Kansas Department of

Social and Rehabilitation Services

Gary Daniels, Secretary

Legislative Budget Committee
August 7, 2006

Social Welfare Deferrals and Audits

Office of Financial Management
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Chairman Umbarger and members of the Committee, I am Gary Daniels, Secretary of the Kansas Department of Social and Rehabilitation Services (SRS). I appreciate the opportunity to discuss the issue of deferrals and audits.

The federal government continues its heightened oversight of state claims of federal funds. As a result, states are facing significant deferrals of federal funds, increased federal audits, challenges to federal cost allocations, and new federal interpretation of existing laws, regulations and state plans. Kansas is no exception. At a recent meeting of the APHSA, I visited with CEOs from other state human service agencies and learned of significant levels of auditing and deferrals, including Colorado, Massachusetts, and Pennsylvania.

Let me place this issue in some context. A Legislative Division of Post Audit report in April, 2003 reported that Kansas ranked 44th in the nation in the amount of federal assistance (per capita) to state and local government. To assist in maximizing more federal funding, SRS contracted with a revenue maximization consulting firm, Maximus. This practice was followed in several other states. SRS submitted to the federal agencies, numerous policy changes that increased federal funds. The policies were reviewed and approved by those federal agencies. These efforts resulted in a significant infusion of federal dollars supporting critical services in Kansas and around the nation.

In the current environment of increased scrutiny by the Office of Inspector General (OIG), one area they have focused on is oversight of these increased federal funds. As federal funds pass through SRS to other agencies and outside providers, SRS is responsible for monitoring and quality control functions. Included in their findings is the recommendation that SRS increase oversight of the programs and increase training of entities that receive these funds.

The fact that Kansas has a unique privatized Child Welfare system is another reason for increased federal scrutiny. The federal claiming for this program is based upon encounter data and not actual expenditures. As this is a hybrid managed care system, the Centers for Medicare and Medicaid Services (CMS) has had difficulty determining which regulations apply to the system. Because this is the only program of this type in the United States and because of the complexity of the payment and federal claiming structure, both CMS and OIG have examined data back to almost the beginning of privatization. As the Legislature is aware, CMS has been deferring federal funds since July 1, 2003. We appreciate the ongoing support of the Legislature and the Governor in providing state funds to maintain critical services to children in our Child

Welfare system. We do expect to reach some settlement with CMS on past quarters that have been deferred.

We recently submitted changes to the Kansas Medicaid Plan and submitted a new waiver request and believe this will correct the issues going forward. Starting in the Spring of 2004, CMS notified SRS that substantial portions of the current Medicaid State Plan governing mental health/behavioral health and substance abuse services are now considered out of compliance with CMS requirements and practice standards. Left unaddressed, these now-identified deficits in Kansas' Medicaid program would render the state - and particularly the mental health/behavioral health and substance abuse service systems - vulnerable to negative funding decisions by CMS that would ultimately cripple our ability to provide these services to Kansans in the greatest need.

In order to comprehensively address the myriad issues CMS had expressed concern about, throughout the first half of this year a collaborative and focused work group of staff from SRS and the Division of Health Policy and Finance (DHPF), assisted by consultants with CMS and state plan expertise, explored available responsive options. Guided by extensive prior stakeholder input, as well as the leadership guidance of state agencies and the legislature, a foundation for responding to CMS was developed.

At the end of June, SRS and DHPF submitted to CMS these documents, designed to come into compliance with CMS requirements while being responsive to the service needs of Kansans:

- proposals to implement extensive amendments to the current state plan;
- application to amend the existing waiver for services to youth with serious emotional disturbance; and
- application for a selective services contracting waiver for all Medicaid mental health and substance abuse services.

With this submission, it was our purpose to comprehensively address pending CMS concerns; to signal clearly to CMS that we understand and will be responsive to their concerns in all affected service systems; and to identify future services that meet Kansans' needs in ways that allow us to continue access to critical Medicaid funding. For a complete overview of the changes, please see Attachment B.

SRS continues to work with federal agencies to resolve all of these issues. In addition to the above state plan changes, we have begun the following major initiatives to minimize the risks we face because of increased scrutiny.

- Federal maximization - SRS is discontinuing its revenue maximization contracts with Maximus.

- Cost Allocation Plan review - SRS is able to claim $185 million in federal fund each year to support SRS administrative costs. These funds are claimed based upon allocation of

total costs that flow through our cost allocation plan (CAP) to numerous funding streams. We have retained an outside consulting firm to review our cost allocation plan for compliance with federal regulations and recommend needed changes.

- Federal reporting - SRS is reviewing all of our state plans and claims for federal funds.

- Medicaid Mental Health administrative claiming - SRS is reviewing and modifying these requirements to address concerns raised by the OIG.

- Certified match - SRS is evaluating all the current uses of certified match to ensure they meet CMS requirements.

- Targeted Case Management - SRS is working collaboratively with a KHPA workgroup to identify our current risks.

- Child Support Enforcement - Enactment of SB420, which excludes child support collections from state unclaimed property laws, has prevented negative audit findings and federal penalties by HHS Office of Inspector General auditors. OIG auditors have been making the rounds of states doing audits and demanding the federal government's share of interest earned on unclaimed property. In anticipation of an audit, SRS sought the change in SB420 which prevented negative findings. Although the federal audit of Kansas had started, SRS audit managers were notified this week by OIG that the audit will be canceled because the federal government will be unable to recover dollars from Kansas.

Attachment A summarizes the status of federal deferrals, audits, and penalties SRS is currently facing.

This concludes SRS's testimony regarding deferrals and audits. Thank you for the opportunity to present this information. I will be happy to stand for questions.

Attachment A

Summary of Deferrals and Audits
July 2006

Federal Findings	
CW Managed Care Deferral (CMS)	● To date, ten quarters have been deferred (QE 9/30/03 to 12/31/05) totaling $54,115,032. ● These deferrals have been covered through settlement with CMS and through the budget process. ● $4,648,786 was proved in the FY 07 approved budget to cover additional anticipated deferrals through 12/31/06. ● CMS has proposed additional deferrals related to periods previously settled. ● Continuing to work with CMS to resolve state plan issues and end deferrals.
Audit of DDS Administration Expenditures (OIG)	● OIG alleges indirect costs were not allocated correctly between 7/1/98 & 3/31/02 ● $4.9 million in administration claimed is at risk. ● The finding is still in the appeal process.
CMHC Admin. Claiming (OIG)	● OIG reviewed the first two quarters of this program (10/1/02 through 3/31/03). ● OIG report recommended $3,060,098 be set aside and SRS is to work with CMS to resolve these reasons for the set aside. ● We have met with CMS to discuss OIG findings. ● We have made changes to the Administrative Claiming Handbook and to the Time Study and are working with CMS to resolve. ● CMS deferred $1,910,331 to date. ● Due to delays in CMS approval, claims are two years behind. SRS has claimed 7 quarters, paid 3 quarters to CMHCs, and has 8 quarters yet to claim.
State Hospital Medicaid Deferral (CMS)	● CMS recently disallowed an additional $2,466,050. This is an amount in addition to the original disallowance. The Departmental Appeals Board found in CMS' favor and agreed the total was higher than the original disallowance. ● We have instructed our legal counsel to file for review by the district court.
Synar Penalty	● In FFY 2004, Kansas' Synar compliance rate dropped to 62 percent. As a result, Kansas was required to expend an additional $2.3 million over two years to improve its compliance with federal tobacco prohibition laws. ● Kansas' most recent Synar Report shows we currently in compliance with an 80.8 percent rate.

Federal Reviews in Progress or Scheduled	
Review of Medicaid Child Welfare Services (OIG)	● OIG reviewed the child welfare Medicaid claims for the period 7/1/00 to 6/30/03. ● The on-site review has been completed. ● Draft report from OIG expected November 2006.
Review of IV-E Child Welfare Services (OIG)	● During OIG's audit of child welfare Medicaid, they expanded their review to audit the IV-E expenditures claimed for child welfare between 7/1/00 and 6/30/03. ● This audit began in May and is still in progress.
CDDO Administration & Certified Match	● CMS Regional completed a Financial Management Review (FMR) of Medicaid payments and the use of certified match for CDDO Administration ● The Regional report has been sent to CMS Central Office for review
Family Fees	● CMS Regional completed an FMR of fees collected from families whose children are served through an HCBS waiver ● The Regional report has been sent to CMS Central Office for review
Targeted Case Management (TCM) Provided by CDDOs	● CMS Regional is currently doing an FMR for TCM provided by CDDOs and the use of certified match used to fund this program. ● CMS will complete the initial review in the Fall and expects the Regional Office to complete the review of the CMS report by Summer 2007.
State Mental Health Hospitals	● CMS Regional will soon begin an FMR for the "certified match" used to provide the state share for state mental health hospitals.

Attachment B

Overview Of SRS Medicaid State Plan Changes
Mental Health & Substance Abuse Services
June 2006

Starting in the Spring of 2004, the federal Centers for Medicare and Medicaid Services (CMS) notified SRS that substantial portions of the current Medicaid State Plan governing mental health/behavioral health/substance abuse services are now considered out of compliance with their practice standards. Some key concerns are:

- Any willing provider
- Comparability of services
- Rehabilitation service definitions and practice
- Institutes for Mental Disease (IMDs)

Now is the time: After extensive internal assessment and external dialogue, now is the time for SRS to address and resolve these issues.

- Left unaddressed, these now-identified deficits in Kansas' approved Medicaid State Plan services would render the state – and particularly the mental health/behavioral health and substance abuse service systems – vulnerable to negative funding decisions by CMS that would ultimately cripple our ability to provide these services to Kansans in the greatest need.

In the context of addressing CMS' concerns, SRS purposed to develop a foundation of response that would be consistent with the values that have guided system partners in developing sturdy community-based services, and would support future transformation goals. The guiding values in building the policy foundation are these:

- The existing public mental health and substance abuse treatment systems will be supported.
- Community Mental Health Centers (CMHCs) will retain primary responsibility for meeting the needs of **all** Kansans accessing the public mental health system.
- A single statewide substance abuse contractor will have primary responsibility for meeting the needs of **all** Kansans accessing the public substance abuse system.
- The public mental health and substance abuse systems will make effective and efficient use of **all** treatment resources available.
- Stakeholders will be actively encouraged to participate in shaping public policies and the functional design of these public service systems.
- The solutions we craft will be supportive of the goals and recommendations identified in the New Freedom Commission report, *Achieving the Promise: Transforming Mental Health Care in America*.

- In addition, the 2006 Kansas Legislature has provided direction regarding the development of this foundation, consistent with what SRS has built.

In collaboration with the Division of Health Policy & Finance, consistent with the guiding values noted above, and supported by consultants with CMS and state plan expertise, SRS has decided to:

- Amend five sections the current state plan (Rehabilitation, EPSDT, Other Licensed Practitioners, PRTFs and Inpatient Hospital), as well as the approved HCBS SED Waiver to come into compliance with CMS requirements;
- Seek a selective services contracting waiver; and
- Collaboratively build the future service system that supports core values of consumer choice and provider access in managed and cost effective ways.

What will this look like?

Mental health services will be provided utilizing a Prepaid Ambulatory Health Plan (PAHP).

- Publicly-funded mental health services will be accessed through the Community Mental Health Centers (CMHCs), who are responsible for a managed system of care – by direct CMHC service delivery, by association agreements with other practitioners, or by gatekeeping/certification of need determinations for facility-based services.
- CMHCs will be required to associate with any willing qualified Licensed Mental Health Practitioner seeking to provide clinical outpatient services.
- CMHCs must provide or arrange for rehabilitation-based specialty mental health services, consistent with contracted standards of care. Whenever the CMHC does not directly deliver these services at the required standard of care, the CMHC must associate with other providers to ensure the services are available.
- CMHC oversight of services delivered by their associates will be guided by common sense standards that essentially contain “no more and no less” oversight, attention and scrutiny than that required for the CMHC’s own services.

Substance abuse services will be provided utilizing a statewide substance abuse contractor.

- Through a single statewide contract, the Kansas Substance Abuse Prepaid Inpatient Health Plan provides for the cooperative administration of Medicaid substance abuse services with the administration of Kansas Department of Social and Rehabilitation Services state and federal block grant funded substance abuse treatment programs.
- A seamless system of care in which block grant funded and Medicaid funded clients may move across and within the continuum.
- Building upon extensive System Redesign work that has already been done – including extensive stakeholder input – regarding the Utilization Management protocols, detox services, screening and assessment, and performance measures.

Some key benefits of this approach are:

- Preserves current system infrastructures
- Develops an integrated and coordinated portal to the public mental health and substance abuse systems
- Increases access to Medicaid for qualified providers through associate agreements
- Expands consumer choice
- Controls the increase of costs in Medicaid
- Allows reinvestment of savings back into the program

The state plan amendment and waiver application with the required changes will be submitted to CMS by June 30th, 2006.

- Extensive stakeholder input will be required over the next several months to successfully build implementation tools that will spell out exact service codes, practice guidelines, reimbursement rates, service authorization and operating limitations, such as:
- Provider manuals
- Contractual Expectations
- Associate provider agreements
- Utilization management tools
- Practice forms
- License standards for Psychiatric Residential Treatment Facilities