Approved: January 31, 2002
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 10:30 a.m. on January 16, 2002 in Room 123-S of the Capitol.

All members were present except: All present

Committee staff present:
Alan Conroy, Chief Fiscal Analyst, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Michael Corrigan, Assistant Revisor of Statutes
Judy Bromich, Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Janet Schalansky, Secretary, Kansas Department of Social and Rehabilitation Services
Connie Hubbell, Secretary, Kansas Department on Aging

Others attending: See attached list

Chairman Morris welcomed Janet Schalansky, Secretary, Kansas Department of Social and Rehabilitation Services, who spoke regarding consensus caseload increases projected for this and the next fiscal year in the Kansas Department of Social and Rehabilitation Services (Attachment 1). Secretary Schalansky explained that there are six populations that are included in the caseload consensus process:

- Temporary Assistance for Families
- General Assistance
- Nursing Facilities for the Mentally Ill
- Regular Medical Assistance
- Foster Care Contract
- Adoption Contract

Secretary Schalanksy also noted that many programs are not included in the caseload consensus estimate such as the waiver programs, family preservation and child care custody. Committee questions and discussion followed.

Regarding the chart found on page seven of the Overview titled, "Medicaid Expenditures by Service Category," Senator Huelskamp requested additional information regarding these expenses in prior years. Chairman Morris requested detailed information regarding eligibility criteria for Medicaid. Senator Salmans requested information on admissions criteria at Larned State Hospital. Senator Barone requested information in regard to comparing Medicaid benefits in surrounding states, comparison of Medicaid pharmacy benefits to state employee insurance benefits and if there are duplicates in the total of the 20 percent population as indicated. Chairman Morris thanked Secretary Schalansky for appearing before the Committee.

Chairman Morris welcomed Connie Hubbell, Secretary, Department on Aging, who spoke regarding the Medicaid Caseloads in the Department on Aging (Attachment 2). Secretary Hubbell explained that the Department on Aging operates two programs that are funded through the federal Medicaid program: the Nursing Facility program and the Home and Community Based Services/Frail elderly (HCBS/FE) program. The Secretary mentioned that while the state's consensus caseload estimating process recognizes only the Nursing Facility program in its annual caseload projections, she included information in her report related to the waiver in order to more accurately depict what is happening in aging-related Medicaid services as a whole. In discussing the cost center reimbursement methodology, Secretary Hubbell noted that the Department was revisiting the issue and would make requests for a new methodology July 1, 2002. Committee questions and discussion followed.

Senator Huelskamp requested information regarding the savings each year with the HCBS/FE waiver. Senator Kerr requested information in regard to the bed capacity now that it appears that nursing home populations have stabilized and he also asked if there might be any potential waivers that would provide better services at less cost.

Chairman Morris asked the Department on Aging and the Department of Social and Rehabilitation Services to look at any possible policy changes. Senator Salmans requested that the Departments to look at any possible obstructive laws that may currently exist. Chairman Morris thanked Secretary Hubbell for appearing before the Committee and mentioned that there may be additional meetings in regard to caseloads in the future.

The meeting was adjourned at 11:40 a.m. The next meeting is scheduled for January 22, 2002.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE January 16, 2002

NAME	REPRESENTING
Carolyn Middendorf	Ks St Dr Assn
JK Scott	SRS
Trudy Racine	SRS
Phil Anderson	SRS
Janet Schalansky	SRS
Laura Howard	SRS
Jane Rhys	KCDD
Connie Hess	KDOA
Mike Hammond	Assoc. of CMHCs
Paul Klotz	"
Scott Brunner	DOB
Julie Thomas	DOB
Bob Harder	UMC of KS
Doug Farmer	KDOA
Sheli Sweeney	KDOA
Cindy Lash	Leg. Post Audit
Ashley Sherard	Johnson County
David Wysong	
Stephanie Skorp	ACS
[illegible]	Hein / Weir Chtd.
Teresa Schwab	KCSL
Bruce Linhos	Children's Alliance

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE January 16, 2002

NAME	REPRESENTING
Jay X. Arnold	Coalition For Independence
Shannon Jones	SILCK
S. Therese Bangert	Archdiocese of KC in KS.
Brenda Eddy	ATK
Gina McDonald	KACIL
John Kiefhaber	Ks Health Care Assn.
Dale Huffman	Families Togeth
Deborah Donaldson	Sedgwick County
Stuart Little	Community MH Partnership

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Docking State Office Building
915 SW Harrison, 6th Floor North
Topeka, Kansas 66612-1570

for additional information, contact:

Operations
Diane Duffy, Deputy Secretary

Office of Budget
J.G. Scott, Director

Office of Planning and Policy Coordination
Trudy Racine, Director

phone: 785.296.3271 ***fax:*** 785.296.4685

Senate Committee on Ways and Means
January 16, 2002
Room 123 S 10:30 am

Consensus Caseloads

Janet Schalansky
Secretary

Senate Ways and Means
1-16-02
Attachment 1

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Committee on Ways and Means
January 16, 2002

Consensus Caseloads

Chairman Morris and members of the Committee, thank you for your invitation to review the consensus caseload increases projected for this, and the next, fiscal year.

Caseload expenditures account for approximately 80 percent of the department's budget. For certain caseloads, Kansas has established a *Caseload Consensus Estimation Process*, in which members of my agency, the Department on Aging, the Division of the Budget, and the Legislative Research Department join to forge an agreement on the expected changes in caseloads. Attachment A is the most recent table of projections from the Consensus Estimating Group.

I pause to point out that the term "caseload estimates" is somewhat misleading. The expenditures for a particular population are determined by both the number of persons served, and the cost of serving clients. There are populations in which the cost per person may change more dramatically than the number of persons served. Furthermore, within the cost per person, the unit cost of a service, the utilization of services, or a combination of both, may result in changes in the overall cost per person. Thus, the concept of caseload estimates covers both people served and their cost. I will point out these differences in my testimony as I review the different caseload populations.

Not all SRS caseload expenditures are included in the consensus process. Many programs are not included such as the waiver programs, family preservation, and child care subsidy. There are six populations that are included in the caseload consensus process:

- ❒ Temporary Assistance for Families
- ❒ General Assistance
- ❒ Nursing Facilities for the Mentally Ill
- ❒ Regular Medical Assistance
- ❒ Foster Care Contract
- ❒ Adoption Contract

The following report starts with a summary of the caseload process within SRS. Following this, each population in the consensus process is briefly described, historic data and projections are presented, and closing each section is an explanation for each caseload change. All of the numbers included in this report are prior to any policy adjustments included in the Governor's Budget.

This is a broad overview of the technical process used to develop Consensus Caseload numbers. As you will see, this is a very complex process and many factors influence the estimates. My staff and I are prepared to provide additional information on the cost drivers and various alternatives to control growth as your schedule permits.

Caseload Consensus Process

The Consensus Caseload Estimates are made twice each year: the first consensus estimate occurs in November, prior to the Governor's Budget Report, and the second occurs prior to the close of the legislative session in March. (It is noted that the department conducts a monthly review of caseload projections involving a larger set of caseload populations.) The caseload consensus meetings have the following purposes:

- To form a consensus on the caseload estimates between the executive and legislative branches to avoid technical differences arising from different projections.
- To improve the accuracy of estimates by incorporating objective estimations.
- To identify the base caseload expenditure level from which policy changes may be made.

With respect to the department's work, the consensus caseload process may be separated into four distinct phases: technical projections, policy staff review, agency executive review, and the consensus meeting. In total, the consensus process involves 21 projections of persons served and the same number of projections for the estimated cost per person.

Technical Projections

A group of SRS analysts evaluates the caseloads using statistical methods to project the number of persons served and the costs per person. Computations are made for each population using forecasting techniques such as regression, exponential smoothing, Box Jenkins, or other methods. When projecting the caseloads, the analysts use all available information to incorporate into the estimates, including deeper research into caseload or cost changes, or external information such as economic and demographic data. It is emphasized that projections based on numerical methods are not the sole basis of the projections. Simple trending may be the basis for an estimate if the projections from forecasting techniques appear implausible.

Policy Staff Review

The technical projections are presented to policy staff who review the estimates. In this phase, the projections are reviewed to ensure the correct interpretation and treatment of policy changes, assess logical soundness, and determine whether the estimates conform to the intuitive trends of policy staff who are involved with the program on a daily basis. Often, questions posed at this stage require some populations to be re-projected.

Executive Review

The resulting projections are presented to the department's leadership team. The estimates are final only when the leadership team approves them.

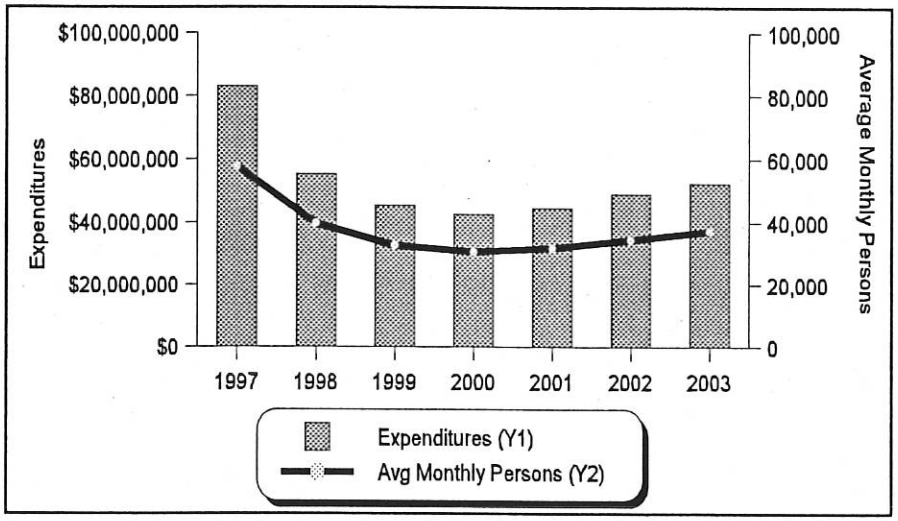
Consensus Meeting

The department shares its estimates in a joint meeting with members of the Division of the Budget and the Legislative Research Department, who also contribute their estimates. Major trends in populations, assumptions underlying the estimates, and differences in estimates are discussed. The resulting consensus estimate for a particular caseload may be a compromise among the three estimates, or, if a compelling argument warrants, the estimate from one agency may be adopted as the consensus estimate. The consensus estimates are then included in the agency's budgets.

The following sections describe the characteristics of each of the six SRS populations included in the consensus caseload estimating process.

Temporary Assistance for Families (TAF)

The TAF program provides financial assistance to low-income families with dependent children, based on income and family size. Families under 34% of the federal poverty level may qualify for TAF assistance. Attachment B is a chart of federal poverty levels related to program eligibility.



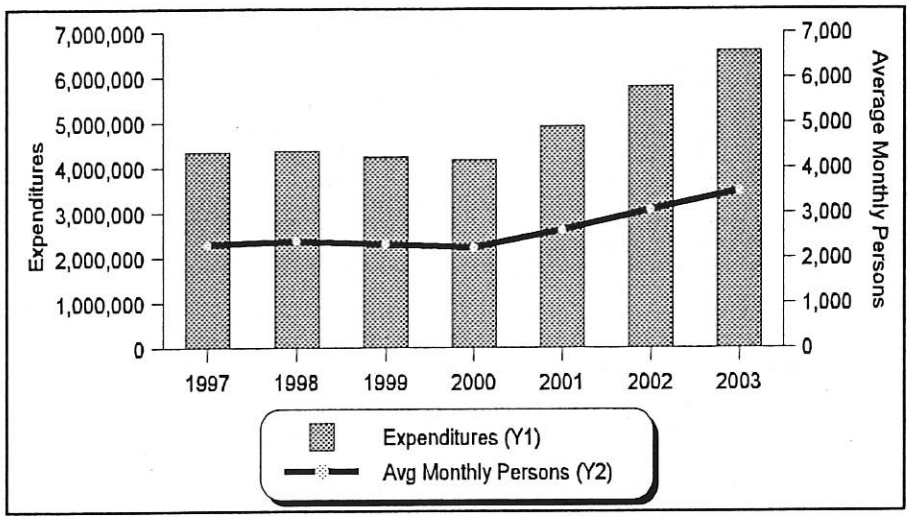
Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1997	57,762		$120		$83,166,723	
1998	39,751	-31%	$116	-3%	$55,453,842	-33%
1999	32,757	-18%	$115	-1%	$45,389,148	-18%
2000	30,692	-6%	$116	1%	$42,660,075	-6%
2001	31,788	4%	$117	1%	$44,674,253	5%
2002 est	34,544	9%	$118	1%	$49,000,000	10%
2003 est	37,338	8%	$117	-1%	$52,500,000	7%

Benefits for the TAF program have remained fixed since 1993; therefore the change in expenditures for this population is the result of variations in the number of persons served. The significant decline in persons served prior to Fiscal Year 2000 is explained by a combination of stricter welfare reform policies and the economy. Beginning in the last quarter of Fiscal Year 1997, TAF applicants were required to search for employment prior to receiving financial assistance. In addition, recipients engaged in employment activities were sanctioned for their failure to comply with work requirements. Concurrently, the robust economy allowed more recipients to leave welfare and find employment.

The projected increase in persons served in Fiscal Years 2002 and 2003 is based on the slowing economy and the resulting tightening of the labor market. The unemployment rate has risen from a low of 3.2 percent (45,826 unemployed) in the second quarter of Fiscal Year 2000 to 3.6 percent (57,583 unemployed) in November 2001. The TAF population is generally characterized by low-skilled workers with intermittent work histories. An improvement in economic conditions will be reflected by declining caseloads only with a lag. Thus, despite projections that the economy will begin to recover in late 2002, the TAF caseload is expected to remain higher for a longer period.

General Assistance (GA)

The GA program serves disabled adults who are unable to work and are waiting for a decision from the Social Security Administration on their application for federal disability benefits. Disabled adults with income less than 34% of the federal poverty level may qualify for cash assistance.



Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1997	2,299		$158		$4,348,868	
1998	2,368	3%	$155	-2%	$4,390,098	1%
1999	2,301	-3%	$154	0%	$4,249,672	-3%
2000	2,220	-3%	$157	2%	$4,183,237	-2%
2001	2,616	18%	$157	0%	$4,938,766	18%
2002 est	3,060	17%	$158	0%	$5,800,000	17%
2003 est	3,480	14%	$158	0%	$6,600,000	14%

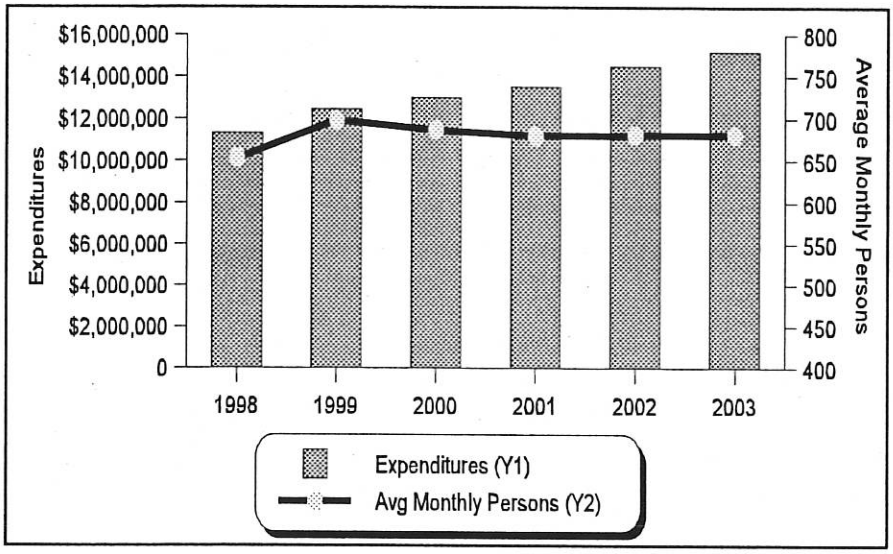
Similar to the TAF program, GA benefits have remained constant since 1993. The change in expenditures is therefore the result of variations in the number of persons served. Prior to Fiscal Year 2001, the number of persons served remained fairly constant, consistent with the absence of major program policy changes. The number served then rose at an unprecedented rate. The underlying cause of the increase is attributed to worsening economic conditions.

Two factors that affect the number served may be ruled out. One factor that would increase the number of GA clients would be stricter federal disability criteria, allowing fewer persons to leave GA. However, the rate of federal disability approvals has not changed significantly as the caseload has increased. More lenient state program policies would also give rise to increasing numbers served, yet no major program policies have been implemented. The number of GA clients does respond to changes in economic conditions, but the connection is somewhat tenuous. Recent analysis indicates that the primary increase in persons served has occurred in the southeast quadrant of the state, coinciding with higher regional unemployment. In addition, the increase is associated with new applicants. Thus, the department concludes that the weaker economy is the chief explanatory factor. Similar to the TAF caseload, the number of GA persons served is projected to lag improvements in the economy. Hence, the caseload projection for Fiscal Years 2002 and 2003 remains high despite the expected economic recovery toward the end of 2002.

Note: The estimate for Fiscal Year 2003 reflects the Caseload Consensus amount before the reduction in the Governor's Budget Report for the proposed time-limited program.

Nursing Facilities for Mental Health (NFsMH)

NFsMH are facilities that meet state licensure standards for nursing facilities. However, in addition to health-related care, these facilities provide specialized mental health rehabilitation services for persons with a severe and persistent mental illness (SPMI).

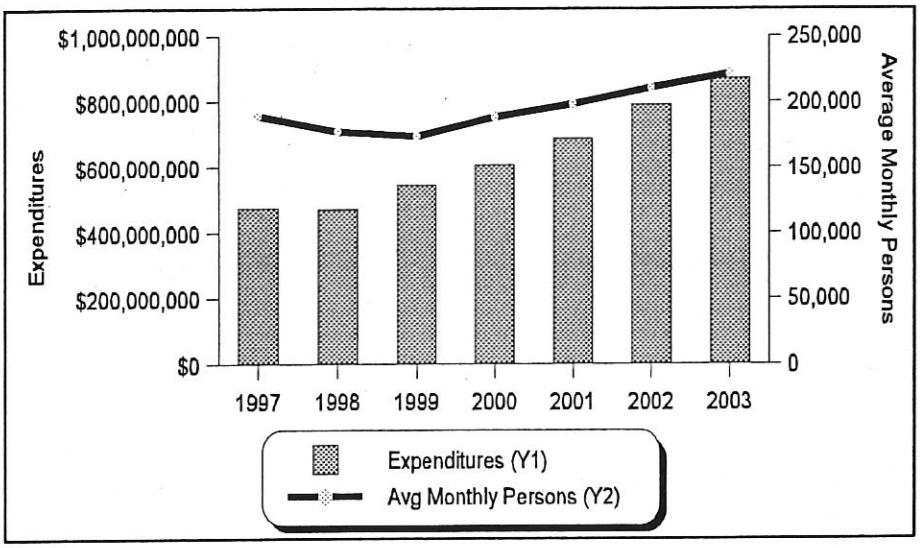


Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1998	653		$1,444		$11,314,957	
1999	698	7%	$1,488	3%	$12,462,579	10%
2000	687	-2%	$1,579	6%	$13,017,723	4%
2001	680	-1%	$1,658	5%	$13,529,803	4%
2002 est	681	0%	$1,774	7%	$14,500,000	7%
2003 est	681	0%	$1,860	5%	$15,200,000	5%

The number of persons served in the NFsMH remained fairly constant over the past several years. The number of NFMH facilities has remained the same during this time and they have a small vacancy rate. For these reasons, the consensus caseload process did not anticipate there would be any increases in the number of persons served in this program. Certain program policy changes are being instituted that will reduce the number of persons served in NFsMH. The fiscal impact of these changes is included in the Governor's Budget Recommendation but was not considered in the consensus caseload process.

State law requires NFsMH be reimbursed at a level that is sufficient to cover the costs of efficient and economically run facilities. Reimbursement rates are determined based on facility cost reports with additional amounts added to account for rising costs due to inflation. Using this required approach causes NFMH reimbursement rates to increase each year. This automatic increase in NFMH reimbursement causes the increased cost of this program.

Regular Medical Assistance



Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1997	189,582		209		$475,930,000	
1998	177,579	-6.3%	221	5.8%	$471,556,744	-0.9%
1999	173,998	-2.0%	261	17.8%	$544,327,399	15.4%
2000	188,250	8.2%	269	3.1%	$607,216,000	11.6%
2001	197,999	5.2%	289	7.6%	$687,297,857	13.2%
2002	210,730	6.4%	312	8.0%	$790,000,000	14.9%
2003	221,400	5.1%	327	4.8%	$870,000,000	10.1%

As the charts on the next page show, one of the largest cost drivers for medical assistance is the cost of prescription drugs. The cost of prescriptions made up 27.5 percent of Medicaid expenditures in FY 2001. Most of the growth in persons comes from low income children and families on cash assistance; however these groups are relatively inexpensive to serve. The medically needy, blind, disabled, and aged populations have the highest demand for services, with greater costs.

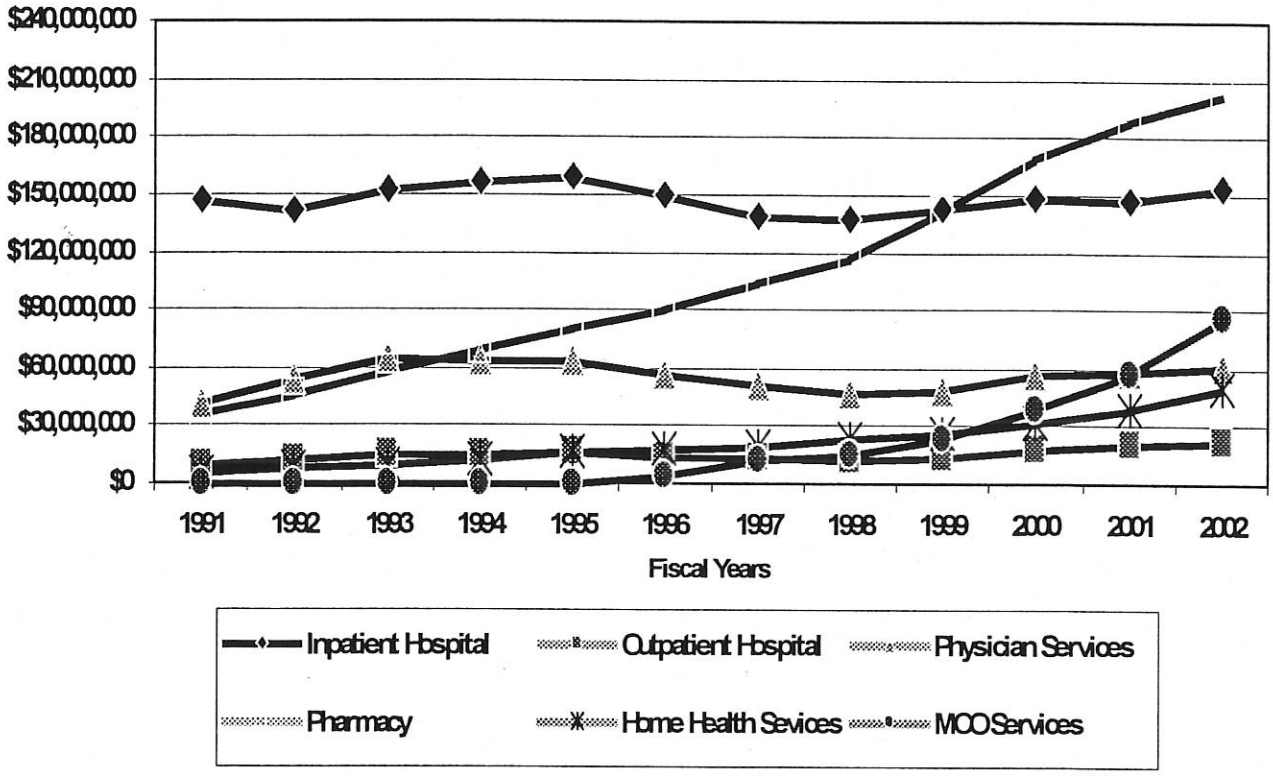
The following three pages break out the Regular Medical expenditures into three major population groups:

- Medicaid for Families
- Aged and Disabled
- All other populations.

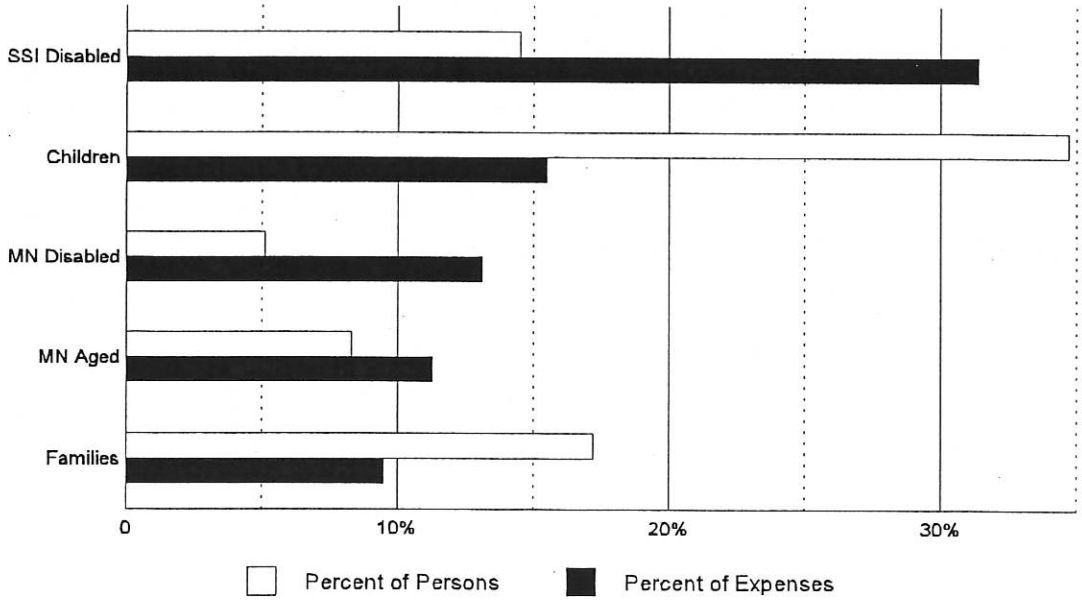
Each population group has unique characteristics; therefore, the nature of the changes in persons and costs is clarified by viewing the Regular Medical Assistance caseload trends within these three populations.

Note: Expenditures for both Fiscal Year 2002 and 2003 assume that no pending of claims will occur. The Fiscal Year 2002 approved budget assumed $11,250,000 in all funds reduction for pending claims.

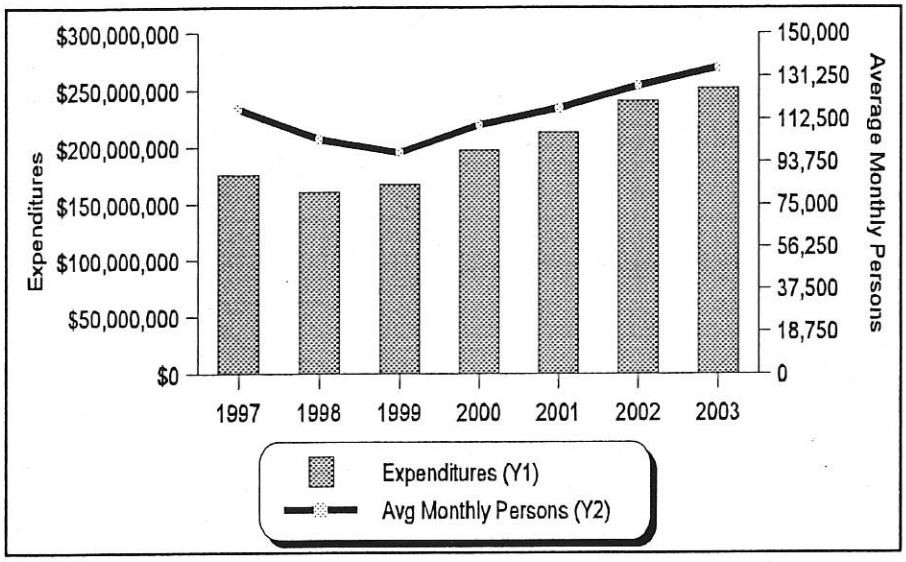
Medicaid Expenditures by Service Category



Percent of Persons Compared to Expenses
by Medicaid Eligibility Category for FY 2001



Medicaid for Families Population

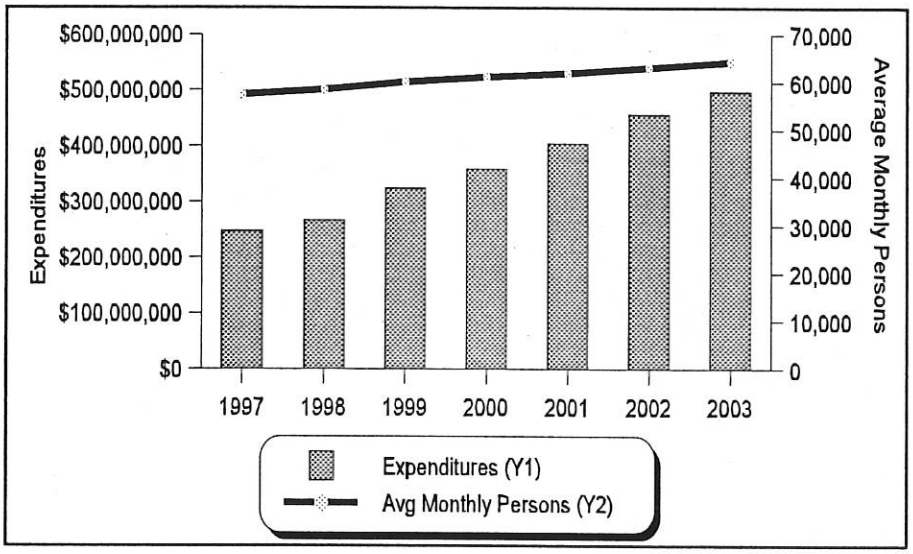


Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1997	116,662		$126		$176,083,967	
1998	103,744	11.1%	$129	2.8%	$160,893,378	-8.6%
1999	97,727	-5.8%	$143	10.5%	$167,545,413	4.1%
2000	110,012	12.6%	$150	4.9%	$197,815,651	18.1%
2001	117,464	6.8%	$152	1.1%	$213,642,083	8.0%
2002 est	127,060	8.2%	$158	4.1%	$240,620,000	12.6%
2003 est	135,320	6.5%	$155	-1.7%	$251,955,000	4.7%

The Temporary Assistance for Families (TAF) and Poverty Level Eligible (PLE) populations are eligible for managed care, including both capitation and primary care case management. From 1995 to 1998 the number of persons on TAF decreased due to Welfare Reform. This trend is now changing based on the slowing economy, the tightening of the labor market and the delinking of Medicaid services from TAF. Since January 1, 1999 with the introduction of HealthWave, there has also been an increase in these populations due to outreach.

The majority of changes in total costs for these populations are due to changes in the number of persons served. The average cost for these persons is relatively low due to the large number of children in these populations who typically have lower costs. From 1997 to 2001 the percentage of children has increased from 70% to 81% of the total for this group.

Aged and Disabled Medicaid Populations

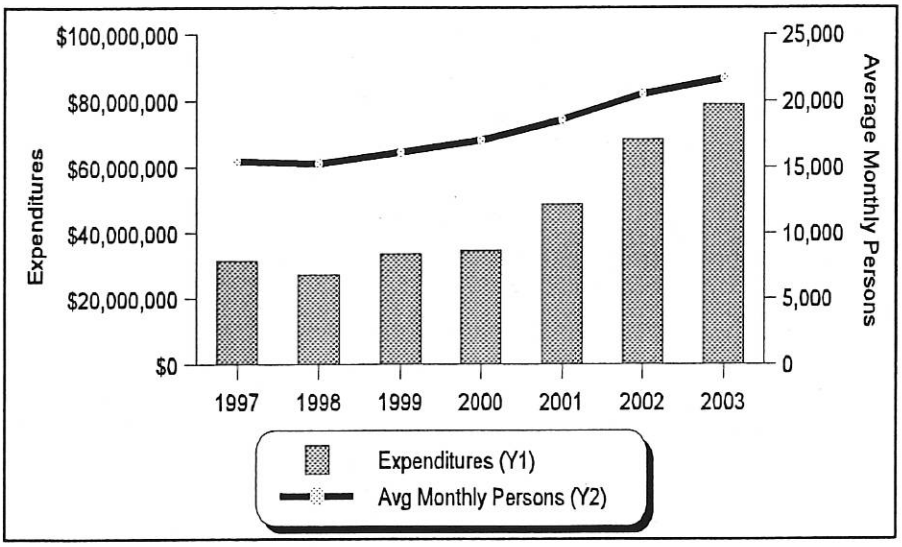


Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1997	57,440		$360		$247,920,483	
1998	58,525	1.9%	$380	5.6%	$266,647,026	7.6%
1999	60,118	2.7%	$451	18.7%	$325,233,343	22.0%
2000	61,150	1.7%	$490	8.7%	$359,656,514	10.6%
2001	61,928	1.3%	$544	11.0%	$404,257,552	12.4%
2002	63,120	1.9%	$603	10.8%	$456,740,000	13.0%
2003	64,380	2.0%	$644	6.9%	$497,905,000	9.0%

This category includes the mandatory SSI Aged and SSI Disabled, as well as the optional Medically Needy Aged and Disabled. These populations have grown consistently at a very low rate. The growth is predominantly related to the disabled rather than the aged. However, they account for the majority of expenditures for regular medical services. The majority of persons in these populations are in an HCBS program or long term care facility. Reductions in the waiting lists for HCBS programs would tend to add persons to these populations.

The majority of changes in total cost for these populations are due to increases in the monthly cost per person. This is primarily a utilization issue rather than an increase in specific rates, except for pharmacy services. Pharmacy continues to have increases in costs mainly because of expensive new drugs on the market. Another key cost driver in this area is the increased utilization of Home Health Agency services.

Other Medical Assistance Populations



Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1997	15,480		$170		$31,549,600	
1998	15,310	-1.1%	$149	12.1%	$27,413,000	13.1%
1999	16,153	5.5%	$174	16.8%	$33,773,000	23.2%
2000	17,087	5.8%	$170	-2.4%	$34,852,600	3.2%
2001	18,607	8.9%	$219	29.0%	$48,955,057	40.5%
2002	20,550	10.4%	$277	26.6%	$68,430,000	39.8%
2003	21,700	5.6%	$304	9.5%	$79,108,000	15.6%

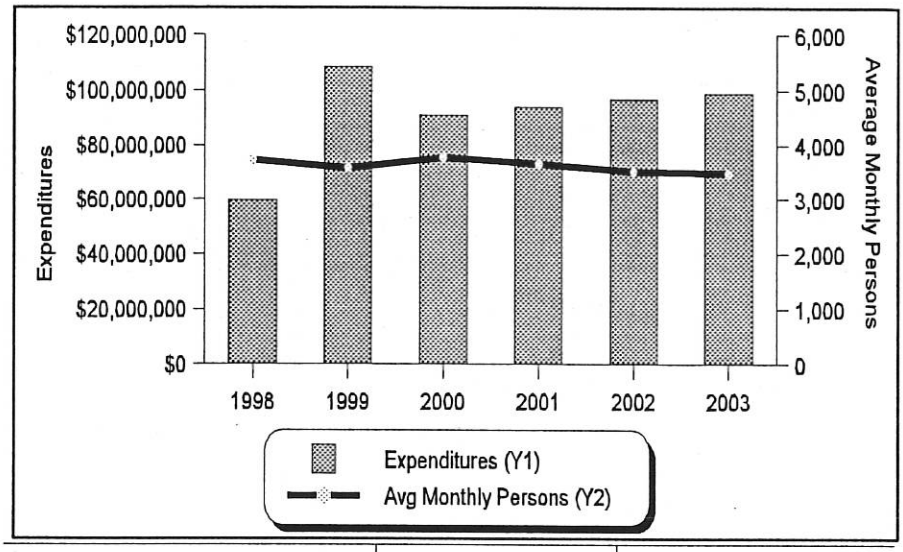
All other Medicaid populations include the MediKan (State only funded), Qualified Medicare Beneficiaries (QMB), Medically Needy Family, Foster Care (SRS, JJA and Adoption), and a few other very small groups.

The numbers of persons and their expenditures are much smaller than the other two groups noted above. With the exception of MediKan, they are not eligible for managed care. Growth in these groups was primarily in two populations - QMB and Foster Care/Adoption. More recently growth has occurred in the MediKan population.

Recent changes in expenditures are primarily related to two items. First is the combined recent population growth in MediKan along with their average cost increase, which is similar to the Disabled population (MediKan clients are disabled individuals awaiting SSI determination). The second is the use of the medical card for psychiatric inpatient and CMHC services to children who are receiving foster care and adoption services.

Foster Care Contract

Foster care services for children who have been removed from their family home and placed in the custody of the Secretary of SRS are provided by five contractors. The emphasis of these services is to return the child to their family as soon as safely possible.



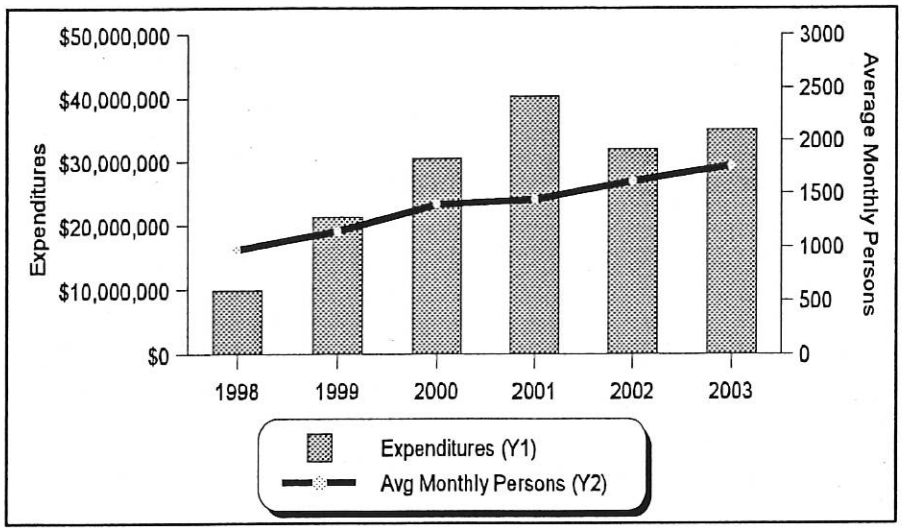
Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1998	3,728		$1,335		$59,719,097	
1999	3,579	-4%	$2,526	89%	$108,467,135	82%
2000	3,776	6%	$2,009	-20%	$91,045,343	-16%
2001	3,661	-3%	$2,141	7%	$94,039,453	3%
2002 est	3,522	-4%	$2,295	7%	$97,000,000	3%
2003 est	3,488	-1%	$2,365	3%	$99,000,000	2%

The number of children served in the Foster Care Contract caseload is a product of several diverse factors. Financial pressures on families induced by economic changes causing an increase in stress within the family, and alcohol or substance abuse are major influences on the number of children served. Less visible factors include the difficulty with which parental rights may be terminated or the propensity of the judicial system to assign children to SRS's custody. For Fiscal Years 2002 and 2003, the caseload is projected to decline, based on recent trends, and the absence of significant external changes.

The chief reason for the increase in expenditures is the cost per child. The department has contracted for foster care services since the latter part of Fiscal Year 1997. The cost of foster care is expensive. Furthermore, the five regional contracts must be negotiated to maintain a provider base capable of serving children across the state. Until the end of Fiscal Year 2001, providers were reimbursed based solely on the number of children served. However, during Fiscal Year 2001, the department recognized that some regions were experiencing financial problems due to a decline in the number of children served. But for a change in the Fiscal Year 2002 contract, this may have had a devastating impact on the availability of foster care providers. The Fiscal Year 2002 contract adopted a fixed payment approach based on the current number of children served. Within this approach, providers may remain financially sound. The new contract also enhances the availability of mental health services, an element of care that could not be ignored for this population. The new contract resulted in higher costs, but in its absence, the department may not have been able to continue serving children with the local expertise they now receive.

Adoption Contract

Adoption services are provided under a statewide contract with Kansas Children's Service League. This contract serves children whose parents have either relinquished their parental rights or had their parental rights terminated. The focus of these services is to establish a new permanent family for the child as expeditiously as possible.



Fiscal Year	Average Monthly Persons	Pct Chg	Average Monthly Cost per Person	Pct Chg	Expenditures	Pct Chg
1998	973		$848		$9,899,778	
1999	1,144	18%	$1,550	83%	$21,272,745	115%
2000	1,397	22%	$1,820	17%	$30,511,700	43%
2001	1,443	3%	$2,328	28%	$40,304,937	32%
2002 est	1,616	12%	$1,650	-29%	$32,000,000	-21%
2003 est	1,761	9%	$1,656	0%	$35,000,000	9%

The number of children served by the adoption contract has increased each year. Assuming a constant number of children in the foster care contract and a constant adoption rate, the number of children served in the adoption contract would remain fairly stable. However, the increase in the number served shows that more children have been referred to the adoption contract than have been adopted. During Fiscal Year 2001, there was a significant decline in the number of adoptions. One problem involved the transition to a new contractor. The new contract also enhances the availability of mental health services, an element of care that could not be ignored for this population The projected increase in the number of children served is based on the current trend in children referred to the Adoption Contract with no major change in the rate of adoption. For this population, the number of children served is the main determinant of the expenditure increase.

The cost per child decreased in Fiscal Year 2002 and is projected to be constant for Fiscal Year 2003.

That concludes my testimony, but I would be happy to address any questions you may have.

Caseload Estimating
November 6, 2001

		FY 2002 Approved	November Revised FY 2002	Difference from Approved	November Est. FY 2003	Diiference from Revised FY 2002
Nursing Facilities	SGF	121,260,309	121,260,309	0	128,800,000	7,539,691
	AF	304,020,475	304,020,475	0	322,000,000	17,979,525
NFMH	SGF	9,029,837	10,408,100	1,378,263	10,910,560	502,460
	AF	12,718,080	14,500,000	1,781,920	15,200,000	700,000
Temporary Assistance to Families	SGF	30,293,070	30,293,070	0	30,293,070	0
	AF	46,000,000	49,000,000	3,000,000	52,500,000	3,500,000
General Assistance	SGF	4,800,000	5,800,000	1,000,000	6,600,000	800,000
	AF	4,800,000	5,800,000	1,000,000	6,600,000	800,000
Regular Medical	SGF	242,119,517	262,505,484	20,385,967	301,484,223	38,978,739
	AF	719,042,900	790,000,000	70,957,100	885,000,000	95,000,000
Foster Care Contract	SGF	33,158,603	42,812,646	9,654,043	44,195,242	1,382,596
	AF	90,700,000	97,000,000	6,300,000	99,000,000	2,000,000
Adoption Contract	SGF	13,074,165	14,824,419	1,750,254	16,756,025	1,931,606
	AF	27,000,000	32,000,000	5,000,000	35,000,000	3,000,000
Total	SGF	453,735,501	487,904,028	34,168,527	539,039,120	51,135,092
	AF	1,204,281,455	1,292,320,475	88,039,020	1,415,300,000	122,979,525

Attachment A

Poverty Guidelines

Selected SRS Services	Percent of 2001 Federal Poverty Level	Annual Income Guidelines for 1-5 Member Households HH1	HH2	HH3	HH4	HH5
TAF and GA-Cash & Medical	34%	$2,921	$3,947	$4,974	$6,001	$7,028
Elderly/Disabled Persons on SSI-Medical	74%	6,357	8,591	10,826	13,061	15,296
Children Age 6-18-Medicaid/Waivers	100%	8,590	11,610	14,630	17,650	20,670
	105%	9,020	12,191	15,362	18,533	21,704
	110%	9,449	12,771	16,093	19,415	22,737
	115%	9,879	13,352	16,825	20,298	23,771
	120%	10,308	13,932	17,556	21,180	24,804
	125%	10,738	14,513	18,288	22,063	25,838
Food Assistance/ Energy Assistance	130%	11,167	15,093	19,019	22,945	26,871
Children Age 1-5-Medicaid	133%	11,424	15,441	19,457	23,474	27,491
	135%	11,597	15,674	19,751	23,828	27,905
	140%	12,026	16,254	20,482	24,710	28,938
	145%	12,456	16,835	21,214	25,593	29,972
Pregnant Women & Infants-Medicaid	150%	12,885	17,415	21,945	26,475	31,005
	155%	13,315	17,996	22,677	27,358	32,039
	160%	13,744	18,576	23,408	28,240	33,072
	165%	14,174	19,157	24,140	29,123	34,106
	170%	14,603	19,737	24,871	30,005	35,139
	175%	15,033	20,318	25,603	30,888	36,173
	180%	15,462	20,898	26,334	31,770	37,206
Child Care Subsidy	185%	15,892	21,479	27,066	32,653	38,240
	190%	16,321	22,059	27,797	33,535	39,273
	195%	16,751	22,640	28,529	34,418	40,307
Children's Health Insurance Program	200%	17,180	23,220	29,260	35,300	41,340

Information contained in this chart is intended to be general and is subject to change.
For specific eligibility requirements, please check with your Area SRS Office.

State of Kansas
Department on Aging

Connie L. Hubbell, Secretary

Janis DeBoer
Deputy Secretary
New England Building
503 S. Kansas Avenue
Topeka, Kansas 66603
phone: (785) 368-6684
fax (785) 296-0256

Doug Farmer
Assistant Secretary
New England Building
503 S. Kansas Avenue
Topeka, Kansas 66603
phone: (785) 296-6295
fax (785) 296-0767

Senate Ways and Means Committee
January 16, 2001

Report on Kansas Department on Aging Caseloads

For information contact:
Sheli Sweeney, Legislative Liaison
(785) 296-5222 or michelle@aging.state.ks.us

Senate Ways and Means
1-16-02
Attachment 2

REPORT TO THE SENATE WAYS AND MEANS COMMITTEE
BY
SECRETARY CONNIE HUBBELL
KANSAS DEPARTMENT ON AGING
January 16, 2002

Good morning, Mr. Chairman and members of the committee. Thank you for this opportunity to present testimony regarding the Kansas Department on Aging's (KDOA) Medicaid caseloads.

The Kansas Department on Aging operates two programs that are funded through the federal Medicaid program: the Nursing Facility program, and the Home and Community Based Services / Frail elderly (HCBS/FE) waiver. Both programs are funded on a 60/40 basis, with the federal government paying 60 percent of costs and the state paying 40 percent. While the state's consensus caseload estimating process recognizes only the Nursing Facility program in its annual caseload projections, I have included information related to the waiver in order to more accurately depict what is happening in aging-related Medicaid services as a whole.

Nursing Facilities

For FY 2002 the Department requested $310.4 million for the Nursing Facility program from all funding sources, including $124.2 million from the State General Fund. This amount would finance an average of 11,200 clients per month at an average cost of $2,310 per client per month ($27,720 per year). The number of individuals receiving services under the NF program remains essentially flat as compared to FY 2001, and costs increase by 6.25 percent.

For FY 2003 the Department's September budget submission included $332.2 million for the Nursing Facility program. That request included funding for an average of 11,200 clients per month at an average cost of $2,472 per client per month. The Department's September request reflected no growth in the number of clients as compared to the 2002 estimate, and cost increases of 7.0 percent. The 7.0 percent increase included .75 percent for utility increases from calendar year 2001 that should make their way into the NF cost reports in FY 2003, and 6.25 percent for all other increases.

The Consensus Caseload Estimating Group determined that the FY 2002 caseload should be left at $304,020,475 as approved by the 2001 Legislature , and that the FY 2003 caseload cost should be $322.0 million. I fully support both numbers achieved through consensus.

As agreed through the Consensus process, the FY 2002 amount provides services for an average of 11,000 clients per month at an average cost of $2,303 per client per month. At this amount, the number of clients decreases by 1.5 percent as compared to FY 2001 actuals, and the cost per client per month increases by 5.5 percent. For FY 2003, the Consensus estimate assumes

an average of 11,000 clients per month at an average cost of $2,439 per client per month. The FY 2003 estimates assumes that the average number of customers per month will remain flat from FY 2002, and costs per client will increase by 5.9 percent.

Nursing Facility Consensus Caseload Estimates

NF Expenditures	FY 2001 Actual	FY 2002 Agency	FY 2002 Consensus	FY 2003 Agency	FY 2003 Consensus
Total Expenditure	$291,281,761	$310,400,000	$304,020,475	$332,200,000	$322,000,000
Average Clients per Month	11,162	11,200	11,000	11,200	11,000
Average Cost per Client per Month	$2,184	$2,310	$2,303	$2,472	$2,439

Home and Community Based Services/ Frail Elderly (HCBS/FE)

For FY 2002 the Department requested $53,600,000 for the HCBS/FE waiver. This funding would provide for an average of 5,520 clients per month at an average cost per client per month of $809 ($9,708 per year). The caseload increases by 5.4 percent over FY 2001 and the cost per client per month increases by 2.5 percent.

For FY 2003 the Department requests $56,800,000 for the HCBS/FFE waiver. This amount will provide for an average of 5,818 clients per month at an average cost per client per month of $813 ($9,756 per year). The caseload increases by 5.4 percent over the FY 2002 request, and the cost per client per month increases by .5 percent.

HCBS/FE Consensus Caseload Estimates

HCBS/ FE Expenditures	FY 2001 Actual	FY 2002 Request	FY 2003 Request
Total Expenditure	$49,528,326	$53,600,000	$56,800,000
Average Clients per Month	5,237	5,520	5,818
Average Cost per Client per Month	$789	$809	$813

Mr. Chairman and members of the committee, thank you for the opportunity to brief you on the important work KDOA is doing for Kansas seniors. I will now stand for questions.