%	3.9%
Pennyroyal	210,666	5.0	9,372	5.8	4.4
River Valley	209,397	5.0	8,591	5.3	4.1
LifeSkills	269,512	6.4	11,197	6.9	4.2
Communicare	253,537	6.0	8,490	5.2	3.3
Seven Counties	911,924	21.7	25,060	15.4	2.7
NorthKey	418,570	10.0	8,244	5.1	2.0
Comprehend	56,184	1.3	3,848	2.4	6.8
Pathways	216,197	5.1	13,355	8.2	6.2
Mountain	157,762	3.8	10,626	6.5	6.7
Kentucky River	117,317	2.8	9,224	5.7	7.9
Cumberland River	239,900	5.7	12,525	7.7	5.2
Adanta	199,545	4.7	9,057	5.6	4.5
Bluegrass	736,923	17.5	24,806	15.3	3.4
State	4,201,291	100.0%	162,383	100.0%	3.9%

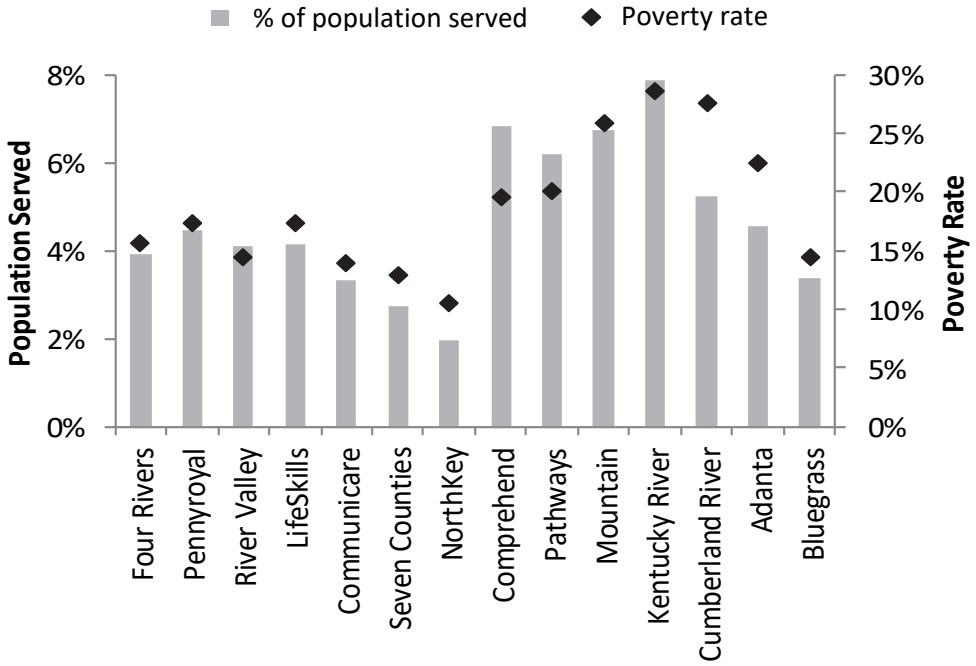
Note: Percentages shown may not total to 100.0 because of rounding. Regional consumer populations do not sum to the total shown because of rounding.
Source: Compiled by Program Review staff from information obtained from the US Census Bureau and the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Table 2.2 shows that some regions, especially those in the eastern part of the state, comprise a greater percentage of the state consumer population than of the total state population. For example, the Kentucky River region in eastern Kentucky has 2.8 percent of the total state population, but its consumer population is 5.7 percent of the statewide consumer population.

In general, regions with higher poverty rates serve a larger proportion of their populations than regions with lower poverty rates.

Figure 2.B compares service populations to poverty rates.[b] The numbers have been averaged for the period FY 2001 to FY 2010. In general, a higher regional poverty rate correlates to a larger percentage of the population accessing community services. For example, Kentucky River has the highest poverty rate at 28.6 percent and also serves the largest percentage of its regional population at 7.9 percent. NorthKey has the lowest poverty rate at 10.5 percent and serves the smallest percentage of its regional population at 2 percent.

Figure 2.B
Percentage Of Population Served And Estimated Poverty Rates By Region
Averages For Fiscal Year 2001 To Fiscal Year 2010



Source: Regional populations were calculated using data from the US Census Bureau. Poverty rates were calculated using the US Census Bureau's Small Area Income and Poverty Estimates. Consumer data were compiled by Program Review staff from information obtained from the Department for Behavioral Health, Developmental and Intellectual Disabilities.

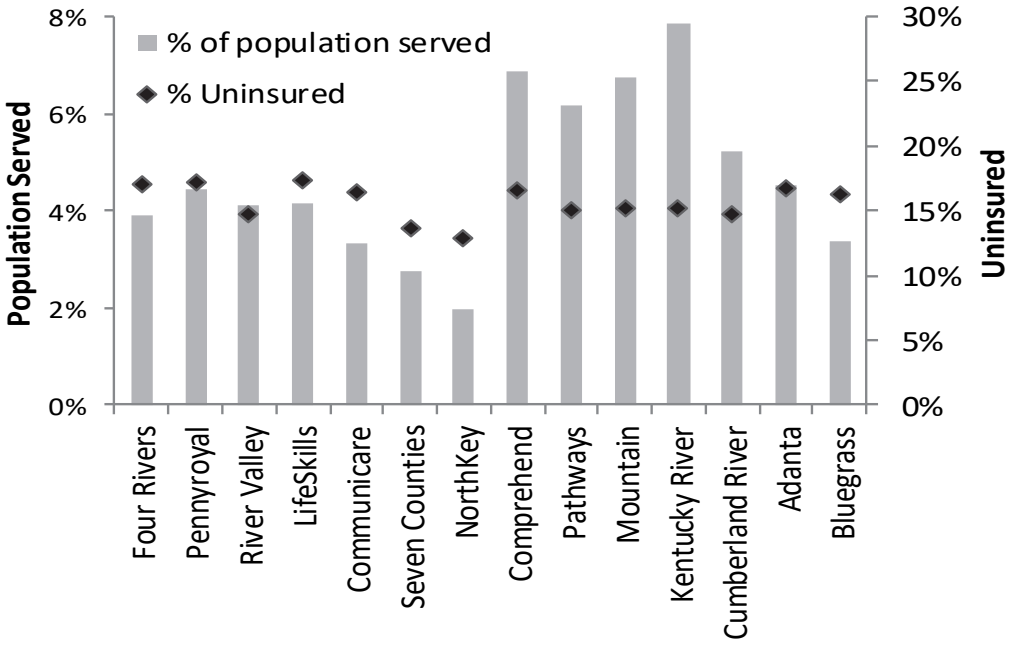
Figure 2.C compares service populations to rates of uninsured individuals in each region. The figures for the service population have been averaged for the FY 2001 to FY 2010 period The figures for the uninsured rates were calculated averages based on data

[b] Poverty estimates were obtained from the US Census Bureau's Small Area Income and Poverty Estimates (SAIPE) for 2001-2009. The SAIPE produces model-based estimates with a specific definition of poverty. Changes in methodology have occurred over time, which make comparisons across years problematic.

available from the US Census Bureau's Small Area Health Insurance Estimates.[c]

Although the uninsured rates level out more than the poverty rates, some comparisons can be made between regions with this data but are subject to significant margins of error. For example, NorthKey and Seven Counties have the lowest uninsured rates at 12.8 percent and 13.7 percent. They also serve the smallest percentages of their regional populations.

Figure 2.C
Percentage Of Population Served And Estimated Uninsured Rates By Region
Averages For Fiscal Year 2001 To Fiscal Year 2010



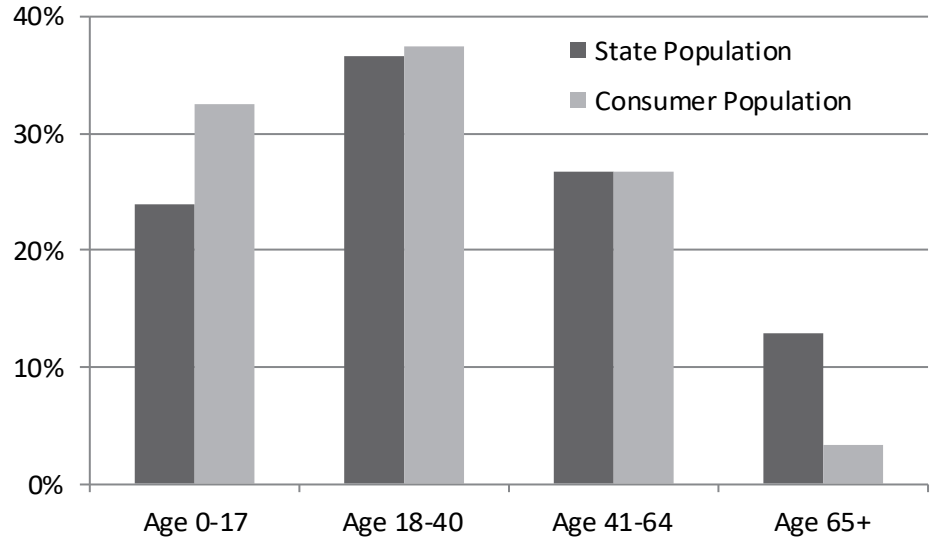
Source: Estimates of the uninsured population are from the US Census Bureau's Small Area Health Insurance Estimates for the years 2000, 2005, 2006, and 2007. Regional populations were calculated using data from the US Census Bureau. Consumer data were compiled by Program Review staff from information obtained from the Department for Behavioral Health, Developmental and Intellectual Disabilities.

[c] Data sets were available from Small Area Health Insurance Estimates for the years 2000, 2001, 2005, 2006, and 2007. All except 2001, which was for women only, were used to calculate an average. The estimates are model-based. Changes in methodology make comparing data problematic. Data are not collected on those 65 and over because most in this age group are considered to be covered by Medicare or Supplemental Security Income.

Over the period of FY 2001 to FY 2010, 37 percent of consumers of services of the centers were aged 18 to 40. Those 18 and younger were 33 percent of consumers, those aged 41 to 64 were 27 percent, and those who were 65 or older were 3 percent.

Figure 2.D displays the average mix of age groups for consumers and the general state population from FY 2001 to FY 2010.[d] Because of differences in data reporting, the first three age groups differ slightly but still offer useful comparisons.[e] Individuals aged 18 to 40 were the largest segment of the consumer population, on average representing 37.4 percent over the 10-year period. As percentages of the service population, consumers younger than 18 were 32.5 percent, consumers aged 41 to 64 years were 26.7 percent, and consumers 65 and older were 3.3 percent. Compared to their percentages of the state population, those who were less than 18 were overrepresented as consumers. Those who were 65 or older were underrepresented. Appendix A provides additional detail.

Figure 2.D
Percentages Of Statewide Population And Consumers By Age Group
Averages For Fiscal Year 2001 To Fiscal Year 2010



Note: The Department for Behavioral Health, Developmental and Intellectual Disabilities and the US Census Bureau compile information on different but similar age groups. The "unknown" age category is not shown in the chart because it represents a small percentage and has no comparable category in Census estimates and the demographic profile.
Source: Compiled by Program Review staff from information obtained from the Department for Behavioral Health, Developmental and Intellectual Disabilities and US Census data.

[d] From FY 2001 to 2010, there were small increases in consumers younger than 18 and consumers aged 41 to 64 as percentages of the consumer population.
[e] The Department for Behavioral Health, Developmental and Intellectual Disabilities and the US Census Bureau compile information on different but similar age groups. The department uses the following groups: less than 18, 18 to 40, 41 to 64, and 65 and over. The groups used by the US Census Bureau have changed over time. Staff used Census age groups closest to those used by the department. US Census estimates by age group were not available for 2001.

Men and women were almost equally represented among consumers.

From FY 2001 to FY 2010, the average percentage of male consumers was 50.6, while the average percentage of female consumers was 49.3. The remaining 0.1 percent was unknown. During the period, male consumers increased by 17.9 percent; female consumers increased by 31.6 percent. With a higher rate of growth among women, the trend has been for the gender composition of the consumer population to become more equal in proportion. Two regions had a higher percentage of women than men. In River Valley, women were 55.3 percent of consumers. In Communicare, women were 53.5 percent of consumers.

The mix of racial groups has remained relatively stable.

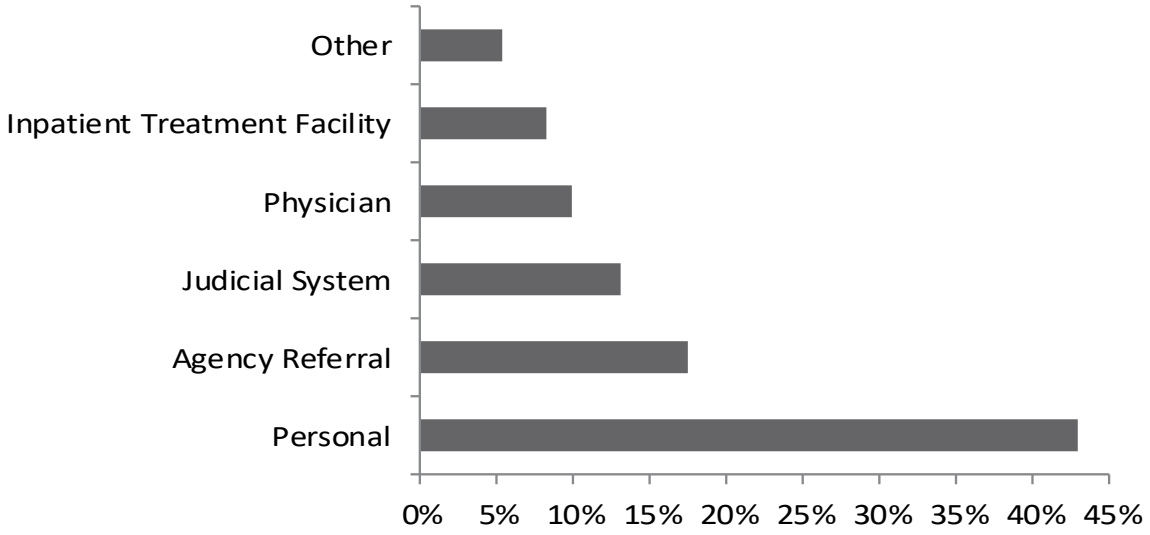
In FY 2010, whites including Hispanics were 83.3 percent of total consumers, and African Americans were 9.5 percent. Other racial groups, including Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and other classifications were 7.1 percent of consumers in FY 2010. In comparison, whites comprised 87.8 percent of the statewide population, and African Americans comprised 7.8 percent of the state's population in FY 2010. Other racial groups made up 4.4 percent of the general population during the same year.

Racial data for FY 2003 was the earliest information available. As a percentage of total consumers, whites increased by 10.8 percent between 2003 and 2010. African Americans increased by 13.8 percent. Other racial groups experienced the largest increase, nearly 300 percent, from 2 percent of consumers in 2003 to 7.1 percent in 2010. Appendix A provides additional detail on consumers' race by region.

Over the period FY 2001 to 2010, more than 40 percent of consumer referrals were personal (self-referrals).

Figure 2.E shows an average index of statewide consumer referral sources to community services from FY 2001 to FY 2010. Forty-three percent of consumer referrals were personal, which are self-referrals. Agency referrals were 17.4 percent of consumers, and judicial system referrals were 13.1 percent.

Figure 2.E
Percentage Of Referrals By Source
Averages For Fiscal Year 2001 To Fiscal Year 2010



Note: The "Not Available/Collected" category is not included in the chart because it was not a category for FY 2006 to FY 2010.
Source: Data provided by Department for Behavioral Health, Developmental and Intellectual Disabilities.

Personal referrals increased 52 percent from FY 2001 to FY 2010. Agency referrals increased by 24 percent. Physician referrals increased by 36 percent, and those referred through an inpatient treatment facility increased by 21 percent. Judicial system referrals declined by 2 percent. Appendix A provides regional details on referral sources.

Eighty-five percent of consumers reside in unstaffed residences, which include their own homes, the homes of parents or guardians, and boarding homes.

On average, consumers living in unstaffed residences, which include their own homes, the homes of parents or guardians, and boarding homes, were 85 percent of the service population. This represented the largest consumer group. Those living in "other" residences were 9.7 percent of consumers. Other residences include foster care, alcohol or drug treatment facilities, and jail or prison. On average, consumers with no fixed residence were 2 percent of the consumer population. Persons living in licensed long-term care facilities were 1.8 percent of the population, and consumers in staffed residences were 1.5 percent.

From FY 2001 to FY 2010, consumers in staffed residences increased by 63.6 percent, which represented the largest increase during the period. Clients with no fixed residence increased by 46.2 percent. Individuals in an unstaffed residence increased by 31.2 percent, and those in a licensed long-term care facility

increased by 10.5 percent. Those with "other" living arrangements declined by 29.7 percent. Appendix A has additional details.

Issues That Negatively Affect Consumers

The centers reported issues related to staffing, transportation, housing, and waiting times for appointments that negatively affect services to clients.

Staffing

Staffing shortages cause a decrease in productivity and a disruption in clients' continuity of care.

The centers reported that staffing shortages have a negative effect on services to clients. Staff productivity is decreased, and the clients' continuity of care is disrupted, resulting in client dissatisfaction with services.

Staffing shortages among community mental health centers generally fall into two categories: the difficulty in filling existing positions or keeping them filled and the need to add positions in order to serve a growing number of clients. Some centers face shortages in professional positions such as psychiatrists, psychologists, nurses, licensed clinical social workers, and case managers. Particular expertise is required, including the ability to build community alternatives to institutional care. The centers need bilingual practitioners in all disciplines. They also need direct support professionals who work in specific programs, such as the Supports for Community Living program. Because of strenuous work and low pay in this program, some centers cannot keep adequate numbers of staff and are forced to pay overtime to existing staff.

Centers noted a need for professionals with the ability to conduct specific assessments and provide billable services. Due to financial strain, some centers are operating under a general rule of hiring only revenue-generating positions and filling other positions only when absolutely necessary. Restrictions on who can bill Medicaid, as well as rates within the program, also make hiring difficult, as regions compete to fill positions that can generate revenue.

Some centers stated it is particularly difficult to recruit the necessary professionals in the outermost rural areas of the regions. For example, some pay thousands of dollars to a "headhunter" when conducting searches for psychiatrists. Education and experience requirements in general make it difficult to fill some positions. In some cases, lower-level professionals are being used,

but they can be difficult to recruit. In other instances, more rigid referral criteria and waiting lists are used to work around staffing shortages.

At some centers, the pressing need for additional staff is in the areas of support, administration, maintenance, information technology, fiscal services, and other nonclinical positions that enable clinical staff to deliver services.

Inadequate funding and increased costs are often cited as obstacles to acquiring necessary staff. Centers state they are currently underfunded by the Department for Behavioral Health, Developmental and Intellectual Disabilities and the Department for Medicaid Services. In turn, these inadequate funding levels result in lower salaries, the inability to fund cost-of-living raises, and a reduction in employee benefits or an increase in the employees' share of benefit costs. Some centers said employees were leaving to work for other organizations or regions, often for higher salaries and better benefits. Both health insurance and retirement costs are increasing beyond the centers' abilities to adequately fund them.

Transportation

Transportation barriers hinder clients' treatment progression because of missed appointments and an inability to work and participate in community life.

Transportation barriers cause clients to miss appointments or be reluctant to schedule appointments. Missed or infrequent appointments hinder clients' overall treatment progression. Lack of transportation also affects clients' ability to obtain and maintain employment and to participate in community life, a situation that also negatively affects treatment progression.

Many clients cannot afford to purchase, insure, or maintain a vehicle. If family or friends are unable or unwilling to transport clients, they must rely on public transportation, which is lacking in most rural areas. Even in areas with public transportation, there are obstacles. Many transportation providers have cut budgets, which has resulted in decreased personnel and hours of operation with increased cost to ride. Some providers do not have routes that take individuals to the clinics. When people can access public transportation, they are sometimes on the vehicle for hours. In some regions, this situation has caused concern among parents and guardians regarding potential abuse and exploitation of clients. Law enforcement vehicles and ambulances are used for transportation in some cases.

Centers find it difficult to educate Medicaid-eligible clients on the rules and processes for using available transportation. A 72-hour

notice typically is required in order to schedule a ride. Some of the vehicles are unable to reach clients who live on poorly maintained roads or during winter when rural roads are not always cleared. Parents who accompany their Medicaid-eligible children on the bus are required to pay a fee. If a family has a vehicle, regardless of its condition, Medicaid transportation is denied.

Even when clients can access transportation to medical appointments, it may be unavailable for travel to and from work or other vital destinations. If clients can access transportation for employment, the available schedules may prevent them from working particular jobs or working as much as they otherwise could. Some centers use their own vans and staff vehicles as options. Some rural centers also noted that it is difficult for staff to be as mobile as needed due to billing rate restrictions.

Housing

Clients of the centers need affordable housing with support services.

Clients need more housing options, particularly affordable accommodations with support services. A range of support services is needed, from minimal support to 24-hour staffed residences, including some medical support.

Housing needs for higher-functioning individuals with developmental or other intellectual disabilities are not well addressed. Transitional housing for persons coming out of substance abuse programs is lacking. There is a need for emergency housing for homeless persons in general and homeless veterans in particular. The Pennyroyal region has received a grant to build transitional housing for homeless veterans.

Fixed housing subsidies are needed for individuals receiving disability income. Most income-based options are subsidized by the US Department of Housing and Urban Development. Such subsidized housing is limited, especially in rural areas, and there is usually a waiting list. Some centers stated a need for additional Section 8 housing vouchers, primarily to assist persons with severe mental illness. Clients sometimes have to pay full rental amounts for substandard housing when subsidized housing is not available.

Individuals with mental illness may be unable to obtain subsidized housing because they owe money to housing authorities or are facing drug charges. Some who might receive special assistance for homeless persons do not qualify because they stay with family or friends. Substance abuse clients with drug felonies are prohibited by federal and state guidelines from receiving subsidized housing.

Some subsidized housing programs require a person to have a case manager. For men with a substance abuse diagnosis, there is no funding source to provide a case manager. Without the support of a case manager, a client may not take medication as prescribed, which can result in disruptive behavior and eviction.

Some centers would like the Department for Behavioral Health, Developmental and Intellectual Disabilities to fund housing options for persons with severe mental illness. Programs for supervised housing similar to adult foster homes or staffed residences could provide an alternative to individuals who are being moved from personal care homes.

Waiting Times For Appointments

A person with an emergent crisis is usually offered an immediate, same-day appointment.

A person with an emergent crisis is usually offered an immediate, same-day appointment. If the person declines, an appointment is scheduled at his or her convenience. The average waiting time for nonemergent cases varies among centers. Some state there is no difference in waiting times for various groups, such as self-referrals or court referrals. Some centers rarely maintain waiting lists for routine outpatient care.

Some centers noted that they provide preferential appointments to the priority populations outlined in their state contracts with the department. For example, one center noted that pregnant females who are using substances, are at risk of using substances, or have a history of substance use are offered an appointment within 48 hours.

If a client's needs are beyond a center's scope of practice, centers will generally refer the person to an appropriate agency. Some centers stated that waiting time increases for specialized programs or for individuals with no payer source.

Most centers stated they do not refuse services to anyone for any reason. However, one center said it will refuse services to individuals who have threatened staff.

Chapter 3

Services And Funding

Program Review staff worked with staff from the Department for Behavioral Health, Developmental and Intellectual Disabilities and the centers to define the services listed on regional cost reports as mental health, substance abuse, intellectual and other developmental disabilities, or other. Services classified as "other" could have been provided to a group of persons, some with a mental health diagnosis, some with a substance abuse diagnosis, and some with a developmental disability diagnosis. Persons with developmental disabilities appear to be the predominant population. Funding information was obtained from the boards' audited financial statements and other sources from the centers and the department. Appendix B has more detail on types of services and sources of payment by region.

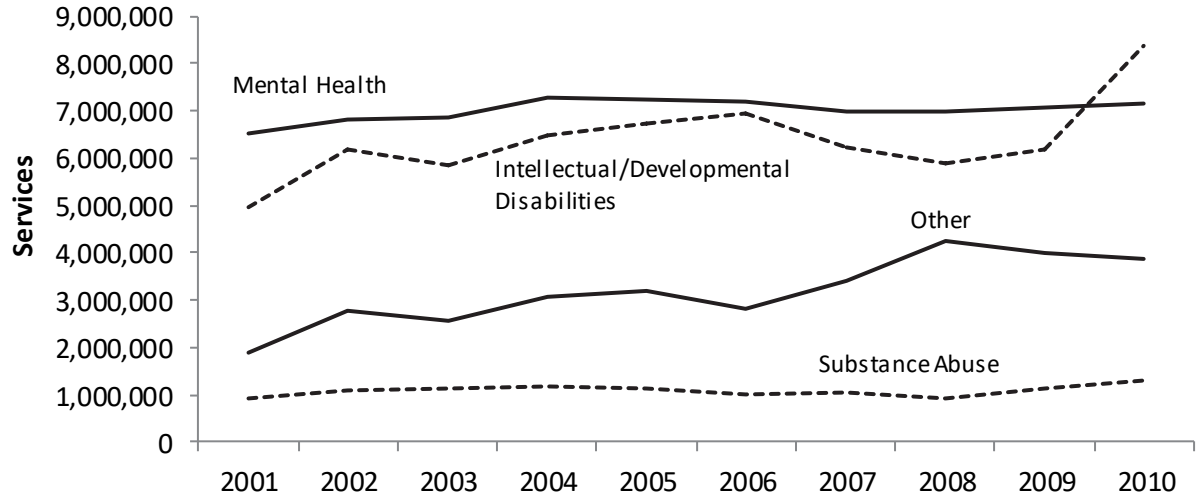
The rate of increase in services the centers have provided has slowed. From FY 2001 to FY 2005, services increased by 27.8 percent. From FY 2006 to FY 2010, services increased by 15.3 percent.

Figure 3.A shows the total number of services provided by the centers from FY 2001 to FY 2010.[f] Over the period, services provided to consumers increased 44.8 percent from approximately 14 million to almost 21 million. The rate of increase in services provided has slowed. From FY 2001 to FY 2005, services increased by 27.8 percent. From FY 2006 to FY 2010, services increased by 15.3 percent.

On average, mental health services were 39.7 percent of services provided, intellectual and other developmental disabilities services were 36.1 percent, substance abuse services were 6.1 percent, and other services were 18.0 percent.

[f] Services provided by one region in out-of-state facilities are excluded from the total.

Figure 3.A
Statewide Services By Type
Fiscal Year 2001 To Fiscal Year 2010



Source: Compiled by Program Review staff from regional cost reports with assistance from the centers and the Department for Behavioral, Developmental and Intellectual Disabilities.

Revenue Sources

Resources received by the centers for providing services can be characterized by type of payer:

- Department for Medicaid Services for the Supports for Community Living waiver program, the Michelle P waiver program, and other eligible services
- Department for Behavioral Health, Developmental and Intellectual Disabilities for services paid from the two major block grants and other state and federal payers for services not reimbursable by Medicaid and other sources
- Other sources, including self-pay consumers, private insurance, Medicare, local contributions, and grants from other organizations

On average over the 10-year period, Medicaid paid for 58 percent of services, the Department for Behavioral Health, Developmental and Intellectual Disabilities paid for nearly 33 percent, and other sources paid for less than 10 percent.

On average, Medicaid paid for 58 percent of services provided by the centers from FY 2001 to FY 2010. The department paid for 32.6 percent of services, and other sources paid less than 10 percent. Table 3.1 shows the percentage change in the number of services by payer in the 5-year period FY 2001 to FY 2005, the 5-year period FY 2006 to FY 2010, and the total 10-year period from FY 2001 to FY 2010. Medicaid payments for the waiver

programs and other services are shown separately for informational purposes only.

Table 3.1 shows a shift in payers over the 10 years, with a greater proportion being paid by Medicaid and lesser proportions being paid by the department and other payers.

Table 3.1
Percentage Change In Statewide Services By Payer
FY 2001 To FY 2005, FY 2006 To FY 2010, And FY 2001 To FY 2010

	% Change		
Payer	**2001 To 2005**	**2006 To 2010**	**2001 To 2010**
Medicaid (other)	17.0%	17.0%	35.4%
Medicaid (waivers)	40.6	66.8	130.8
Dept. for Behavioral Health, Developmental and Intellectual Disabilities	52.4	-28.6	7.6
Other payers	-24.4	16.5	-18.5
Total	27.8%	15.3%	44.8%

Source: Compiled by Program Review staff from regional cost reports with assistance from the centers and the Department for Behavioral Health, Developmental and Intellectual Disabilities.

From FY 2001 to FY 2005, services paid for by the department increased by more than 52 percent, but from FY 2006 to FY 2010, they decreased by more than 28 percent. The proportion of services paid under the Medicaid waiver programs increased by more than 40 percent from FY 2001 to FY 2005 and by nearly 67 percent from FY 2006 to FY 2010, for an overall 10-year increase of more than 130 percent.

Services paid for by other payers decreased by 24.4 percent from FY 2001 to FY 2005 but increased by 16.5 percent from FY 2006 to FY 2010. This situation may indicate that consumers with no insurance or other ability to pay are being asked to contribute a minimal amount toward their services. The overall 10-year decrease was more than 18 percent.

Another way to characterize funding is to analyze revenue from levels of government and other sources. For example, local revenues can be analyzed to indicate local governments' ability and willingness to participate in funding local services, as recommended in the 1966 Pattern for Change report. Support can include local in-kind contributions, such as donated space. In this type of analysis, revenue and support can be divided into six major sources:

- Federal government

- State government
- Local taxes and/or appropriations
- Other local support
- Charges to patients
- Other miscellaneous

Table 3.2 shows the percentage change in total revenue by source in the 4-year period FY 2002 to FY 2005, the 5-year period FY 2006 to FY 2010, and the 9-year percentage change from FY 2002 to FY 2010.[g] The amounts in Table 3.2 are adjusted for inflation to reflect 2001 dollars.[h] Appendix C has more detail on trends in inflation-adjusted revenue by region.

Table 3.2
Percentage Change In Inflation-Adjusted Revenue By Source
FY 2002 To FY 2005, FY 2006 To FY 2010, And FY 2002 To FY 2010

	% Change			% of Total
Revenue Source	**2002-2005**	**2006-2010**	**2002-2010**	**2002-2010**
Federal	4.8%	14.9%	19.3%	54.1%
State	0.2	10.9	16.2	32.1
Local Tax Match	11.4	5.8	-12.0	0.7
Other Local Match	17.5	7.3	45.0	3.1
Charges to Patients	19.0	-12.3	-20.2	5.8
Other Revenue	24.2	21.7	104.6	4.3
Total	5.2%	12.1%	18.7%	100.0%

Note: FY 2001 is excluded due to lack of detail on sources from one region. Amounts received by one region for services provided in other states are excluded. Percentages do not add up to 100.0% because of rounding.
Source: Compiled by Program Review staff from financial information from information submitted by centers.

On average, from FY 2002 to FY 2010, 54 percent of revenue came from the federal government, and 32 percent came from state government sources. Combined local match was just under 4 percent. Charges to patients comprised nearly 6 percent, and other revenue was a little more than 4 percent during the period.

Adjusted for inflation, revenue from the federal government increased approximately 19 percent from FY 2002 to FY 2010; revenue from the state increased 16 percent.

Adjusted for inflation (using 2001 dollars), revenue from the federal government increased 19.3 percent from FY 2002 to FY 2010, from $178 million to $212 million. Revenue from the state increased from nearly $105 million to nearly $121 million, a 16 percent increase. Revenue from all other revenue sources

[g] FY 2001 is excluded because details on revenue sources were unavailable from one region. The amounts exclude Medicaid revenue received by one region for services provided in other states and paid from other states' Medicaid programs.
[h] Adjustments were made using the Consumer Price Index (CPI) from the US Bureau of Labor Statistics. Medical inflation is typically higher than the CPI.

combined increased from approximately $41 million to $50 million.

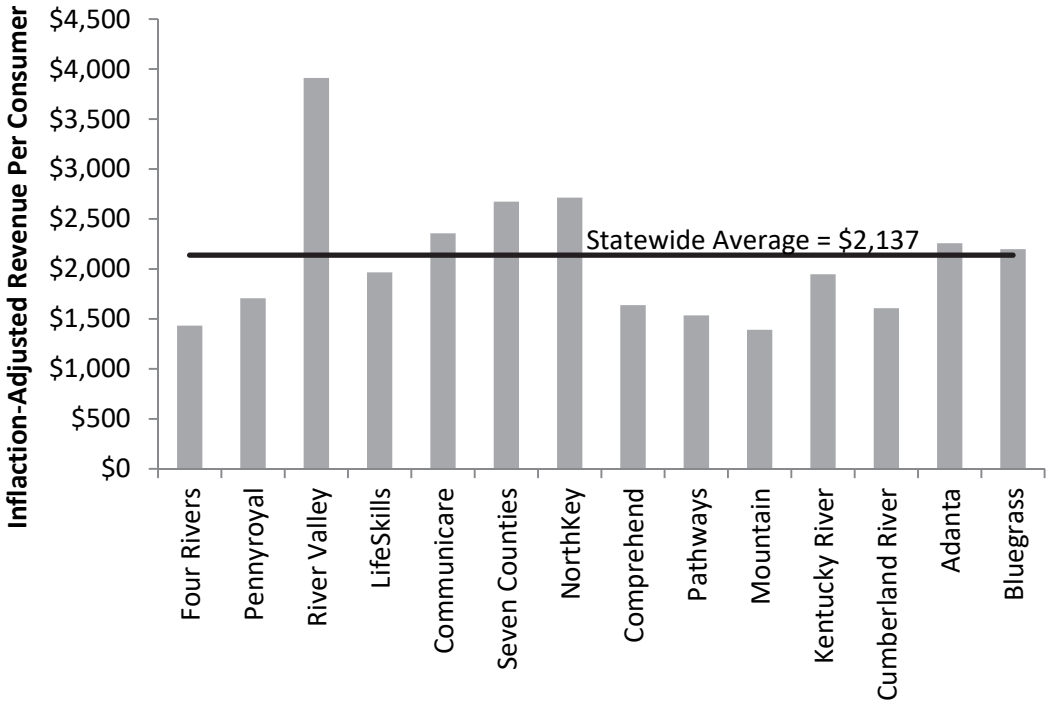
From FY 2002 to FY 2010, total inflation-adjusted revenue increased by almost 19 percent, much less than increases in consumers (27 percent) and services (45 percent).

From FY 2002 to FY 2010, total inflation-adjusted revenue and support increased 8.7 percent, from $324 million to $385 million. From FY 2001 to FY 2010, the number of consumers increased by 27.1 percent, and the number of service units increased by 44.8 percent.

From FY 2002 to FY 2010, statewide average revenue per consumer was $2,137. Average revenue per capita was $83. For both measures, there was significant variation among regions.

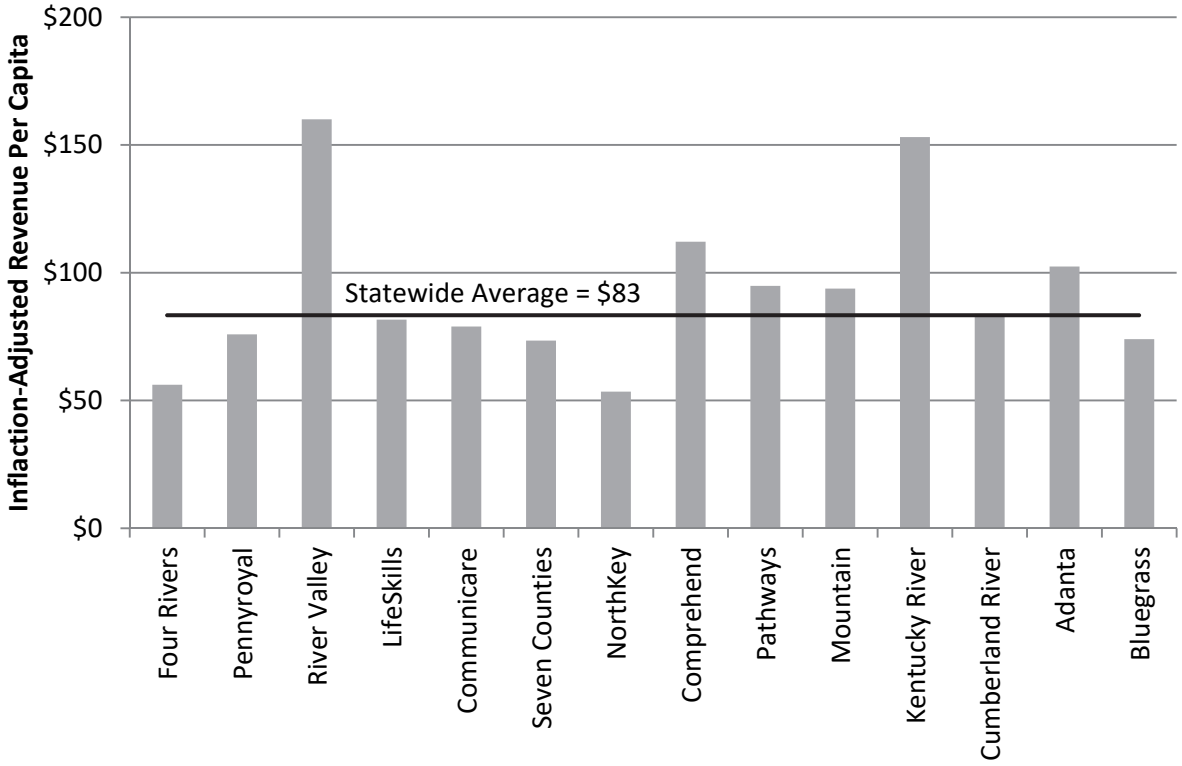
Revenue and support per consumer and per capita varied among the regions during the period. This reflects regional differences in overall population, the number of people accessing services, and the types of services they received. From FY 2002 to FY 2010, average annual revenue per consumer statewide was $2,137. Regional averages ranged from $1,392 in Mountain to $3,911 in River Valley. Over the same period, average annual revenue per capita statewide was $83, ranging from $53 in NorthKey to $160 in River Valley. Figures 3.B and 3.C show revenue and support per consumer and per capita, averaged for FY 2002 to FY 2010.

Figure 3.B
Average Annual Inflation-Adjusted Revenue Per Consumer By Region
Fiscal Year 2002 To Fiscal Year 2010



Note: Revenue is adjusted for inflation to be in 2001 dollars.
Source: Prepared by Program Review staff from financial information obtained from the centers and consumer information obtained from the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Figure 3.C
Average Annual Inflation-Adjusted Revenue Per Capita By Region
Fiscal Year 2002 To Fiscal Year 2010



Note: Revenue is adjusted for inflation to be in 2001 dollars.
Source: Prepared by Program Review staff from financial information obtained from the centers and population information obtained from the US Census Bureau.

Federal Revenue

On average, Medicaid provided nearly 82 percent of federal funding.

Federal revenue to the centers comes from the Medicaid program, the Community Mental Health Services block grant, the Substance Abuse Prevention and Treatment block grant, and grants from other federal agencies awarded to individual regions. On average, Medicaid provided nearly 82 percent of federal funding, with the community mental health services and substance abuse block grants providing another 12 percent. Table 3.3 depicts federal revenue by source for FY 2002 and FY 2010 and the percentage change.

Table 3.3
Inflation-Adjusted Federal Revenue By Source
(In Millions Of Dollars)
Fiscal Year 2002 And Fiscal Year 2010

	2002		2010		
Federal Revenue Source	Amount	% of Federal Revenue	Amount	% of Federal Revenue	% Change 2002 to 2010
Medicaid (other)	$109.1	61.2%	$122.3	58.3%	12.2%
Medicaid (SCL)	32.9	18.5	45.0	21.4	36.8
Medicaid (MPW)	0	0.0	10.2	4.9	N/A
CMHS block grant	5.2	2.9	5.6	2.7	8.3
SAPT block grant	16.0	9.0	16.2	7.7	1.4
Other	15.1	8.5	10.7	5.1	-29.2
Total	$178.2	100.0%	$210.1	100.0%	17.9%

Note: Revenue is adjusted for inflation to be in 2001 dollars. SCL is Supports for Community Living waiver, MPW is Michelle P waiver, CMHS is Community Mental Health Services, SAPT is Substance Abuse Prevention and Treatment. Figures do not add up to totals shown because of rounding.
Source: Compiled by Program Review staff from financial information submitted by the centers.

Adjusted for inflation to be in 2001 dollars, federal revenue increased from $178 million in 2002 to $210 million in 2010, an increase of almost 18 percent. Most of the increase came from a 37 percent increase in revenue from services provided to recipients of Medicaid's Supports for Community Living waiver. Other Medicaid revenue, excluding the Michelle P waiver, increased by 12 percent, while combined revenue from the block grants increased approximately 10 percent. Revenue from other federal sources declined 29 percent.

In FY 2009, most of the centers began implementing services under the Michelle P Medicaid waiver program. This program enables persons with developmental disabilities to continue living in their homes by purchasing support services, such as personal and attendant care services. The centers complete a consumer's assessment and reassessment, and all but one help the consumers access needed services in the community. In the Comprehend region, the acquisition of services is assisted by the Area Agency on Aging.

State Revenue

Department for Behavioral Health, Developmental and Intellectual Disabilities revenue declined more than 16 percent from FY 2002 to FY 2010. State revenue increased more than 12 percent.

Revenue from the Department for Behavioral Health, Developmental and Intellectual Disabilities declined more than 16 percent from FY 2002 to FY 2010. This revenue represented 82 percent of centers' state revenue from FY 2002 to FY 2005 and

61 percent from FY 2006 to FY 2010. The remaining state revenue came from other agencies, such as the Department for Community Based Services. Table 3.4 shows state revenue from the department and other state sources for FY 2002 and FY 2010 and the percentage change over the period.

Table 3.4
Inflation-Adjusted State Revenue By Source
(In Millions Of Dollars)
Fiscal Year 2002 And Fiscal Year 2010

	2002		2010		
State Revenue Source	**Amount**	**% of State Revenue**	**Amount**	**% of State Revenue**	**% Change 2002 to 2010**
DBHDID	$85.8	82.0%	$71.8	61.2%	-16.3%
Other state revenue	18.8	18.0	45.5	38.9	142.5
Total	$104.5	100.0%	$117.3	100.0%	12.2%

Note: Revenue is adjusted for inflation to be in 2001 dollars. DBHDID is the Department for Behavioral Health, Developmental and Intellectual Disabilities. Amounts do not add up to totals shown because of rounding.
Source: Compiled by Program Review staff from information obtained from the regions.

Revenue from the department declined more than 16 percent from FY 2002 to FY 2010. Other state revenue increased more than 142 percent. Total state revenue increased approximately 12 percent over the period.

Community Care Support

The community care support grants are state general funds intended to support the safety net by funding services for consumers who have no other payer source.

The majority of the centers' state general fund revenue is for specific services for specific consumer populations. For example, certain general fund allocations are dedicated to substance abuse, mental health, and intellectual and other developmental disabilities services, and they include specific allocations for services such as jail triage and crisis response. The community care support grants to each region from the state general fund are flexible and are intended to support the safety net by funding services for consumers who have no other payer source.

Community care support funding is allocated by the department to the regions based on a formula in 908 KAR 2:050. The four parts of the formula are

- per capita funds (15 percent),
- discretionary funds (10 percent) allocated at the discretion of the cabinet secretary,
- cost-related fee-for-service funds (60 percent) allocated based on service units reported in each region's annual plan and budget, and

- Incentive funds (15 percent) allocated based on the local tax match and other local match of each region. These funds are weighted based on the per capita wealth of the region. Local tax match may be a mental health and intellectual disability tax and/or a direct appropriation by a county fiscal court or city legislative body. Other local match includes in-kind contributions, cash donations, sale of workshop products, interest income, rental income, and certain funds derived from affiliates.

Adjusted for inflation, the community care support funds declined more than 18 percent from $24 million in FY 2001 to $19.6 million in FY 2010.

Adjusted for inflation, community care support funds declined more than 18 percent from $24 million in FY 2001 to $19.6 million in FY 2010. Table 3.5 shows the total allocation of community care support dollars by region for FY 2001 and FY 2010 and the percentage change over the period. Included for each year is the percentage of the total allocation for that region.

Table 3.5
Inflation-Adjusted Community Care Support Allocations By Region
Fiscal Year 2001 And Fiscal Year 2010

	2001		2010		
Region	Amount	% of Total	Amount	% of Total	% Change 2001 to 2010
Four Rivers	$1,137,139	4.7%	$950,729	4.8%	-16.4%
Pennyroyal	1,139,091	4.7	872,402	4.4	-23.4
River Valley	1,141,330	4.7	954,501	4.9	-16.4
LifeSkills	1,506,801	6.3	1,218,901	6.2	-19.1
Communicare	1,445,403	6.0	1,093,030	5.6	-24.4
Seven Counties	5,030,762	21.0	4,176,378	21.3	-17.0
NorthKey	1,858,637	7.7	1,805,966	9.2	-2.8
Comprehend	470,441	2.0	387,860	2.0	-17.6
Pathways	1,476,235	6.1	1,260,682	6.4	-14.6
Mountain	1,542,018	6.4	1,134,658	5.8	-26.4
Kentucky River	1,302,726	5.4	1,060,425	5.4	-18.6
Cumberland River	1,503,188	6.2	1,146,652	5.8	-23.7
Adanta	955,806	4.0	761,241	3.9	-20.4
Bluegrass	3,573,823	14.8	2,798,110	14.3	-21.7
State	$24,083,400	100.0%	$19,621,534	100.0%	-18.5%

Note: Allocations are adjusted for inflation to be in 2001 dollars. Amounts may not sum to totals shown because of rounding.
Source: Compiled by Program Review staff from information obtained from the Department for Behavioral Health, Developmental and Intellectual Disabilities.

Potential Revenue Is Decreased By Charity Allowances

The charity allowance is the amount an indigent person is not required to pay.

The centers are required by statute to provide services regardless of a person's ability to pay. The charity allowance is the amount an indigent person is not required to pay and is determined on an income-related sliding fee schedule unique to each region.
In the 2007 study, Program Review staff obtained from each region its calculated charity allowance for FY 2001 to FY 2005. Staff used the calculations as an estimate of the amount of community care support funds that would be needed to maintain the safety net. However, the reliability of the estimate was uncertain because of different interpretations of what should be measured and variations in accounting systems among the centers. As a result, the estimate was not repeated in this update.

The variations among regions demonstrated the different ways that charity allowances are defined and reported. The differences may be caused, in part, by the definitions used by the centers in preparing their annual cost reports, which are required by the department. Certain costs, including charity allowances, courtesy allowances, and bad debts, are not allowed to be paid with federal funds and are deducted from total costs on the cost report.
Page 208.01 of the cost report instructions defines these terms:

- Charity allowances are reductions in charges made by the provider of services because of the person's indigence or medical indigence.
- Courtesy allowances are reductions in charges for services as approved by the policies of the governing board.
- Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services.

For the annual cost report, it would not be necessary for a center's accounting system to be able to distinguish between charity allowances, courtesy allowances, and bad debts, since the total of the three must be reported. However, the three terms imply different intent. A charity allowance is required by statute to ensure that indigent people are not denied care. A courtesy allowance is a business decision to collect less than the normal charge for a service, for example, to a corporate employer for which the center provides an employee assistance program. A bad debt is a charge that was expected to be collected but was not. Neither bad debts nor courtesy allowances are directly related to the statutory requirement to provide care to indigent persons.

The department, the centers, and legislators need to know how much charity care is being provided, and a standardized method of calculating and reporting charity care is necessary for developing a reasonable budget estimate. The recommendation from the 2007 report is repeated in this update.

Recommendation 3.1 (4.1 in 2007 report)

Recommendation 3.1

The Department for Behavioral Health, Developmental and Intellectual Disabilities should develop a standardized method to calculate charity allowances. The department should require the boards to use that method and report annually, in conjunction with their annual financial statement audit, a separate schedule of charity allowances. The boards' independent auditors should be required to certify that the charity allowances are reported in accordance with the department's instructions.

That recommendation has been partially implemented by the department. On June 15, 2007, the commissioner sent a letter to the regions with instructions on how to calculate charity allowances. However, the commissioner did not instruct the regions to include a separate schedule of charity allowances in their financial statements or to have independent auditors certify that the charity allowances are reported in accordance with the department's instructions. For this update, Program Review staff reviewed the regions' FY 2010 audited financial statements. Three regions reported an amount for the charity allowance in the notes to the statements. The other regions either did not report a charity allowance or combined it with courtesy allowances and/or bad debts. Thus, the centers appear to be able to calculate the amount of charity care they provide, but the calculation is not reported in publicly available financial statements.

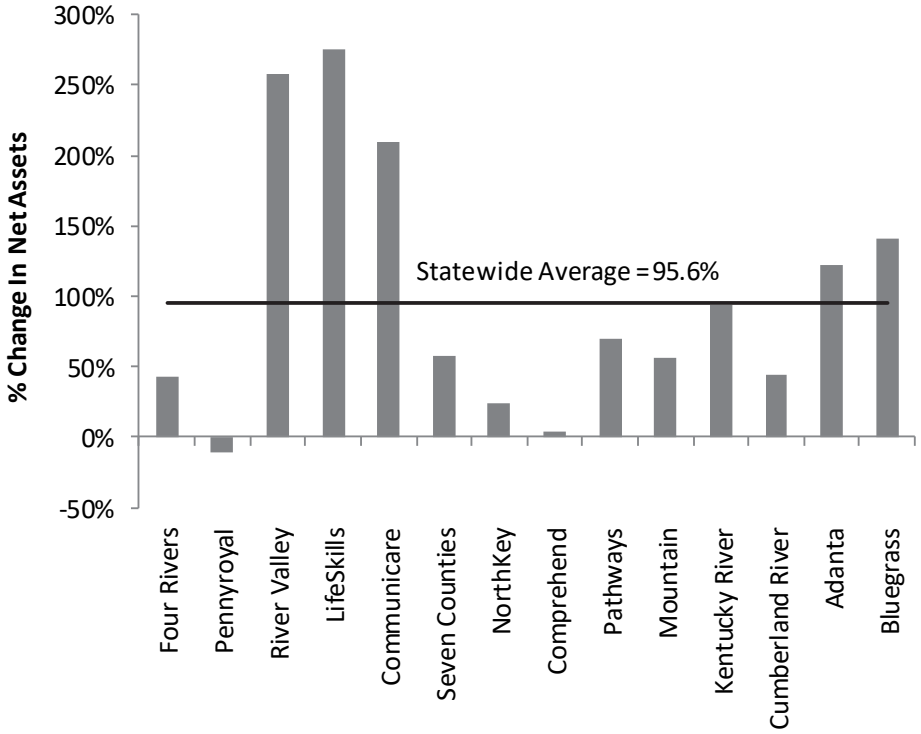
Financial Results Vary Among Regions

Figures 3.D and 3.E illustrate the total percentage change in net assets and the average annual operating margin for each region from FY 2001 to FY 2010. These indicators illustrate the financial health, operational efficiency, and profitability of the regions and the statewide system. These analyses include the effect of revenue received by one center for providing services to consumers in out-of-state facilities, since those revenues affect the overall financial health and profitability of that region. Appendix D has more detail on assets and operating margin by region.

Net assets of the regions, defined as total assets less total liabilities, nearly doubled from $94.5 million in FY 2001 to $184.8 million in FY 2010, an increase of more than 95 percent, on average. Net assets of Pennyroyal declined by 10 percent during the period. Those of LifeSkills increased 276 percent. However, the rate of increase in net assets is declining. From FY 2001 to FY 2005, net assets across all regions increased by 41 percent. Net assets increased 31 percent from FY 2006 to FY 2010.

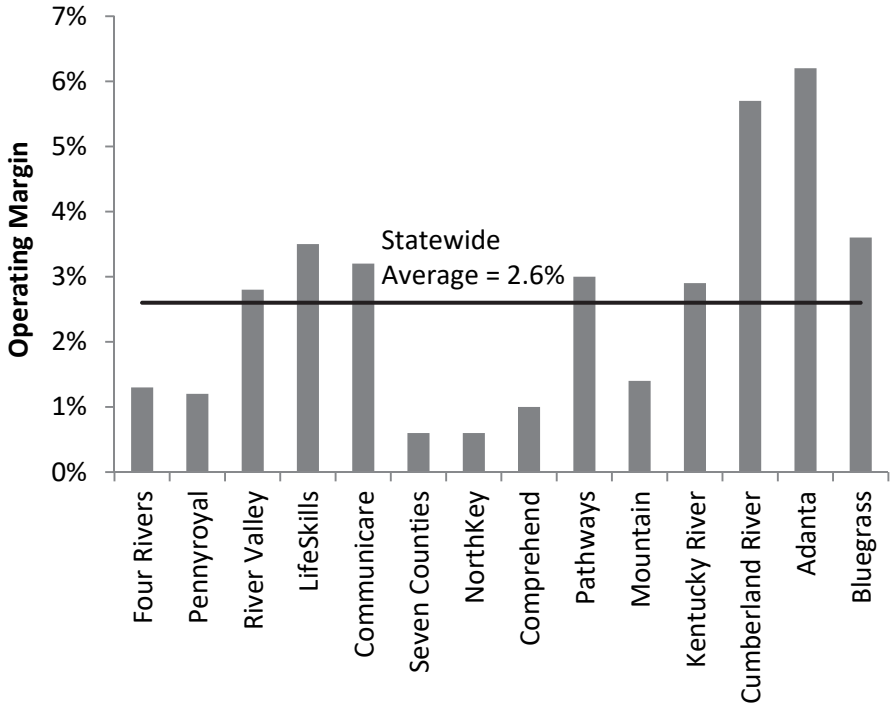
Similar variations are seen between regions in operating margins, defined as revenues divided by operating expenses minus 1. The operating margin is a measure of profit being earned compared to the cost of conducting business. The department considers an operating margin of greater than 2 percent to be acceptable. The statewide average was 2.6 percent. Average margins ranged from more than 6 percent in Adanta to 0.6 percent in Seven Counties and NorthKey. The average operating margin has been increasing at a faster rate in recent years. It had declined to 2 percent in FY 2006 but rose to 3.7 percent in FY 2010.

Figure 3.D
Percentage Change In Net Assets By Region
Fiscal Year 2001 To Fiscal Year 2010



Note: Assets are not adjusted for inflation.
Source: Compiled by Program Review staff from the regions' audited financial statements.

Figure 3.E
Average Operating Margin By Region
Fiscal Year 2001 To Fiscal Year 2010



Note: Margins ae not adjusted for inflation.
Source: Compiled by Program Review staff from regions' audited financial statements.

Financial results vary greatly among regions. The system statewide appears to be capable of providing current services to current populations, but the ability to expand services or serve larger populations is questionable, particularly in some regions.

Financial results vary greatly among regions. In general, the system statewide appears to be capable of providing current services to current populations. The system's capacity to expand services or serve larger populations is questionable, particularly in some regions.

The relative financial stability of the system could suffer with the state's implementation of Medicaid managed care for some behavioral health services. To continue to provide these services to existing and new clients, all boards except Seven Counties and Communicare are required to contract with the managed care organizations selected by the state. This requirement will increase the centers' administrative costs by working with up to three managed care organizations in addition to the Department for Medicaid Services. It is Program Review staff's understanding that the boards will receive their current Medicaid rates in the initial contracts. These rates, however, are subject to change upon notice by the managed care organizations.

Chapter 4

Consumer Outcomes And Other Performance Measures

Community Mental Health Services Block Grant

To receive federal Community Mental Health Services block grant funds, each regional board submits a comprehensive care plan that includes performance goals, spending plans, and data related to performance indicators and outcomes.

Federal Community Mental Health Services block grant funds may be used only for the care of adults with severe mental illness and children with serious emotional disturbance. Most of the block grant funding in Kentucky is delegated to the regional boards. The boards are allowed flexibility to accommodate local needs. The boards submit comprehensive regional care plans that include performance goals, spending plans, and data related to national and state performance indicators and outcomes.

For adults with severe mental illness, the major program initiatives in the 2011 application that involve the regions included

- continuing collaborative work to get peer support services as a Medicaid reimbursable service,
- acting as pilot sites for implementation of high fidelity supported employment services,
- continuing to develop criminal justice and behavioral health infrastructure,
- continuing to transition psychiatric long-term residents to the community,
- receiving necessary training related to administration of the Dual Diagnosis Capability in Addiction Treatment index within substance abuse and mental health programs,
- increasing homeless services, and
- designating 50 percent of block grant funds to evidence-based practices.[3]

For children with serious emotional disturbance, the major program initiatives included

- increasing consumer and family involvement in the children's behavioral health services system,
- promoting evidence-based and best practices and shared information among stakeholders,
- continuing collaborative work to promote suicide prevention efforts, and
- enhancing services through provider training for youth transitioning to adulthood.[4]

Substance Abuse Prevention And Treatment Block Grant

States are allowed to design solutions to specific local problems under the Substance Abuse Prevention and Treatment block grant.

The federal Substance Abuse Prevention and Treatment block grant pays for addiction prevention and treatment services, allowing states to design solutions to specific local problems. Covered services include outreach, detoxification, outpatient counseling, residential rehabilitation, hospital-based care (but not inpatient hospital services), vocational counseling, case management, central intake, and program administration. The grant also provides funding for primary prevention activities.

The requirements of the block grant are as follows:

- States must spend at least 20 percent on primary prevention efforts. Programs should provide individuals with education and counseling on substance abuse and activities to reduce risk of such abuse.
- Programs should target special populations, including pregnant and postpartum women and their children.
- The application for the grant must include a state plan for substance abuse prevention and treatment services.[5]

The Department for Behavioral Health, Developmental and Intellectual Disabilities is required to respond to 17 federal goals, objectives, and activities, noting the last year's accomplishments and the next year's related target objectives.

Unified Mental Health And Substance Abuse Block Grant Application

In 2012, the US Substance Abuse and Mental Health Services Administration will implement a unified mental health and substance abuse block grant application.

Beginning in 2012, the US Substance Abuse and Mental Health Services Administration (SAMHSA) will implement a unified mental health and substance abuse block grant application. The unified application process acknowledges the close relationship of mental health and substance abuse populations and services.

SAMHSA has established strategic initiatives for states to use in planning and using block grant funds for mental health and substance abuse, including the following:

- Prevention of substance abuse and mental illness: Community stakeholders, including individuals, families, schools, faith-based organizations, and workplaces, work to promote emotional health and reduce substance abuse. This initiative includes anti-tobacco and anti-suicide education and increased focus on the populations of high-risk youth, tribal youth, and military families.

- Trauma and justice: Health, behavioral health, and related systems reduce the impact of violence and trauma through education and treatment of at-risk populations in the criminal and juvenile justice systems.
- Military families: Military families are supported by ensuring behavioral health services are available.[6]

An area of emphasis is youth and adolescents. Other initiative areas include recovery support; health reform; health information technology; data, outcomes, and quality; and public awareness and support.

National Outcome Measures

National outcome measures focus on the major areas of mental health services, substance abuse treatment, and substance abuse prevention.

SAMHSA developed national outcome measures in an attempt to give a current and accurate national representation of mental health and substance abuse services. The measures are performance objectives or indicators of state and federally funded programs for substance abuse prevention, mental health promotion, early intervention, and treatment services.[7]

The major areas of mental health services, substance abuse treatment, and substance abuse prevention are divided into domains that include

- decreased symptoms from mental illness and abstinence from alcohol or drugs,
- increased functioning in the community,
- increased or retained employment or returning to or staying in school,
- decreased criminal justice involvement,
- increased stability in housing,
- increased social supports or social connectedness,
- increased access to services,
- increased retention in substance abuse treatment,
- increased youth retention of substance abuse prevention message,
- reduced utilization of psychiatric inpatient beds,
- clients' perception of care,
- cost effectiveness, and
- use of evidence-based practices.[8]

SAMHSA collects outcomes data from the states in three data sets: the National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services, the Center for Mental

Health Services Uniform Reporting System, and the Drug Abuse Warning Network.[9]

Compared to the averages of other reporting states, Kentucky was better for some outcome measures for consumers of mental health and substance abuse services but worse for others measures.

As shown in Table 4.1, Kentucky's mental health service consumer outcomes differed from the average outcomes of other reporting states. The rate of adult consumers competitively employed decreased from 21.8 percent in 2003 to 16.4 percent in 2010.[i] The percentage in 2010 for reporting states was 19 percent. The percentage of patients in Kentucky who were readmitted to state psychiatric hospitals within 180 days increased from 2003 to 2010, and Kentucky's rate was higher than that of reporting states in 2010.

For some measures, however; Kentucky had positive trends from 2003 to 2010 and better outcomes than other states in 2010:

- The percentage of consumers in private residences
- Utilization of services
- Readmissions to state psychiatric hospitals within 30 days

Table 4.2 indicates that outcomes for Kentuckians with substance use disorders also differed from the average outcomes of reporting states. The percentage of those needing treatment for alcohol abuse declined from 2003 to 2010 in Kentucky for those aged 12 to 17 and 18 to 25. For those age groups and for those 26 or older, the percentage needing treatment as of 2010 was lower in Kentucky than in reporting states. The worst Kentucky trend was the increase in the percentage for those aged 18 to 25 needing but not receiving treatment for illicit drug use. Compared to other states, Kentucky's percentage was lower than other states in 2003 but higher in 2010.

[i] Competitive employment is full- or part-time work for which the person is paid the typical wage the employer pays for other employees doing similar work.

Table 4.1
Selected National Outcome Measures For Persons With Mental Illness, 2003 And 2010

Outcome: Increased/retained employment
Measure: Percentage of adult consumers competitively employed

	2003	2010
Reporting states	21.9	19.0
Kentucky	21.8	16.4

Outcome: Stability in housing
Measure: Percentage of consumers by living situation

	Private Residence		Jail/Correctional Facility		Homeless Or Shelter	
	2003	2010	2003	2010	2003	2010
Reporting states	77.3	82.7	2.9	1.8	3.7	2.7
Kentucky	87.2	90.2	0.8	0.7	1.4	2.1

Outcome: Increased access to services
Measure: Rate of utilization of services per 1,000 population

	2003	2010
Reporting states	18.6	20.9
Kentucky	27.2	34.3

Outcome: Reduced utilization of psychiatric inpatient beds
Measure: Percentage of patients with readmissions to state psychiatric hospitals

	Within 30 Days		Within 180 Days	
	2003	2010	2003	2010
Reporting states	8.5	9.2	18.9	21.3
Kentucky	8.3	7.4	27.9	29.3

Outcome: Clients' perception of care
Measure: Percentage of consumers reporting positive outcomes from care

	Adult Consumers		Families Of Child/Adolescent Consumers	
	2003	2010	2003	2010
Reporting states	72.2	71.1	60.0	62.1
Kentucky	No report	73.2	No report	64.2

Source: Prepared by Program Review staff from information on the website of the Substance Abuse and Mental Health Services Administration.

Table 4.2
Selected National Outcome Measures For Persons With Substance Use Disorders, 2003 And 2009

Outcome: Increased access to services
Measure: Percentage needing but not receiving treatment for alcohol abuse in the past year

	Ages 12 to 17		Ages 18 to 25		Ages 26 or Older	
	2003	2009	2003	2009	2003	2009
Reporting States	5.6	4.5	16.9	15.9	5.7	5.8
Kentucky	5.2	3.8	14.2	13.3	4.6	4.7

Outcome: Increased access to services
Measure: Percentage needing but not receiving treatment for illicit drug abuse in the past year

	Ages 12 to 17		Ages 18 to 25		Ages 26 or Older	
	2003	2009	2003	2009	2003	2009
Reporting States	5.0	4.2	7.5	7.1	1.5	1.5
Kentucky	5.0	3.9	7.0	8.3	1.5	1.9

Source: Prepared by Program Review staff from information on the website of the Substance Abuse and Mental Health Services Administration.

Connection Between State And Federal Outcome Measures

During the Department for Behavioral Health, Developmental and Intellectual Disabilities' annual plan and budget process, the centers report progress on more than 20 outcome measures for persons with mental health and substance use disorders.

The contracts between the Department for Behavioral Health, Developmental and Intellectual Disabilities and the boards require the centers to collect consumer outcome data and support the use of additional outcome measures. During the department's annual plan and budget process, the centers are required to report progress on more than 20 federally designated outcome measures for persons with mental health and substance use disorders. The indicators fall into the following broad categories:

- Access to services
- Hospital readmission rates
- Evidence-based practices
- Crisis stabilization services (residential and mobile)
- Access and retention for substance abuse treatment

The focus of future federal funding provided by the department to the centers will be directed toward four purposes:

- To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time
- To fund those priority treatment and support services that are not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery

- To fund primary prevention—universal, selective, and indicated prevention activities and services for persons not identified as needing treatment
- To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis

Appendix A

Consumer Demographics By Region

Tables were compiled by Program Review staff based on data sets provided by the Department for Behavioral Health, Developmental and Intellectual Disabilities. Percentages may not add to 100.0 because of rounding.

Age Groups
Fiscal Year 2001 And Fiscal Year 2010

		FY 2001		FY 2010		
Region	**Age**	**Consumers**	**% Of Total**	**Consumers**	**% Of Total**	**% Change 2001-2010**
Four Rivers	<18	1,963	25.8	2,823	31.0	43.8
	18-40	3,391	44.6	3,667	40.3	8.1
	41-64	2,035	26.8	2,386	26.2	17.2
	65+	210	2.8	228	2.5	8.6
	Unknown	0	–	3	0.0	N/A
	Total	7,599	100.0	9,107	100.0	
Pennyroyal	<18	2,228	26.8	2,885	25.2	29.5
	18-40	3,576	43.0	4,727	41.4	32.2
	41-64	1,982	23.8	3,364	29.4	69.7
	65+	529	6.4	455	4.0	-14.0
	Unknown	0	–	0	–	N/A
	Total	8,315	100.0	11,431	100.0	
River Valley	<18	2,412	32.8	2,704	29.7	12.1
	18-40	3,047	41.5	3,451	37.9	13.3
	41-64	1,657	22.6	2,705	29.7	63.2
	65+	230	3.1	256	2.8	11.3
	Unknown	0	–	0	–	N/A
	Total	7,346	100.0	9,116	100.0	
LifeSkills	<18	3,231	29.3	3,625	34.8	12.2
	18-40	4,454	40.3	3,625	34.8	-18.6
	41-64	2,949	26.7	2,863	27.5	-2.9
	65+	354	3.2	311	3.0	-12.1
	Unknown	53	0.5	2	0.0	-96.2
	Total	11,041	100.0	10,426	100.0	
Communicare	<18	1,833	28.9	3,908	37.7	113.2
	18-40	2,640	41.7	3,625	34.9	37.3
	41-64	1,621	25.6	2,518	24.3	55.3
	65+	242	3.8	326	3.1	34.7
	Unknown	0	–	0	–	N/A
	Total	6,336	100.0	10,377	100.0	

Region	Age	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
Seven Counties	<18	8,403	39.6	12,078	41.1	43.7
	18-40	6,800	32.1	9,594	32.7	41.1
	41-64	4,732	22.3	6,538	22.3	38.2
	65+	1,278	6.0	1,149	3.9	-10.1
	Unknown	1	0.0	1	0.0	0.0
	Total	21,214	100.0	29,360	100.0	
NorthKey	<18	2,006	33.2	2,994	28.4	49.3
	18-40	2,358	39.0	4,198	39.8	78.0
	41-64	1,460	24.2	3,090	29.3	111.6
	65+	220	3.6	262	2.5	19.1
	Unknown	0	–	0	–	N/A
	Total	6,044	100.0	10,544	100.0	
Comprehend	<18	1,146	34.1	1,310	31.3	14.3
	18-40	1,353	40.3	1,576	37.7	16.5
	41-64	746	22.2	1,149	27.5	54.0
	65+	112	3.3	146	3.5	30.4
	Unknown	0	–	0	–	N/A
	Total	3,357	100.0	4,181	100.0	
Pathways	<18	2,942	28.1	3,789	27.5	28.8
	18-40	4,581	43.7	5,742	41.7	25.3
	41-64	2,579	24.6	3,800	27.6	47.3
	65+	380	3.6	427	3.1	12.4
	Unknown	2	0.0	13	0.1	550.0
	Total	10,484	100.0	13,771	100.0	
Mountain	<18	2,501	22.3	2,801	25.4	12.0
	18-40	4,532	40.5	4,039	36.6	-10.9
	41-64	3,652	32.6	3,804	34.5	4.2
	65+	311	2.8	364	3.3	17.0
	Unknown	204	1.8	14	0.1	-93.1
	Total	11,200	100.0	11,022	100.0	
Kentucky River	<18	1,895	25.5	2,515	25.6	32.7
	18-40	3,265	43.9	4,069	41.4	24.6
	41-64	2,138	28.8	2,964	30.2	38.6
	65+	137	1.8	229	2.3	67.2
	Unknown	1	0.0	42	0.4	4100.0
	Total	7,436	100.0	9,819	100.0	
Cumberland River	<18	2,603	27.8	4,374	32.5	68.0
	18-40	3,713	39.7	4,955	36.8	33.5
	41-64	2,775	29.7	3,793	28.2	36.7
	65+	257	2.7	334	2.5	30.0
	Unknown	0	–	0	–	N/A
	Total	9,348	100.0	13,456	100.0	

Region	Age	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
Adanta	<18	3,400	34.5	3,508	38.8	3.2
	18-40	3,587	36.4	2,956	32.7	-17.6
	41-64	2,559	25.9	2,267	25.1	-11.4
	65+	319	3.2	306	3.4	-4.1
	Unknown	1	0.0	0	–	-100.0
	Total	9,866	100.0	9,037	100.0	
Bluegrass	<18	7,477	33.0	9,692	38.5	29.6
	18-40	9,208	40.6	8,421	33.4	-8.5
	41-64	5,286	23.3	6,426	25.5	21.6
	65+	693	3.1	659	2.6	-4.9
	Unknown	8	0.0	4	0.0	-50.0
	Total	22,672	100.0	25,202	100.0	
State	<18	44,040	31.0	59,006	33.4	34.0
	18-40	56,505	39.7	64,645	36.5	14.4
	41-64	36,171	25.4	47,667	27.0	31.8
	65+	5,272	3.7	5,452	3.1	3.4
	Unknown	270	0.2	79	0.0	-70.7
	Total	142,258	100.0	176,849	100.0	

Racial Demographics
Fiscal Year 2003 And Fiscal Year 2010

Region	Race	FY 2003 Consumers	FY 2003 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2003-2010
Four Rivers	White	6,758	86.8	7,993	87.8	18.3
	African American	932	12.0	997	10.9	7.0
	Other	91	1.2	117	1.3	28.6
	Unknown	1	0.0	0	0.0	-100.0
	Total	7,782	100.0	9,107	100.0	
Pennyroyal	White	7,705	86.7	9,150	80.0	18.8
	African American	1,066	12.0	1,524	13.3	43.0
	Other	121	1.4	757	6.6	525.6
	Unknown	0	0.0	0	0.0	N/A
	Total	8,892	100.0	11,431	100.0	
River Valley	White	7,468	89.9	7,608	83.5	1.9
	African American	617	7.4	670	7.3	8.6
	Other	224	2.7	838	9.2	274.1
	Unknown	0	0.0	0	0.0	N/A
	Total	8,309	100.0	9,116	100.0	
LifeSkills	White	10,151	89.4	8,728	84.0	-14.0
	African American	943	8.3	740	7.1	-21.5
	Other	162	1.4	854	8.2	427.2
	Unknown	93	0.8	73	0.7	-21.5
	Total	11,349	100.0	10,395	100.0	
Communicare	White	6,213	86.5	9,473	91.3	52.5
	African American	526	7.3	791	7.6	50.4
	Other	214	3.0	113	1.1	-47.2
	Unknown	232	3.2	0	0.0	-100.0
	Total	7,185	100.0	10,377	100.0	
Seven Counties	White	13,867	55.3	14,738	50.2	6.3
	African American	6,554	26.1	7,708	26.3	17.6
	Other	668	2.7	6,901	23.5	933.1
	Unknown	3,988	15.9	13	0.0	-99.7
	Total	25,077	100.0	29,360	100.0	
NorthKey	White	6,346	91.3	9,550	90.6	50.5
	African American	490	7.0	715	6.8	45.9
	Other	117	1.7	279	2.6	138.5
	Unknown	0	0.0	0	0.0	N/A
	Total	6,953	100.0	10,544	100.0	
Comprehend	White	3,376	94.5	3,978	95.1	17.8
	African American	137	3.8	162	3.9	18.2
	Other	60	1.7	41	1.0	-31.7
	Unknown	0	0.0	0	0.0	N/A
	Total	3,573	100.0	4,181	100.0	

Region	Race	FY 2003 Consumers	FY 2003 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2003-2010
Pathways	White	11,972	94.8	13,366	97.1	11.6
	African American	168	1.3	240	1.7	42.9
	Other	489	3.9	152	1.1	-68.9
	Unknown	0	0.0	13	0.1	N/A
	Total	12,629	100.0	13,771	100.0	
Mountain	White	10,747	99.3	10,943	99.3	1.8
	African American	48	0.4	40	0.4	-16.7
	Other	27	0.2	32	0.3	18.5
	Unknown	0	0.0	7	0.1	N/A
	Total	10,822	100.0	11,022	100.0	
Kentucky River	White	7,755	98.9	9,620	98.0	24.0
	African American	48	0.6	76	0.8	58.3
	Other	13	0.2	66	0.7	407.7
	Unknown	22	0.3	57	0.6	159.1
	Total	7,838	100.0	9,819	100.0	
Cumberland River	White	11,726	98.5	13,355	99.2	13.9
	African American	154	1.3	92	0.7	-40.3
	Other	20	0.2	9	0.1	-55.0
	Unknown	0	0.0	0	0.0	N/A
	Total	11,900	100.0	13,456	100.0	
Adanta	White	9,210	95.5	8,531	94.4	-7.4
	African American	301	3.1	262	2.9	-13.0
	Other	130	1.3	242	2.7	86.2
	Unknown	0	0.0	2	0.0	N/A
	Total	9,641	100.0	9,037	100.0	
Bluegrass	White	19,678	84.8	20,253	80.4	2.9
	African American	2,704	11.6	2,705	10.7	0.0
	Other	828	3.6	2,241	8.9	170.7
	Unknown	4	0.0	3	0.0	-25.0
	Total	23,214	100.0	25,202	100.0	
State	White	132,972	85.7	147,286	83.3	10.8
	African American	14,688	9.5	16,722	9.5	13.8
	Other	3,164	2.0	12,642	7.1	299.6
	Unknown	4,340	2.8	168	0.1	-96.1
	Total	155,164	100.0	176,818	100.0	

Note: “Other” includes Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and other classifications. These were combined because of the low numbers attributed.

Referral Sources
Fiscal Year 2001 And Fiscal Year 2010

Region	Type Of Referral	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
Four Rivers	Agency referral	879	11.6	1,271	14.0	44.6
	Inpatient treatment facility	642	8.4	1,029	11.3	60.3
	Judicial system	1,878	24.7	1,709	18.8	-9.0
	Not available/collected	886	11.7	N/A	N/A	N/A
	Personal	2,578	33.9	3,801	41.7	47.4
	Physician	602	7.9	1,121	12.3	86.2
	Other	134	1.8	176	1.9	31.3
	Total	7,599	100.0	9,107	100.0	
Pennyroyal	Agency referral	928	11.2	1,104	9.7	19.0
	Inpatient treatment facility	523	6.3	641	5.6	22.6
	Judicial system	1,710	20.6	2,146	18.8	25.5
	Not available/collected	0	0.0	N/A	N/A	N/A
	Personal	3,510	42.2	6,074	53.1	73.0
	Physician	809	9.7	1,466	12.8	81.2
	Other	835	10.0	0	0.0	-100.0
	Total	8,315	100.0	11,431	100.0	
River Valley	Agency referral	1,266	17.2	677	7.4	-46.5
	Inpatient treatment facility	501	6.8	646	7.1	28.9
	Judicial system	1,081	14.7	442	4.8	-59.1
	Not available/collected	126	1.7	N/A	N/A	N/A
	Personal	2,542	34.6	5,368	58.9	111.2
	Physician	417	5.7	1,074	11.8	157.6
	Other	1,413	19.2	909	10.0	-35.7
	Total	7,346	100.0	9,116	100.0	
LifeSkills	Agency referral	1,596	14.5	1,647	15.8	3.2
	Inpatient treatment facility	568	5.1	687	6.6	21.0
	Judicial system	2,164	19.6	1,582	15.2	-26.9
	Not available/collected	1,693	15.3	N/A	N/A	N/A
	Personal	3,392	30.7	4,290	41.3	26.5
	Physician	1,157	10.5	1,046	10.1	-9.6
	Other	471	4.3	1,143	11.0	142.7
	Total	11,041	100.0	10,395	100.0	
Communicare	Agency referral	759	12.0	2,478	23.9	226.5
	Inpatient treatment facility	411	6.5	1,007	9.7	145.0
	Judicial system	1,058	16.7	800	7.7	-24.4
	Not available/collected	222	3.5	N/A	N/A	N/A
	Personal	2,775	43.8	4,819	46.4	73.7
	Physician	697	11.0	1,033	10.0	48.2
	Other	415	6.5	240	2.3	-42.2
	Total	6,337	100.0	10,377	100.0	

Region	Type Of Referral	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
Seven Counties	Agency referral	5,047	23.8	7,797	26.6	54.5
	Inpatient treatment facility	2,511	11.8	3,328	11.3	32.5
	Judicial system	1,776	8.4	2,534	8.6	42.7
	Not available/collected	419	2.0	N/A	N/A	N/A
	Personal	6,591	31.1	11,445	39.0	73.6
	Physician	825	3.9	1,454	5.0	76.2
	Other	4,044	19.1	2,802	9.5	-30.7
	Total	21,213	100.0	29,360	100.0	
NorthKey	Agency referral	1,285	21.3	1,955	18.5	52.1
	Inpatient treatment facility	739	12.2	1,392	13.2	88.4
	Judicial system	763	12.6	1,521	14.4	99.3
	Not available/collected	84	1.4	N/A	N/A	N/A
	Personal	2,033	33.6	4,242	40.2	108.7
	Physician	676	11.2	1,122	10.6	66.0
	Other	464	7.7	312	3.0	-32.8
	Total	6,044	100.0	10,544	100.0	
Comprehend	Agency referral	725	21.6	664	15.9	-8.4
	Inpatient treatment facility	187	5.6	251	6.0	34.2
	Judicial system	768	22.9	713	17.1	-7.2
	Not available/collected	13	0.4	N/A	N/A	N/A
	Personal	1,244	37.1	1,811	43.3	45.6
	Physician	360	10.7	689	16.5	91.4
	Other	60	1.8	53	1.3	-11.7
	Total	3,357	100.0	4,181	100.0	
Pathways	Agency referral	2,915	27.8	2,898	21.0	-0.6
	Inpatient treatment facility	718	6.8	1,012	7.3	40.9
	Judicial system	2,195	20.9	1,986	14.4	-9.5
	Not available/collected	227	2.2	N/A	N/A	N/A
	Personal	3,496	33.4	6,033	43.8	72.6
	Physician	853	8.1	1,408	10.2	65.1
	Other	78	0.7	434	3.2	456.4
	Total	10,482	100.0	13,771	100.0	
Mountain	Agency referral	1,023	9.1	1,480	13.4	44.7
	Inpatient treatment facility	968	8.6	897	8.1	-7.3
	Judicial system	1,193	10.7	1,228	11.1	2.9
	Not available/collected	266	2.4	N/A	N/A	N/A
	Personal	5,400	48.2	4,861	44.1	-10.0
	Physician	1,763	15.7	2,318	21.0	31.5
	Other	584	5.2	238	2.2	-59.2
	Total	11,197	100.0	11,022	100.0	

Region	Type Of Referral	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
Kentucky River	Agency referral	920	12.4	1,011	10.3	9.9
	Inpatient treatment facility	546	7.3	236	2.4	-56.8
	Judicial system	919	12.4	873	8.9	-5.0
	Not available/collected	338	4.5	N/A	N/A	N/A
	Personal	3,141	42.2	4,751	48.4	51.3
	Physician	1,181	15.9	1,241	12.6	5.1
	Other	390	5.2	1,707	17.4	337.7
	Total	7,435	100.0	9,819	100.0	
Cumberland River	Agency referral	1,569	16.8	1,937	14.4	23.5
	Inpatient treatment facility	671	7.2	533	4.0	-20.6
	Judicial system	1,476	15.8	2,092	15.5	41.7
	Not available/collected	140	1.5	N/A	N/A	N/A
	Personal	3,735	40.0	7,709	57.3	106.4
	Physician	1,057	11.3	1,185	8.8	12.1
	Other	700	7.5	0	0.0	-100.0
	Total	9,348	100.0	13,456	100.0	
Adanta	Agency referral	1,898	19.2	1,517	16.8	-20.1
	Inpatient treatment facility	526	5.3	318	3.5	-39.5
	Judicial system	1,552	15.7	1,258	13.9	-18.9
	Not available/collected	715	7.2	N/A	N/A	N/A
	Personal	3,995	40.5	4,151	45.9	3.9
	Physician	1,144	11.6	1,033	11.4	-9.7
	Other	36	0.4	760	8.4	2011.1
	Total	9,866	100.0	9,037	100.0	
Bluegrass	Agency referral	3,918	17.3	4,309	17.1	10.0
	Inpatient treatment facility	2,392	10.6	2,433	9.7	1.7
	Judicial system	2,973	13.1	2,196	8.7	-26.1
	Not available/collected	143	0.6	N/A	N/A	N/A
	Personal	9,254	40.8	12,324	48.9	33.2
	Physician	2,255	9.9	2,575	10.2	14.2
	Other	1,732	7.6	1,365	5.4	-21.2
	Total	22,667	100.0	25,202	100.0	
State	Agency referral	24,728	17.4	30,745	17.4	24.3
	Inpatient treatment facility	11,903	8.4	14,410	8.1	21.1
	Judicial system	21,506	15.1	21,080	11.9	-2.0
	Not available/collected	5,272	3.7	N/A	N/A	N/A
	Personal	53,686	37.7	81,679	46.2	52.1
	Physician	13,796	9.7	18,765	10.6	36.0
	Other	11,356	8.0	10,139	5.7	-10.7
	Total	142,247	100.0	176,818	100.0	

Living Arrangements
Fiscal Year 2001 And Fiscal Year 2010

		FY 2001		FY 2010		
Region	Living Arrangement	Consumers	% Of Total	Consumers	% Of Total	% Change 2001-2010
Four Rivers	No fixed residence	80	1.1	156	1.7	95.0
	Staffed residence	77	1.0	124	1.4	61.0
	Unstaffed residence	6,312	83.1	8,300	91.1	31.5
	Licensed long-term care	62	0.8	101	1.1	62.9
	Other	1,068	14.1	426	4.7	-60.1
	Total	7,599	100.0	9,107	100.0	
Pennyroyal	No fixed residence	21	0.3	90	0.8	328.6
	Staffed residence	8	0.1	171	1.5	2037.5
	Unstaffed residence	8,043	96.7	10,438	91.3	29.8
	Licensed long-term care	130	1.6	434	3.8	233.8
	Other	113	1.4	298	2.6	163.7
	Total	8,315	100.0	11,431	100.0	
River Valley	No fixed residence	224	3.0	145	1.6	-35.3
	Staffed residence	90	1.2	204	2.2	126.7
	Unstaffed residence	5,825	79.3	8,318	91.2	42.8
	Licensed long-term care	289	3.9	221	2.4	-23.5
	Other	918	12.5	228	2.5	-75.2
	Total	7,346	100.0	9,116	100.0	
LifeSkills	No fixed residence	60	0.5	153	1.5	155.0
	Staffed residence	94	0.9	125	1.2	33.0
	Unstaffed residence	9,517	86.2	8,668	83.4	-8.9
	Licensed long-term care	216	2.0	162	1.6	-25.0
	Other	1,154	10.5	1,287	12.4	11.5
	Total	11,041	100.0	10,395	100.0	
Communicare	No fixed residence	82	1.3	136	1.3	65.9
	Staffed residence	134	2.1	119	1.1	-11.2
	Unstaffed residence	5,260	83.0	9,345	90.1	77.7
	Licensed long-term care	138	2.2	138	1.3	0.0
	Other	723	11.4	639	6.2	-11.6
	Total	6,337	100.0	10,377	100.0	
Seven Counties	No fixed residence	876	4.1	1,128	3.8	28.8
	Staffed residence	538	2.5	539	1.8	0.2
	Unstaffed residence	14,821	69.9	22,581	76.9	52.4
	Licensed long-term care	557	2.6	544	1.9	-2.3
	Other	4,421	20.8	4,568	15.6	3.3
	Total	21,213	100.0	29,360	100.0	

Region	Living Arrangement	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
NorthKey	No fixed residence	205	3.4	433	4.1	111.2
	Staffed residence	156	2.6	302	2.9	93.6
	Unstaffed residence	4,954	82.0	8,748	83.0	76.6
	Licensed long-term care	263	4.4	312	3.0	18.6
	Other	466	7.7	749	7.1	60.7
	Total	6,044	100.0	10,544	100.0	
Comprehend	No fixed residence	31	0.9	45	1.1	45.2
	Staffed residence	17	0.5	18	0.4	5.9
	Unstaffed residence	3,125	93.1	3,846	92.0	23.1
	Licensed long-term care	87	2.6	43	1.0	-50.6
	Other	97	2.9	229	5.5	136.1
	Total	3,357	100.0	4,181	100.0	
Pathways	No fixed residence	78	0.7	186	1.4	138.5
	Staffed residence	161	1.5	394	2.9	144.7
	Unstaffed residence	8,551	81.6	12,455	90.4	45.7
	Licensed long-term care	0	0.0	133	1.0	N/A
	Other	1,692	16.1	603	4.4	-64.4
	Total	10,482	100.0	13,771	100.0	
Mountain	No fixed residence	73	0.7	95	0.9	30.1
	Staffed residence	36	0.3	73	0.7	102.8
	Unstaffed residence	9,113	81.4	10,045	91.1	10.2
	Licensed long-term care	218	1.9	177	1.6	-18.8
	Other	1,757	15.7	632	5.7	-64.0
	Total	11,197	100.0	11,022	100.0	
Kentucky River	No fixed residence	45	0.6	164	1.7	264.4
	Staffed residence	41	0.6	103	1.0	151.2
	Unstaffed residence	6,681	89.9	8,587	87.5	28.5
	Licensed long-term care	82	1.1	217	2.2	164.6
	Other	586	7.9	748	7.6	27.6
	Total	7,435	100.0	9,819	100.0	
Cumberland River	No fixed residence	55	0.6	141	1.0	156.4
	Staffed residence	83	0.9	95	0.7	14.5
	Unstaffed residence	8,209	87.8	12,777	95.0	55.6
	Licensed long-term care	160	1.7	152	1.1	-5.0
	Other	841	9.0	291	2.2	-65.4
	Total	9,348	100.0	13,456	100.0	

Region	Living Arrangement	FY 2001 Consumers	FY 2001 % Of Total	FY 2010 Consumers	FY 2010 % Of Total	% Change 2001-2010
Adanta	No fixed residence	69	0.7	74	0.8	7.2
	Staffed residence	132	1.3	225	2.5	70.5
	Unstaffed residence	8,291	84.0	8,219	90.9	-0.9
	Licensed long-term care	130	1.3	175	1.9	34.6
	Other	1,244	12.6	344	3.8	-72.3
	Total	9,866	100.0	9,037	100.0	
Bluegrass	No fixed residence	781	3.4	971	3.9	24.3
	Staffed residence	354	1.6	650	2.6	83.6
	Unstaffed residence	19,351	85.4	22,541	89.4	16.5
	Licensed long-term care	471	2.1	287	1.1	-39.1
	Other	1,710	7.5	753	3.0	-56.0
	Total	22,667	100.0	25,202	100.0	
State	No fixed residence	2,680	1.9	3,917	2.2	46.2
	Staffed residence	1,921	1.4	3,142	1.8	63.6
	Unstaffed residence	118,053	83.0	154,868	87.6	31.2
	Licensed long-term care	2,803	2.0	3,096	1.8	10.5
	Other	16,790	11.8	11,795	6.7	-29.7
	Total	142,247	100.0	176,818	100.0	

Appendix B

Services By Type And Payment Source
Fiscal Year 2001 And Fiscal Year 2010

This table was compiled by Program Review staff from Schedule D of the regions' audited cost reports. Service types were defined as mental health (MH), substance abuse (SA), intellectual and other developmental disabilities (ID/DD), and other. "Other" represents services to persons with, for example, an acquired brain injury or services provided to a mix of consumers with various diagnoses. Percentages may not add to 100.0 because of rounding.

Types Of Services

Region	Service Type	FY 2001		FY 2010		% Change
		Services	% Of Total	Services	% Of Total	2001-2010
Four Rivers	MH	149,813	28.1	182,444	26.9	21.8
	SA	84,990	15.9	60,890	9.0	-28.4
	ID/DD	254,292	47.6	355,013	52.3	39.6
	Other	44,739	8.4	80,359	11.8	79.6
	Total	533,834	100.0	678,706	100.0	27.1
Pennyroyal	MH	204,464	32.4	200,374	36.7	-2.0
	SA	79,158	12.5	105,499	19.3	33.3
	ID/DD	217,606	34.4	72,868	13.3	-66.5
	Other	130,640	20.7	167,835	30.7	28.5
	Total	631,868	100.0	546,576	100.0	-13.5
River Valley	MH	421,518	48.6	441,473	38.5	4.7
	SA	27,970	3.2	89,659	7.8	220.6
	ID/DD	349,450	40.3	514,919	44.9	47.4
	Other	68,705	7.9	100,218	8.7	45.9
	Total	867,643	100.0	1,146,269	100.0	32.1
LifeSkills	MH	442,554	37.6	512,898	22.1	15.9
	SA	30,132	2.6	155,642	6.7	416.5
	ID/DD	596,484	50.6	1,305,071	56.3	118.8
	Other	109,275	9.3	345,131	14.9	215.8
	Total	1,178,445	100.0	2,318,742	100.0	96.8
Communicare	MH	172,935	15.9	466,473	14.8	169.7
	SA	31,934	2.9	49,101	1.6	53.8
	ID/DD	880,323	80.7	771,868	24.5	-12.3
	Other	5,166	0.5	1,867,668	59.2	36,053.1
	Total	1,090,358	100.0	3,155,110	100.0	189.4
Seven Counties	MH	1,263,206	61.7	1,243,085	61.1	-1.6
	SA	203,580	9.9	188,214	9.3	-7.5
	ID/DD	488,447	23.9	487,597	24.0	-0.2
	Other	92,649	4.5	114,114	5.6	23.2
	Total	2,047,882	100.0	2,033,010	100.0	-0.7

Region	Service Type	FY 2001 Services	FY 2001 % Of Total	FY 2010 Services	FY 2010 % Of Total	% Change 2001-2010
NorthKey	MH	222,440	44.1	327,633	31.8	47.3
	SA	40,474	8.0	50,216	4.9	24.1
	ID/DD	80,761	16.0	287,588	27.9	256.1
	Other	161,137	31.9	365,611	35.5	126.9
	Total	504,812	100.0	1,031,048	100.0	104.2
Comprehend	MH	153,317	28.6	194,609	27.6	26.9
	SA	43,407	8.1	136,623	19.4	214.7
	ID/DD	274,618	51.3	234,471	33.3	-14.6
	Other	63,991	12.0	138,307	19.6	116.1
	Total	535,333	100.0	704,010	100.0	31.5
Pathways	MH	576,383	35.3	532,742	40.0	-7.6
	SA	110,961	6.8	117,399	8.8	5.8
	ID/DD	303,794	18.6	496,743	37.3	63.5
	Other	640,284	39.2	185,327	13.9	-71.1
	Total	1,631,422	100.0	1,332,211	100.0	-18.3
Mountain	MH	371,652	57.9	383,418	43.7	3.2
	SA	18,260	2.8	37,770	4.3	106.8
	ID/DD	169,995	26.5	410,500	46.8	141.5
	Other	82,208	12.8	45,977	5.2	-44.1
	Total	642,115	100.0	877,665	100.0	36.7
Kentucky River	MH	314,726	52.3	415,441	45.0	32.0
	SA	25,302	4.2	58,469	6.3	131.1
	ID/DD	212,852	35.4	317,039	34.3	48.9
	Other	49,180	8.2	133,103	14.4	170.6
	Total	602,060	100.0	924,052	100.0	53.5
Cumberland River	MH	538,957	45.6	755,811	40.5	40.2
	SA	15,862	1.3	42,638	2.3	168.8
	ID/DD	521,016	44.1	923,845	49.5	77.3
	Other	106,724	9.0	145,057	7.8	35.9
	Total	1,182,559	100.0	1,867,351	100.0	57.9
Adanta	MH	600,782	50.7	399,578	22.6	-33.5
	SA	88,103	7.4	89,392	5.1	1.5
	ID/DD	345,208	29.2	1,130,887	64.0	227.6
	Other	150,016	12.7	147,377	8.3	-1.8
	Total	1,184,109	100.0	1,767,234	100.0	49.2
Bluegrass	MH	1,099,899	66.0	1,084,620	43.9	-1.4
	SA	107,759	6.5	121,351	4.9	12.6
	ID/DD	275,155	16.5	1,222,210	49.5	344.2
	Other	184,647	11.1	42,093	1.7	-77.2
	Total	1,667,460	100.0	2,470,274	100.0	48.1
State Total	MH	6,532,646	45.7	7,140,599	34.5	9.3
	SA	907,892	6.3	1,302,863	6.3	43.5
	ID/DD	4,970,001	34.8	8,530,619	40.5	68.6
	Other	1,889,361	13.2	3,878,177	18.7	105.3
	Total	14,299,900	100.0	20,852,258	100.0	44.8

This table was compiled by Program Review staff from Schedule D of the regions' audited cost reports. Payment sources were defined as

- Medicaid (other): Medicaid other than Supports for Community Living (SCL) waiver and the Michelle P waiver (MPW);
- Medicaid through the SCL and MPW waivers;
- DBHDID: Department for Behavioral Health, Developmental and Intellectual Disabilities; and
- Other: self-pay clients, private insurance, and other revenue.

Percentages may not add to 100.0 because of rounding.

Payment Sources

		FY 2001		FY 2010		
Region	**Payment Source**	**Services**	**% Of Total**	**Services**	**% Of Total**	**% Change 2001-2010**
Four Rivers	Medicaid (other)	67,391	12.6	84,101	12.4	24.8
	Medicaid (SCL MPW)	235,258	44.1	315,291	46.5	34.0
	DBHDID	168,381	31.5	215,161	31.7	27.8
	Other	62,804	11.8	64,153	9.5	2.1
	Total	533,834	100.0	678,706	100.0	27.1
Pennyroyal	Medicaid (other)	95,325	15.1	117,442	21.5	23.2
	Medicaid (SCL MPW)	206,254	32.6	108,077	19.8	-47.6
	DBHDID	192,142	30.4	178,259	32.6	-7.2
	Other	138,147	21.9	142,798	26.1	3.4
	Total	631,868	100.0	546,576	100.0	-13.5
River Valley	Medicaid (other)	265,333	30.6	282,515	24.6	6.5
	Medicaid (SCL MPW)	317,375	36.6	328,372	28.6	3.5
	DBHDID	200,810	23.1	287,575	25.1	43.2
	Other	84,125	9.7	247,807	21.6	194.6
	Total	867,643	100.0	1,146,269	100.0	32.1
LifeSkills	Medicaid (other)	282,578	24.0	287,024	12.4	1.6
	Medicaid (SCL MPW)	572,242	48.6	1,560,334	67.3	172.7
	DBHDID	242,552	20.6	349,776	15.1	44.2
	Other	81,073	6.9	121,608	5.2	50.0
	Total	1,178,445	100.0	2,318,742	100.0	96.8
Communicare	Medicaid (other)	93,882	8.6	374,711	11.9	299.1
	Medicaid (SCL MPW)	237,661	21.8	2,157,380	68.4	807.8
	DBHDID	681,807	62.5	546,332	17.3	-19.9
	Other	77,008	7.1	76,687	2.4	-0.4
	Total	1,090,358	100.0	3,155,110	100.0	189.4
Seven Counties	Medicaid (other)	883,816	43.2	1,071,684	52.7	21.3
	Medicaid (SCL MPW)	374,740	18.3	505,067	24.8	34.8
	DBHDID	511,277	25.0	359,354	17.7	-29.7
	Other	278,049	13.6	96,905	4.8	-65.1
	Total	2,047,882	100.0	2,033,010	100.0	-0.7

Region	Payment Source	FY 2001 Services	FY 2001 % Of Total	FY 2010 Services	FY 2010 % Of Total	% Change 2001-2010
NorthKey	Medicaid (other)	128,341	25.4	249,266	24.2	94.2
	Medicaid (SCL MPW)	65,907	13.1	225,746	21.9	242.5
	DBHDID	278,255	55.1	505,358	49.0	81.6
	Other	32,309	6.4	50,678	4.9	56.9
	Total	504,812	100.0	1,031,048	100.0	104.2
Comprehend	Medicaid (other)	101,019	18.9	97,729	13.9	-3.3
	Medicaid (SCL MPW)	267,771	50.0	233,756	33.2	-12.7
	DBHDID	132,683	24.8	324,032	46.0	144.2
	Other	33,860	6.3	48,493	6.9	43.2
	Total	535,333	100.0	704,010	100.0	31.5
Pathways	Medicaid (other)	244,700	15.0	506,087	38.0	106.8
	Medicaid (SCL MPW)	200,129	12.3	344,012	25.8	71.9
	DBHDID	318,147	19.5	426,814	32.0	34.2
	Other	868,446	53.2	55,298	4.2	-93.6
	Total	1,631,422	100.0	1,332,211	100.0	-18.3
Mountain	Medicaid (other)	267,674	41.7	285,461	32.5	6.6
	Medicaid (SCL MPW)	139,319	21.7	412,399	47.0	196.0
	DBHDID	209,762	32.7	121,258	13.8	-42.2
	Other	25,360	3.9	58,547	6.7	130.9
	Total	642,115	100.0	877,665	100.0	36.7
Kentucky River	Medicaid (other)	235,083	39.0	343,456	37.2	46.1
	Medicaid (SCL MPW)	183,580	30.5	303,040	32.8	65.1
	DBHDID	151,505	25.2	227,079	24.6	49.9
	Other	31,892	5.3	50,477	5.5	58.3
	Total	602,060	100.0	924,052	100.0	53.5
Cumberland River	Medicaid (other)	340,937	28.8	613,054	32.8	79.8
	Medicaid (SCL MPW)	503,617	42.6	910,477	48.8	80.8
	DBHDID	279,326	23.6	293,836	15.7	5.2
	Other	58,679	5.0	49,984	2.7	-14.8
	Total	1,182,559	100.0	1,867,351	100.0	57.9
Adanta	Medicaid (other)	484,574	40.9	610,913	34.6	26.1
	Medicaid (SCL MPW)	281,258	23.8	410,430	23.2	45.9
	DBHDID	284,230	24.0	222,140	12.6	-21.8
	Other	134,047	11.3	523,751	29.6	290.7
	Total	1,184,109	100.0	1,767,234	100.0	49.2
Bluegrass	Medicaid (other)	742,064	44.5	806,957	32.7	8.7
	Medicaid (SCL MPW)	204,564	12.3	933,827	37.8	356.5
	DBHDID	587,612	35.2	502,910	20.4	-14.4
	Other	133,220	8.0	226,580	9.2	70.1
	Total	1,667,460	100.0	2,470,274	100.0	48.1
State Total	Medicaid (other)	4,232,717	29.6	5,730,400	27.7	35.4
	Medicaid (SCL MPW)	3,789,675	26.5	8,748,208	42.3	130.8
	DBHDID	4,238,489	29.6	4,559,884	22.0	7.6
	Other	2,039,019	14.3	1,813,766	8.0	-18.5
	Total	14,299,900	100.0	20,852,258	100.0	44.8

Appendix C

Inflation-Adjusted Revenue By Region
Fiscal Year 2002 And Fiscal Year 2010

Tables were compiled by Program Review staff from financial information self-reported by the regions and reconciled in total to their audited financial statements. Revenues have been adjusted for inflation to be in 2001 dollars using the Consumer Price Index from the US Department of Labor's Bureau of Labor Statistics. Annual revenues are rounded to the nearest dollar, so they may not add to the totals shown. Percentages may not add to 100.0 because of rounding.

Total Revenue

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$9,720,887	3.0%	$11,410,216	3.0%	17.4%
Pennyroyal	12,816,980	4.0	18,940,291	4.9	47.8
River Valley	26,686,510	8.2	38,332,160	10.0	43.6
LifeSkills	21,568,540	6.7	24,246,870	6.3	12.4
Communicare	16,176,363	5.0	29,675,189	7.7	83.4
Seven Counties	64,670,692	20.0	73,935,682	19.2	14.3
NorthKey	19,391,410	6.0	25,375,334	6.6	30.9
Comprehend	6,073,626	1.9	6,476,610	1.7	6.6
Pathways	20,839,314	6.4	21,626,708	5.6	3.8
Mountain	15,668,098	4.8	15,800,783	4.1	0.8
Kentucky River	18,208,666	5.6	18,791,984	4.9	3.2
Cumberland River	19,445,670	6.0	22,432,708	5.8	15.4
Adanta	22,764,003	7.0	18,263,255	4.7	-19.8
Bluegrass	50,065,840	15.4	59,255,814	15.4	18.4
Total	$324,096,600	100.0%	$384,563,604	100.0%	18.7%

Federal Revenue

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$5,072,200	2.8%	$4,457,974	2.1%	-12.1%
Pennyroyal	5,262,461	3.0	7,366,294	3.5	40.0
River Valley	17,737,933	9.9	24,598,579	11.6	38.7
LifeSkills	12,428,983	7.0	13,965,257	6.6	12.4
Communicare	8,140,662	4.6	19,175,898	9.0	135.6
Seven Counties	40,175,822	22.5	34,816,820	16.4	-13.3
NorthKey	10,334,796	5.8	16,202,998	7.6	56.8
Comprehend	3,632,782	2.0	2,929,195	1.4	-19.4
Pathways	11,095,307	6.2	12,759,250	6.0	15.0
Mountain	8,995,409	5.0	8,053,384	3.8	-10.5
Kentucky River	8,473,101	4.8	11,965,476	5.6	41.2
Cumberland River	12,320,267	6.9	15,505,556	7.3	25.9
Adanta	11,911,953	6.7	13,137,013	6.2	10.3
Bluegrass	22,712,719	12.7	27,771,558	13.1	22.3
Total	$178,294,396	100.0%	$212,705,252	100.0%	19.3%

State Revenue

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$3,043,701	2.9%	$4,282,352	3.5%	40.7%
Pennyroyal	5,422,280	5.2	9,794,715	8.1	80.6
River Valley	4,091,140	3.9	11,567,613	9.5	182.7
LifeSkills	7,015,772	6.7	7,964,074	6.5	13.5
Communicare	5,994,703	5.7	5,477,450	4.5	-8.6
Seven Counties	19,382,672	18.5	34,467,664	28.3	77.8
NorthKey	6,832,020	6.5	5,556,340	4.6	-18.7
Comprehend	2,037,145	1.9	2,264,440	1.9	11.2
Pathways	7,234,588	6.9	6,233,913	5.1	-13.8
Mountain	4,779,135	4.6	4,653,218	3.8	-2.6
Kentucky River	8,404,897	8.0	4,684,259	3.9	-44.3
Cumberland River	5,277,833	5.0	3,710,195	3.1	-29.7
Adanta	9,415,942	9.0	4,053,656	3.3	-56.9
Bluegrass	15,700,978	15.0	16,889,683	13.9	7.6
Total	$104,632,804	100.0%	$121,599,573	100.0%	16.2%

Local Tax Match

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$301,373	12.1%	$385,376	17.5%	27.9%
Pennyroyal	0	0.0	7,840	0.4	4.0
River Valley	8,300	0.3	0	0.0	-100.0
LifeSkills	260,127	10.4	0	0.0	-100.0
Communicare	0	0.0	0	0.0	0.0
Seven Counties	832,739	33.3	550,142	25.0	-33.9
NorthKey	788,345	31.6	974,522	44.3	23.6
Comprehend	0	0.0	0	0.0	0.0
Pathways	0	0.0	0	0.0	0.0
Mountain	0	0.0	0	0.0	0.0
Kentucky River	11,873	0.5	9,800	0.4	-17.5
Cumberland River	17,983	0.7	12,439	0.6	-30.8
Adanta	17,414	0.7	0	0.0	-100.0
Bluegrass	260,426	10.4	259,122	11.8	-0.5
Total	$2,498,582	100.0%	$2,199,241	100.0%	-12.0%

Other Local Match

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$428,025	5.0	$739,460	5.9%	72.8%
Pennyroyal	820,732	9.5	580,319	4.6	-29.3
River Valley	975,068	11.3	0	0.0	-100.0
LifeSkills	115,635	1.3	1,052,536	8.4	810.2
Communicare	1,269,470	14.7	2,886,177	23.1	127.4
Seven Counties	1,024,111	11.9	703,657	5.6	-31.3
NorthKey	202,662	2.3	943,391	7.5	365.5
Comprehend	324,978	3.8	215,920	1.7	-33.6
Pathways	168,118	1.9	1,357,834	10.8	707.7
Mountain	1,116,684	12.9	1,226,321	9.8	9.8
Kentucky River	776,465	9.0	261,719	2.1	-66.3
Cumberland River	282,684	3.3	1,514,016	12.1	435.6
Adanta	229,292	2.7	102,766	0.8	-55.2
Bluegrass	900,983	10.4	933,188	7.5	3.6
Total	$8,634,904	100.0	$12,517,303	100.0%	45.0%

Charges To Patients

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$742,246	3.6%	$543,493	3.3%	-26.8%
Pennyroyal	1,108,489	5.3	1,191,124	7.2	7.5
River Valley	3,819,696	18.4	1,967,503	11.9	-48.5
LifeSkills	859,412	4.1	1,081,141	6.5	25.8
Communicare	544,105	2.6	1,455,343	8.8	167.5
Seven Counties	2,499,622	12.0	1,124,297	6.8	-55.0
NorthKey	740,146	3.6	1,328,849	8.0	79.5
Comprehend	78,722	0.4	750,516	4.5	853.4
Pathways	2,124,576	10.2	1,165,023	7.0	-45.2
Mountain	637,202	3.1	1,709,470	10.3	168.3
Kentucky River	502,729	2.4	1,183,703	7.1	135.5
Cumberland River	1,138,980	5.5	429,331	2.6	-62.3
Adanta	710,221	3.4	638,530	3.8	-10.1
Bluegrass	5,259,374	25.3	2,009,159	12.1	-61.8
Total	$20,765,519	100.0%	$16,577,482	100.0%	-20.2%

Other Revenue

Region	FY 2002	% of Total	FY 2010	% of Total	% Change 2002-2010
Four Rivers	$133,342	1.4%	$1,001,561	5.3%	651.1%
Pennyroyal	203,018	2.2	0	0.0	-100.0
River Valley	54,373	0.6	198,465	1.0	265.0
LifeSkills	888,612	9.6	183,862	1.0	-79.3
Communicare	227,424	2.5	680,321	3.6	199.1
Seven Counties	755,725	8.2	2,273,102	12.0	200.8
NorthKey	493,441	5.3	369,234	1.9	-25.2
Comprehend	0	0.0	316,539	1.7	1.7
Pathways	216,726	2.3	110,689	0.6	-48.9
Mountain	139,669	1.5	158,389	0.8	13.4
Kentucky River	39,600	0.4	687,027	3.6	1634.9
Cumberland River	407,923	4.4	1,261,170	6.7	209.2
Adanta	479,181	5.2	331,290	1.7	-30.9
Bluegrass	5,231,359	56.4	11,393,104	60.1	117.8
Total	$9,270,394	100.0%	$18,964,752	100.0%	104.6%

Appendix D

Financial Indicators By Region

Tables were compiled by Program Review staff from the regional boards' audited financial statements. Amounts are not adjusted for inflation.

Net assets equal assets minus liabilities and are an indicator of a region's financial position.

Percentages may not add to 100.0 because of rounding.

Net Assets By Region
Fiscal Year 2001 And Fiscal Year 2010

	FY 2001		FY 2010		
Region	Assets	% Of Total	Assets	% Of Total	% Change 2001-2010
Four Rivers	$3,075,375	3.3%	$4,395,343	2.4%	42.9%
Pennyroyal	6,871,828	7.3	6,157,102	3.3	-10.4
River Valley	4,128,925	4.4	14,755,615	8.0	257.4
LifeSkills	2,921,374	3.1	10,979,630	5.9	275.8
Communicare	3,891,888	4.1	12,019,323	6.5	208.8
Seven Counties	12,083,254	12.8	19,048,430	10.3	57.6
NorthKey	8,133,454	8.6	10,106,638	5.5	24.3
Comprehend	3,134,598	3.3	3,259,024	1.8	4.0
Pathways	7,161,604	7.6	12,128,882	6.6	69.4
Mountain	3,919,673	4.1	6,134,930	3.3	56.5
Kentucky River	5,644,363	6.0	10,971,293	5.9	94.4
Cumberland River	4,531,158	4.8	6,531,892	3.5	44.2
Adanta	7,498,355	7.9	16,652,397	9.0	122.1
Bluegrass	21,456,022	22.7	51,630,874	27.9	140.6
Total	$94,451,871	100.0%	$184,771,373	100.0%	95.6

Operating margin is defined as revenue divided by expenditures minus 1. It is an indicator of a region's profitability.

Operating Margin By Region
Fiscal Year 2001, Fiscal Year 2005, And Fiscal Year 2010

Region	FY 2001	FY 2005	2001-2005 Average	FY 2010	2001-2010 Average
Four Rivers	-1.3%	9.0%	3.9%	4.3%	1.3%
Pennyroyal	12.6	2.7	7.7	0.6	1.2
River Valley	0.6	0.3	0.5	5.2	2.8
LifeSkills	2.1	4.3	3.2	2.6	3.5
Communicare	3.5	2.7	3.1	11.1	3.2
Seven Counties	0.1	1.1	0.6	0.9	0.6
NorthKey	-1.0	-1.3	-1.2	3.3	0.6
Comprehend	2.5	0.9	1.7	-0.7	1.0
Pathways	7.2	-1.3	3.0	4.6	3.0
Mountain	-0.4	4.0	1.8	0.2	1.4
Kentucky River	4.2	3.2	3.7	0.8	2.9
Cumberland River	0.8	1.7	1.3	13.1	5.7
Adanta	7.7	3.7	5.7	3.0	6.2
Bluegrass	2.4	5.5	4.0	2.3	3.6
Average	2.9%	2.6%	2.8%	3.7%	2.6%

Appendix E

Response From The Department Of Behavioral Health, Developmental And Intellectual Disabilities

The department responded to the recommendations in the 2007 report that were repeated in this update. Recommendation 2.3 in the 2007 report is recommendation 1.3 in the update. Recommendation 4.1 in the 2007 report is recommendation 3.1 in the update.

Recommendation 2.3

The Department has begun making incremental changes as part of statewide strategic planning for improved intellectual and developmental disability, behavioral health and substance abuse services. In order to assist the Community Mental Health Centers (CMHCs) with their strategic planning, our Department continues to provide guidance through our plan and budget process and has also initiated meetings throughout the year with the Executive Directors of the CMHC's to discuss transformation of the behavioral health system.

During the plan and budget period, the CMHCs are required to report progress on over twenty federally designated National Outcome Measures for both mental health and substance use disorders. CMHCs also report on several State Performance Indicators. These indicators fall into the broad categories of the following:

- Access to Services
- Hospital Readmission Rates (30 and 180 days)
- Evidence Based Practices (EBPs)
- Crisis Stabilization Services (Residential and Mobile)
- Access and Retention for Substance Abuse Treatment

Due to a variety of factors including recent federal legislation, federal level Medicaid changes, economic conditions, military action abroad and growing best practices & prevention research, the focus of federal funding, that is allocated to the CMHCs from DBHDID, is now directed toward **four** purposes:

1) To fund priority treatment and support services for **individuals without insurance** or for whom coverage is terminated for short periods of time;

2) To fund those **priority treatment and support services not covered by Medicaid, Medicare or private insurance** for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery;

3) To **fund primary prevention** – universal, selective and indicated prevention activities and services for persons not identified as needing treatment; and

4) To **collect performance and outcome data** to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to **plan the implementation of new services** on a nationwide basis.

Additional activities aimed at ensuring that the CMHCs program planning is in line with the goals of the Department and its state and federal funders includes:

1) Since SFY 2011, the Division of Behavioral Health has required the CMHC's to allocate at least fifty percent of their Mental Health Block Grant funds to support the implementation of evidence-based practices for adults with SMI and/or children with SED; the CMHCs do not have requirements for spending a set amount on each population.
2) CMHC's must select from a list of recommended practices and report those they are implementing. These funds may be spent to provide evidence-based services to adults with SMI or children with SED.
3) There is an expectation for the CMHC's that receive Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to utilize EBPs. There are no requirements for what percentage of the funds must be spent on EBPs and there are no mandates for specific EBPs to be utilized.

DBH staff provide training and technical assistance regarding the implementation of evidence-based practices with fidelity. These include:

a) Motivational Interviewing
b) Seeking Safety
c) Medication Assisted Treatment
d) Cannabis Youth Treatment
e) Seven Challenges
f) Screening, Brief Intervention and Referral to Treatment
g) Supported Employment
h) Supported Housing
i) Network for the Improvement of Addiction Treatment (NIATx)
j) Peer Support (adult and youth)
k) Integrated treatment for co-occurring disorders
l) Assertive Community Treatment
m) Illness management and recovery
n) Medication management
o) Suicide Prevention
p) Wraparound services, and
q) Utilization of assessment and screening tools such as the Global Assessment of Individual Need (GAIN) and the Dual Diagnosis Capability in Addiction Treatment/Dual Diagnosis Capability in Mental Health Treatment (DDCAT/DDCMHT).

Since SFY 2011, the Department has been realigning the allocated amount of mental health block grant funding to more equitably correspond with the number of individuals each region serves.

Recommendation 4.1

During June of 2007, our Department provided guidance to the CMHC's and the Kentucky Association of Regional Programs (KARP) concerning the establishment of a uniform procedure to address charity care and the distinction from courtesy allowances and contractual adjustments that are provided to other providers. At present the CMHC's are not providing separate schedules in conjunction with their audited financial statements. Charity allowances are noted within the notes to the financial statements. A review of the financial statements for all CMHC's did not reveal any reportable issues involving charitable allowances.

The financial audits performed by the CPAs are in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits conducted in accordance with Government Auditing Standards. This examination related to revenues would include a review of all contractual allowances and write-offs. CPA firms are required to report significant issues within the audited financial statements of each CMHC. A review of the independent audits did not reveal any material misstatements. Financial statements for all CMHC's were found to fairly represent, in all material aspects, in relation to the financial statements taken as a whole.

In addition to the standards referenced above the CMHC annual cost report audits include CMHC Audit Specifications issued by the Cabinet for Health and Family Services. A review of the audits for all CMHC's were found to fairly represent, in all material aspects, the information submitted on the cost report.

Going forward our Department is reviewing all CMHC fee structures. The intent is to provide feedback and guidance regarding uniformity and consistency. The review will include an examination of sliding fee schedules at each CMHC and assist in the further development of a uniform approach to the application of charitable allowances.

Other comments from the department:

The centers are required by statute to provide services regardless of a person's ability to pay. The charity allowance is a center charge amount an indigent person is not required to pay and is determined on an income-related sliding fee schedule unique to each region. Adjusted for inflation, the statewide community care support allocation for FY 2010 has $4.5 million less spending power than for FY 2001. Given that cross subsidization of payers did not occur, such as Medicaid or Medicare paying more for their covered clients without corresponding cost increases, this reduction in spending power would have to be absorbed by the centers. The regions in the past have not defined and reported charity allowances consistently, which would represent the value of charges provided to those deemed indigent by the centers and not necessarily the unreimbursed cost that a provider might incur.

(Note: Obtaining the total charity allowance value would represent a charge amount only and not the actual amount of uncompensated care provided. To calculate that, one would have to break down the charity allowance charges by service category and then apply a cost to charge ratio for each service provided. Charge and cost are not interchangeable; although some providers might set them to be equal, most usually the charges are higher than costs and that is a basic tenet of healthcare reimbursement. Better measures of the situation might include how much access do

clients have to services when they don't have a payer source? The assumption that centers are serving all in need will likely fail a serious challenge from my perspective and mean that the CMHC numbers do not represent the total financial need of a region's clients. Therefore, you are only getting reported what activity that the CMHCs are providing and quantifying but that is problematic when looking at the service trends such as maximizing clients with payment status as seen in recent years. This means that getting a charity care amount would not be the final answer to the question of unmet need.)

Recommendation: BHDID should analyze the sliding fee scale charge practices for the centers along with ensuring that client needs are being met in region of the state or at a minimum quantifying such funding shortfalls for inclusion in the annual biennial budget process. The Department should strive for uniform reporting of charity care allowances among the centers given that cost benefit factors could arise as each center is an independent 501(c)(3) corporation as recognized by the Internal Revenue Service and as such they will have differing accounting and billing systems.

Appendix F

Response From The Kentucky Association Of Regional Programs

Program Review and Investigations Committee
Thursday October 13, 2011
Room 131 Capitol Annex

Kentucky's Community Mental Health System is Expanding and Would Benefit from Better Planning and Reporting: An Update

Members

1	Senator Higdon – Co-Chair	5 – 14 – 15	Marion County - 5
2	Representative Steele – Co-Chair	12 - 13	Perry County - 12
3	Senator Clark	6	Jefferson County - 6
4	Senator McGaha	14	Russell County - 14
5	Senator Pendleton	2 – 4	Christian County - 2
6	Senator Schickel	7	Boone County - 7
7	Senator Seum	6	Jefferson County - 6
8	Senator Smith	12 – 13	Perry County - 12
9	Senator Stine	7	Campbell County - 7
10	Representative Butler	3 – 5 – 6	Breckenridge County - 5
11	Representative Combs	11 – 12 – 13	Pike County - 11
12	Representative Mills	5 – 14	Marion County - 5
13	Representative Osborne	6	Jefferson/Oldham Counties - 6
14	Representative Palumbo	15	Fayette County - 15
15	Representative Rand	6 - 7	Trimble County - 6
16	Representative Simpson	7	Kenton County - 7

Hello my name is Steve Shannon and I am the Executive Director of the KY Association of Regional Mental Health and Mental Retardation Programs, Inc. (KARP). KARP is the association of the fourteen (14) Community Mental Health – Mental Retardation Centers (CMHCs) throughout the Commonwealth. The CMHCs are the public safety net for Kentuckians needing mental health, addictions and intellectual & developmental disability services and supports. The CMHCs were established by the KY General Assembly in 1966 (KRS 210.370 – 485) following *The Community Mental Health Act* signed by President Kennedy on October 31, 1963. As the report indicates, the CMHCs served over 178,000 individuals in FY '10 – this represents approximately 1 out of every 25 Kentuckians. I would to re-emphasize that point – the CMHCs serve and support approximately 1 out of every 25 Kentuckians. This is a great way to quantify the impact the CMHCs have on all communities throughout Kentucky. In addition to serving a huge number of our neighbors, we employ approximately 9,000 individuals in a wide array of positions from administrative to clinical to medical. Based upon data from the KY Chamber of Commerce, the CMHCs employ approximately 1 out of every 200 working Kentuckians. As required by statute, the CMHCs have Board members representing all 120

counties; there are approximately 310 CMHC Board members who volunteer their time to provide oversight to the CMHCs. We support local communities through employment, leadership and, most importantly, services to our most vulnerable neighbors.

Chairmen Higdon and Steele, I would like to thank the Program Review and Investigations Committee for the opportunity to comment upon this update of the report adopted in 2007 *Kentucky's Community Mental Health System is Expanding and Would Benefit from Better Planning and Reporting: An Update.* I appreciate the patience and thoughtful consideration displayed by the Committee staff while working with the CMHCs. The last four (4) months has been a very busy time for the CMHCs.

I would like to address the four recommendations included in the update.

Recommendation 1.1 (page 13)

It if is the intent of the General Assembly that the HB 843 Commission and the HB 144 Commission develop comprehensive plans for needed services and funding, then the General Assembly may wish to direct the commissions to present a plan to the governor and the Legislative Research Commission in sufficient time before each biennium so that the plan could be useful in the budgetary process. The plan should include specific population and service targets, funding needs, and measurable outcomes.

- We concur with this recommendation. It would be beneficial for all members of both HB 843 and HB 144 to participate in the deliberative process in developing funding needs and measurable outcomes.

Recommendation 1.2 (page 13)

The General Assembly may consider merging the 843 Commission and the HB 144 Commission to identify needs, prepare a plan for services and associated funding, and identify expected outcomes for individuals with mental illness, substance use disorders, mental retardation and other developmental disabilities, and dual diagnoses. The General Assembly may consider requiring the combined commission to have a legislator and the secretary of the Cabinet for Health and Family Services as co-chairs.

- We believe the combined commission would be less effective than the two distinct commissions. The primary reason is the size needed to insure adequate representation of both HB 843 and HB 144 on the new combined commission would diminish its effectiveness.
- In addition, the service needs of the two broad groups represented by HB 843 and HB 144 are not necessarily consistent with each other. We do support the combined recommendations of both HB 843 and HB 144.
- The Regional Planning Councils which are essential to HB 843 assures the recommendations from the HB 843 Commission are based upon local need. The grassroots focus of the Regional Planning Councils is not included in the HB 144 Commission process.
- We do believe a legislator co-chair is an effective strategy for both Commissions.

Recommendation 1.3 (page 13)

Each regional board should develop a strategic plan that describes clearly set objectives, strategies and a timetable to implement them, and cost estimates. The board's plan should include expected outcomes and measurable indicators. The plans should be an integral part of statewide planning decisions.

- Regional boards and CMHCs develop strategic plans which are used to guide the actions of the Regional Boards. At times the strategic plans are shared with local government officials. The DBHDIDS plan and budget process is a component of strategic planning. We agree the strategic plans should be an integral part of statewide planning decisions.

Recommendation 3.1 (page 41)

The Department for Behavioral Health, Developmental and Intellectual Disabilities should develop a standardized method to calculate charity care allowances. The department should require the Boards to use that method and report annually, in conjunction with their annual financial statement audit, a separate schedule of charity care allowances. The boards' independent auditors should be required to certify that the charity allowances are reported in accordance with the department's instructions.

- The CMHCs and Regional Boards received the Commissioner's letter dated June 15, 2007 regarding charity care calculations.
- We believe that the other categories, courtesy allowances and bad debts, included in the update (page 41) need to be identified and counted since this provides additional information about the financial status of the CMHCs and their contribution to their respective communities.
- If the goal of gathering this information is to accurately reflect the financial status of the CMHCs, it would be beneficial to include a broader definition of charity care which includes: bad debts, usual and customary charges, and other uncompensated care.

I would also like to take this opportunity to address some areas which were not delineated in update and have an impact on both the current financial picture and the near future financial picture of the CMHCs. These include the pending implementation of Medicaid managed care, administrative cost increases and the Kentucky Employee Retirement System.

Medicaid Managed Care

As I am sure everyone knows Medicaid managed care will be implemented on Tuesday November 1, 2011. Currently, twelve (12) of fourteen (14) CMHCs will begin providing behavioral health services under contract with the three (3) managed care organizations operating outside of the Passport region. The two (2) CMHCs in the Passport region, Communicare (Elizabethtown) and Seven Counties Services (Louisville) are working with Passport to expand Medicaid managed care to behavioral health services in their respective regions. The twelve (12) CMHCs have either signed contracts with the three (3) MCOs or are in final negotiations with them.

The CMHCs have been very active with the three (3) MCOs in preparation for the implementation of Medicaid managed care. This process has been very time consuming but our goal is to insure the CMHCs can continue to be viable after November 1, 2011. There are some concerns that we are sure will take place in the near future.

1. The first concern is the increased administrative cost associated with Medicaid managed care.

1. The CMHCs will now have three (3) additional billing and claims processes they must implement. The CMHCs' business offices are investing significant time to be prepared to submit claims on November 1, 2011. Since some individuals will receive services through traditional Medicaid and the SCL and MPW waivers will continue, the CMHCs still need to be able to bill Medicaid directly.
2. Also, we are required to submit outpatient treatment requests (OTRs) to two (2) MCOs and notify the third of services we have provided. The OTRs are prior authorization forms. These need to be completed by clinicians and the time needed to complete them is uncompensated; even if the time is relatively small it is still time taken away from providing services.
3. The utilization review process imposed by the MCOs will result in additional administrative costs.
4. The reporting requirements have also increased; therefore, the CMHCs are required to report additional information to each of the MCOs.
5. CMHCs are required to report the same data to the MCOs and the DBHDID – it would make sense to report it one time and let the MCOs and DBHDID share the information.
6. The CMHCs will need to confirm with which MCO the person is enrolled. This is another step which must be completed.
7. Since the CMHCs serve a relatively large number of individuals who are Medicaid beneficiaries, the compounded increase on administrative costs will be significant.

2. The second concern relates to the impact on the revenues CMHCs derive from Medicaid services. We know the administrative expenses will increase and we are confident that during the coming months revenues will decrease. It should be noted that we are not 100% sure revenues under Medicaid managed care will decrease but we are anticipating a decrease. This is premised upon the Cabinet reporting savings to the Medicaid program due to the signed contracts with the MCOs and the MCOs reporting administrative costs and profits in the 6% to 10% range. If the total funds available for Medicaid services are reduced either by savings or MCO costs, the CMHCs must be prepared to anticipate a reduction in revenues.
3. Decreasing revenues and increasing administrative costs can only mean less access to services for individuals currently served or needing services in the coming years. This is clearly problematic for individuals and families.
4. All the news about Medicaid managed care is not discouraging; there is some opportunity in Medicaid managed care, especially in the area of substance abuse treatment. The CMHCs would like to provide the Committee members a letter dated November 4, 2009 from CMS indicating the provisions of the Mental Health Parity and Addictions Education Act passed by Congress in 2008 apply to Medicaid MCOs. It appears this will result in additional substance abuse treatment services being available to the Medicaid population. As you are aware, substance use disorders may be the number one public policy challenge facing the Commonwealth and the expansion of a Medicaid benefit will greatly assist treatment efforts. We are encouraged by this communication from CMS and are anticipating an expansion of substance abuse treatment services.

<u>Other Administrative Costs</u>

Other programs have implemented additional administrative costs which negatively impact the CMHCs. For example, the Supports for Community Living waiver will require all providers, including the fourteen (14) CMHCs, to train all staff giving medications to individuals in the SCL program in a medication administration curriculum. The training must be conducted by a Registered Nurse and modules of the training are conducted online which will require several laptops and training time. As we are required to implement this curriculum, the CMHCs will incur additional costs associated with RN staff time and training. Currently, the CMHCs conduct their own medication administration training and follow all regulations for the administration of medications. We acknowledge the importance of safe medication administration but believe the SCL program should set outcomes for medication administration. The provider community will then implement policies and procedures to accomplish the outcomes.

Both the SCL and MPW programs have a Consumer Directed Option (CDO) component that results in dollars passing through the CMHCs to employees of individuals selecting services through CDO. We realize individuals participating in the SCL and MPW programs benefit from the CDO but the relatively large growth of this program has resulted in additional administrative costs for the CMHCs since they are the fiscal intermediary for this program. The costs associated with payroll have continued to escalate. Also, the oversight of the employees has resulted in additional administrative costs. The CMHCs are also concerned that when a program review is completed there is the possibility of a recoupment by KY Medicaid for services the CMHCs have not provided and over which they have very little oversight and control. The risks associated with CDO present additional administrative challenges.

KY Employee Retirement System

FY ’06 – 5.89%	FY ’07 – 7.75%
FY ’08 – 8.5%	FY ’09 – 10.01%
FY ’10 – 11.61%	FY ’11 – 16.98%
FY ’12 – 19.82	Each 1% increase represents approximately $2.8 million.

We believe the significant increase in the employers’ contribution to KERS since the end of SFY 2006 poses the greatest threat to the financial stability of the thirteen (13) CMHCs participating in it. Since the end of SFY 2006 (June 30, 2006) to present, the KERS mandated employers’ contribution has increased from 5.89% to 19.82%. Unfortunately, we anticipate additional increases in SFY 2013 and SFY 2014. I cannot adequately emphasize the huge risk this escalating unfunded mandate poses to the CMHCs and the individuals served and supported by them.

The employer contribution impacts all facets of operations at the thirteen (13) participating CMHCs. Every decision made by the leadership of the CMHCs must be viewed through the KERS employer contribution lens.

- The CMHCs ability to secure competitive grant funding is hampered by it.
- Service expansions to new markets and service diversification are restricted by having to account for a 20% and increasing employer contribution.
- We are reluctant to hire new staff since we must be able to support the employer contribution.

- The CMHCs salary levels have become less competitive since dollars must be directed to the employers' contribution and away from direct wages.

We want to thank the General Assembly for hearing our concerns during the 2010 Regular Session and taking bold action to address the escalating KERS employer contribution. The General Assembly included approximately $2.5 million in SFY 2011 and $3.8 million in SFY 2012. Also, language was included that the funding expansion could be used as state match to draw down federal dollars through the KY Medicaid program. The intent of the KY General Assembly was to fund a rate increase in SFY 2010 and SFY 2011 to help cover the increased cost of KERS. Again, the thirteen (13) participating CMHCs would like again thank you for your leadership and support.

Unfortunately, the CMHCs have not realized any of the additional funding to date. Again, we have not received any new dollars as the result of budget language included in the SFY 2011 – SFY 2012 Biennium Budget. We have worked with KY Medicaid to submit a state plan amendment (SPA) required to increase the CMHCs rates. We have not heard if the responses to CMS questions have been submitted by KY Medicaid. We are committed to using the appropriation as state match for additional federal dollars as opposed to just receiving the state general fund dollars. I would be remiss if I did not include that the CMHC Medicaid rates have not increased since 2001; we have now gone one decade without a rate increase, the entire period covered by this report update. Let me reiterate this point, the CMHC Medicaid rates have not increased since 2001 and there is now budget language directing a Medicaid rate increase and we are working with KY Medicaid to submit the necessary information to CMS.

In closing, Medicaid managed care poses significant challenges to the CMHCs due to increasing administrative costs and most likely decreasing revenue. Clearly, KERS has increased personnel costs and will continue to do in the coming years. The CMHCs continue to see more people (27% increase), provide more services (45% increase) while revenue does not keep pace (19% increase). This is a formula which cannot be sustained.

The future of the fourteen (14) CMHCs does not appear to be bright as costs continue to grow and revenue from our largest source most assuredly will decrease. The financial viability of KY's behavioral health safety net is in question. Actually, it may not be in question; it may be fairly certain to be at risk. This risk forces us to ask what will happen to the 178,000 Kentuckians currently accessing services and what will happen to individuals in the coming years who show the first signs of a mental illness, an addiction or an intellectual or developmental disability?

Chairmen Higdon and Steele and members of the Committee, thank you.

Endnotes

[1] United States. Dept. of Health and Human Services. Office of Applied Studies. *Results from the 2008 National Survey on Drug Use and Health: National Findings*. Sept. 2009. Web. Sept. 30, 2011. P. 100.
[2] United States. Dept. of Health and Human Services. Center for Behavioral Health Statistics and Quality. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. Sept. 2011. Web. Sept. 30, 2011. P. 6.
[3] Kentucky. Dept. for Behavioral Health, Developmental and Intellectual Disabilities. "Annual Block Grant Applications and Reports." Web. Aug. 19, 2011. Pp. 7-8.
[4] Ibid. Pp. 8-9.
[5] United States. General Services Administration. Catalog of Federal Domestic Assistance. *Block Grants for Prevention and Treatment of Substance Abuse*. Web. Oct. 4, 2011.
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[7] United States. Substance Abuse and Mental Health Services Administration. "NOMs 101: National Outcome Measures." Web. Oct. 4, 2011.
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[9] United States. Substance Abuse and Mental Health Services Administration. "NOMs 101: National Outcome Measures." Web. Oct. 4, 2011.