Kansas Department of

Social and Rehabilitation Services

Don Jordan, Secretary

House Appropriations Committee
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Consensus Caseloads and Federal Funds

SRS Operations
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Chairperson Schwartz and members of the committee, thank you for the opportunity to provide information on our Consensus Caseloads and Federal Funds.

Consensus Caseloads

The Consensus Caseload estimating group consisting of staff from SRS, Kansas Department on Aging, Kansas Health Policy Authority, Division of Budget, and Legislative Research met on November 2, 2007 to revise the FY 2008 estimates and make the first FY 2009 estimates for the Consensus Caseloads. The SRS caseloads included in this process are Temporary Assistance for Families (TAF), General Assistance (GA), Foster Care Contracts (FC), Nursing Facilities for Mental Health (NFMH), Mental Health Services (MH), Community Supports and Services (CSS), and Addiction and Prevention Services (AAPS). Consensus Caseload programs comprise 39% SGF (32% AF) of the total SRS budget. The consensus estimate for each caseload is presented in the table below.

	FY 2008			FY 2009		
Program	**Avg. People**	**SGF**	**AF**	**Avg. People**	**SGF**	**AF**
TAF	35,066	$29,821,028	$51,000,000	33,595	$29,821,028	$49,000,000
GA	4,026	8,700,000	8,700,000	4,035	8,700,000	8,700,000
FC	5,829	102,163,619	149,636,886	6,041	115,600,000	165,000,000
NFMH	555	11,348,890	13,300,000	555	12,000,000	14,000,000
CSS	8,314	17,800,000	44,000,000	8,517	17,219,690	42,963,300
MH*	227,846	77,500,000	199,000,000	236,690	76,500,000	192,200,000
AAPS*	227,846	9,325,491	23,105,776	236,690	9,135,354	22,792,800
Total Consensus Budget		**$256,659,028**	**$488,742,662**		**$268,976,072**	**$494,656,100**

*The average people for MH and AAPS include all people in the managed care plans eligible for services. Kansas pays a monthly rate to the managed care organizations for these eligible people.

The CSS caseload includes Head Injury Rehabilitation Hospitals, Positive Behavior Support, Attendant Care for Independent Living, and CDDO Targeted Case Management. The MH Services caseload includes the Mental Health Prepaid Ambulatory Plan (PAHP) the Psychiatric Residential Treatment Facilities (PRTF), and all mental health screenings for SRS and JJA. The AAPS caseload includes the Prepaid Inpatient Health Plan (PIHP).

The following table shows the amounts added in the Governor's Budget Report (GBR) for the Consensus Caseload adjustments. All numbers reflect the consensus estimates except $50,000 SGF added to ACIL in the GBR to replace Children's Initiative Funds (CIF). In total, FY 2008 is a reduction of $1.7 million in State General Fund from the approved budget, while FY 2009 is an increase of $10.6 million SGF from the FY 2008 approved. In the aggregate, for

all SRS caseloads, FY 2009 reflects an increase of 4.8 percent SGF from FY 2008.

Program	FY 2008 Change from Approved		FY 2009 Change from FY 2008 Approved	
	SGF	All Funds	SGF	All Funds
TAF	$0	$0	$0	($2,000,000)
GA	(300,000)	(300,000)	(300,000)	(300,000)
Foster Care	(2,836,381)	1,636,886	10,600,000	17,000,000
NFMH	48,890	0	700,000	700,000
CSS	275,575	675,248	(304,735)	(361,452)
MH	2,000,000	12,000,000	1,000,000	5,200,000
AAPS	(874,509)	(2,294,224)	(1,064,646)	(2,607,200)
Total Change	**($1,686,425)**	**$11,717,910**	**$10,630,619**	**$17,631,348**

The following are brief descriptions of the significant changes to the spring 2007 estimates.

Temporary Assistance to Families (TAF)

- The number of persons receiving services is estimated to continue to decrease into FY 2009 as a result of the improved economy and tougher work requirements.
- Savings in this program are in the TANF Block Grant.

General Assistance (GA)

- The current estimate for people served was reduced based on the current number of recipients receiving services following implementation of Presumptive Medicaid Disability Determination.

Foster Care

- Costs for the FC contracts are projected to increase due to increasing caseloads and a change in the privatized contracts. The FC costs now include placement costs that used to be paid through Medicaid. The estimates include $5.7 million SGF ($7 million AF) in both fiscal years for children that used to be in Level V and Level VI facilities that did not qualify for PRTF placement and are in Youth Residential Care (YRC) which is not a Medicaid placement.
- The FC estimates also include an increase of $1.6 million SGF ($2 million AF) in FY 2008 and $3 million SGF ($3.7 million AF) in FY2009 from a DD Waiver policy change. These funds were transferred from the DD waiver.
- The large difference between FY2008 and FY2009 is a result of a change in the contracts from prepayment to payment after the month of service. This resulted in 11 months of payments in FY2008 and a full 12 months in FY2009.
- The decrease in SGF needed in FY2008 is a result of updating our cost allocation process and how Federal IV-E administrative and maintenance funds are actually claimed for the CW contracts compared to how we estimated they would be last spring.

Nursing Facilities for Mental Health (NFMH)

- The number of persons served is projected to remain constant.
- The increase in the SGF amount is a result of fewer Medicaid eligible people in NFMHs.
- FY2009 includes a rate increase which is based on annual nursing facility cost reports.

Community Supports and Services (CSS)

- TCM for CDDOs is projected to be lower in both FY2008 and FY2009 because of a change in the rate and the units that can be billed.
- Costs in the Head Injury Rehabilitation Hospitals are projected to be higher in both years.
- People receiving Attendant Care for independent Living are projected to be higher than the prior estimate.
- Combining these caseloads resulted in a budget increase of $0.3 million SGF in FY2008 and a decrease of $0.3 million SGF in FY2009. The decrease in expenditures from FY2008 to FY2009 was a result of $1.8 million SGF of FY2007 costs that were not paid until FY2008. Without this prior year reconciliation, FY2009 expenditures would have been larger than FY2008.

Mental Health

- Effective July 1, 2007, mental health services are provided utilizing a Prepaid Ambulatory Health Plan (PAHP). The increased costs in FY2008 represent the change to a prepaid managed care plan and reflect 13 months of services.
- The smaller SGF requirement related to the AF figure is because the change to PRTFs allow a better federal fund match and because the FY 2008 estimate includes a recoupment of $3.2 million of certified match from the CMHCs that was not expended in the prior year.

Addiction and Prevention Services (AAPS)

- Effective July 1, 2007, addiction services are also provided under a managed care plan. This plan is a Prepaid Inpatient Health Plan (PIHP). The decrease from the spring estimate is a result of changing to the managed care contract.

In April, the Consensus Caseload group will meet again to revise these caseload estimates using all information available at that time.

Federal Funding Issues

In the past few years, the federal government has increased oversight, reinterpreted policies, greatly increased the number of audits and reviews, and scrutinized all claims of federal funds. As a result, Kansas, like most other states, has faced deferrals and disallowances of federal funds, has changed state plans, policies, and cost allocation methods to satisfy the federal agencies. This has resulted in the need of state funds to replace lost federal funds.

SRS has worked closely with the Kansas Health Policy Authority and the Center for Medicare and Medicaid Services (CMS) to resolve some longstanding federal Medicaid issues. We appreciate the support of the Governor and the Legislature in providing needed state funds during last year's Session related to these payment reforms. With the recent changes to the Medicaid State Plan, CMS has stopped deferring of federal Medicaid funding related to mental health and child welfare, and has worked with the state to resolve prior year deferrals. Beginning with the first quarter of this fiscal year, CMS did not defer child welfare Medicaid claims that they have deferred since July 1, 2003. SRS and KHPA are currently working with CMS to try and recover a portion of the previously deferred funds. Also on July 1, 2007, CMHC Medicaid Administrative Claiming was ended and an agreement has been reached with CMS to

resolve four years of prior claims and complete payments to the CMHCs.

While there are many federal reviews still in progress, we have been able to resolve some of the issues that have been ongoing for years. SRS will continue to work with the federal government to provide the required accountability and reduce the risk of future losses in federal funding.

This concludes my testimony and I will be glad to stand for questions.