Approved Thomas F. Walker [illegible] -88
Date

MINUTES OF THE HOUSE COMMITTEE ON GOVERNMENTAL ORGANIZATION.

The meeting was called to order by Representative Thomas F. Walker (Chairperson) at 9:00 a.m./p.m. on Tuesday, March 15, 1988 in room 522-S of the Capitol.

All members were present except:

Representative Brown -Ex. Representative Sebelius
Representative Schauf Representative Peterson

Committee staff present:
Avis Swartzman - Revisor
Carolyn Rampey - Legislative Research Dept.
Mary Galligan - Legislative Research Dept.
Robin Hunn - Legislative Research Dept.
Jackie Breymeyer - Committee Secretary

Conferees appearing before the committee:

John Schneider, Commissioner, Income Maintenance and Medical Services (SRS)

The meeting was called to order by Representative Thomas F. Walker, Chairman. He introduced John Schneider, present to speak on the services his agency provides.

Mr. Schneider distributed two attachments to the committee (Attachments 1 and 2) He began with Aid to Dependent Children and General Assistance Programs. Aid to Dependent Children is funded 55% federal - 45% state. There are 22,000 to 24,000 families in the program which amounts to approximately 65,000 persons total.

The General Assistance Program, funded entirely by the state, has 3500 to 4,000 persons in the program. The $234 a month received would include food stamps and medical card in almost every case.

Mr. Schneider said with regard to the commodity program that food that is going overseas now will greatly cut into what will be available to offer to the needy in this country.

With regard to the heating/cooling assistance, 50,000 persons participate in heating; approximately half that number for cooling.

Mr. Schneider also discussed food stamps and housing.

As time was running short, Mr. Schneider turned to the second attachment and spoke on Medicaid mandated categories of service and Medikan and its optional services.

Chairman Walker told Mr. Schneider the committee might have him back to speak further on his agency.

The meeting was adjourned.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

GUEST LIST

COMMITTEE: GOVERNMENTAL ORGANIZATION

DATE: MARCH 15, 1988

NAME	ADDRESS	COMPANY/ORGANIZATION
Kathryn Klassen	DSOB 6th fl. South 915 Harrison, Topeka	SRS
Carla Nakata	DSOB 6th Floor S	SRS
John Schmidt	Topeka	SRS
Susan Duffy	Topeka	Budget Division
Douglas [illegible]	Wamego	Budget Division

Aid to Dependent Children Program: This program provides basic financial support to families with children who are deprived of parental support due to the death, absence, incapacity or unemployment of a parent. Persons eligible for Aid to Dependent Children automatically receive medical assistance as well.

General Assistance Program: Funded entirely by the state, this program provides minimum financial support for eligible individuals and families in need who do not meet eligibility requirements for other types of public assistance. GA recipients are persons who are: 1) age 55 or older, 2) parents and their minor children not eligible for Aid to Dependent Children, 3) persons medically determined to be disabled for 30 days or longer, 4) non-ADC eligible pregnant women and their husbands, 5) persons participating in vocational rehabilitation and participants in a mental health treatment program, 6) residents of alcohol and drug abuse facilities, or 7) persons needed to care for a family member unable to care for himself or herself. Most GA recipients receive 80 percent of the assistance they would receive if they were Aid to Dependent Children recipients; however, GA families with children and individuals who participate in the Community Work Experience Program or in Vocational Rehabilitation receive 100 percent of the Aid to Dependent Children standard. With the exception of children and pregnant women who are covered by the federally-funded Medicaid Program, persons eligible for GA automatically receive limited medical coverage through MediKan, a state-funded medical assistance program.

Food Stamp Program: This federally funded program is designed to safeguard the health and well-being of the nation's population by raising the level of nutrition among low-income households. The Department is responsible for developing policies and procedures for Kansas within federal guidelines and issuing of Food Stamp benefits to eligible households.

Low Income Energy Assistance Program: The purpose of the federally funded Low Income Energy Assistance Program (LIEAP) is to provide assistance to eligible low-income households to supplement the household's ability to cope with the high costs of energy, rather than to reimburse for total costs. In addition to meeting income tests, eligible households must have made energy payments during two of the three months prior to application for assistance.

- Winter Heating Phase: Application for assistance must be made during the period December through March. The size of the one-time benefit is determined by four household factors: 1) income, 2) type of housing structure, 3) type of heating fuel, and 4) rates charged by the applicant's utility. Although there are no age or disability requirements for Winter Heating assistance, 43 percent of 1987 winter recipient households contained an elderly member and more than half of those elderly households had incomes below the poverty level.

- Summer Cooling Phase: Application for assistance must be made during July or August. Summer cooling assistance is designed to aid eligible elderly and disabled populations most susceptible to heat stroke and other heat-related illness. The size of the benefit is determined by three factors: 1) income, 2) type of housing structure, and 3) the electric rates charged by the applicant's utility. More than half of summer recipients are over 75 years of age.

- o Medical Emergency Assistance Cooling Phase: Application for this very limited form of crisis assistance must be made during July or August. It is designed to assist in energy-related medical emergencies if a household is 1) without a cooling appliance or 2) in a disconnect situation with the electric utility. A physician's statement is required indicating that a household member has an existing medical condition which may be aggravated by the heat. Size of benefit level is determined by the delinquent amount of the cooling energy bill, up to $300, if electric assistance is the desired benefit. If the household needs the purchase, rental, repair, or installation of a cooling appliance, up to $50 will be paid for a fan, or up to $300 for an air conditioner.

Housing Assistance Program: The purpose of the federally funded Section 8 Housing Program is to provide safe, decent, and sanitary housing for qualifying families. The service areas of Department responsibility are defined by HUD. The following housing programs were administered in FY 1987:

A. The "New Construction" Program assists 291 low income households in 7 cities with their monthly rent. The tenant is required to contribute 30% of his adjusted gross income with the remaining 70% of the rent paid using HUD funds. The seven projects involved were finalized through the Kansas Housing Development Corporation in the early 1980's. The seven projects are located in the following cities:

Bookridge Plaza	Derby	45 Units
Tumbleweed Apartments	Lyons	16
Mulberry Court	Abilene	45
Mission Woods	Ottawa	36
Brittany Court	Gardner	45
Lom Vista Estates	Osawatomie	64
Jewell Crest	Leavenworth	47
Total		291

The Department assumes the role of Public Housing Agency (PHA) for these public housing projects built in cities without Housing Authorities, and provides monthly rent payments on behalf of eligible tenants. In addition, SRS monitors management of the housing projects, including fiscal management. This includes performing reviews, evaluating financial statements, and inspecting the units.

B. The "Homeless Program" was initiated by HUD in FY 1986 to serve homeless families in the Greater Kansas City Area. Fifteen Section 8 certificates were initially issued to the Kansas Department of Economic Development to administer this small program in Johnson, Wyandotte, and Leavenworth counties. When the housing programs were transferred to SRS in July of 1986, HUD began to expand the number of assistance units and by the end of FY 1987, authorization had been received from HUD to house 119 total households.

C. The "Emergency Shelter Grants Program" was funded for the first time in FY 1987 through the U.S. Department of Housing and Urban Development. It was designed to 1) improve the quality of existing emergency shelters for the homeless, 2) help make available additional emergency shelters, and 3)

assist in meeting the costs of operating emergency shelters. HUD's initial allocation to the state this year was $283,000, however a supplemental of unknown amount is anticipated.

Refugee Assistance Program: The primary goal of the federally funded Kansas Refugee Resettlement Program is to promote economic self-sufficiency and effective resettlement for refugees within the shortest possible time after entrance into Kansas, through the coordinated and effective use of support services, cash and medical assistance. Economic self-sufficiency is defined as gainful employment in nonsubsidized jobs with at least 90-day retention and receipt of a wage adequate for the basic economic needs of the person and family, without reliance on public assistance. Effective resettlement means refugees have become self-reliant in utilizing community resources, have learned English, and have adjusted socially and culturally.

Commodity Distribution Programs: The Temporary Emergency Food Assistance Program (TEFAP) enables needy Kansans to receive, at no cost, surplus U.S. Department of Agriculture (USDA) food commodities for home consumption or as a part of prepared meals at soup kitchens. This federally funded program helps to improve the diet of needy persons and at the same time strengthens the agricultural market for food that American farmers produce. Over 300 agencies and organizations statewide volunteered to distribute the commodities to thousands of needy Kansans each month during Fiscal Year 1987.

The Charitable Institution Commodity Program (CICP) provides donated foods to eligible institutions for use in their prepared meal feeding programs. In Kansas CICP began in June 1985 as a pilot project, and it was expanded into a statewide program during Fiscal Year 1986. Over 250 nonprofit institutions currently participate in CICP. Some examples of eligible institutions include: Meals-on-Wheels programs, soup kitchens, homes for the aged, temporary shelters, orphanages, correctional institutions offering rehabilitative activities, group homes for the mentally retarded, and hospitals that offer general long-term health care.

Medical Assistance Program

In 1967, with the passage of Title XIX of the Social Security Act, the Kansas Department of Social and Rehabilitation Services (SRS) was designated the single state agency to administer the Medical Assistance Program in Kansas. In doing so, SRS was mandated to establish a program of medical services for persons eligible as determined by federal regulations and for those persons on general assistance.

The Division of Medical Programs is responsible for overseeing the Medical Assistance Program, assuring that the state plan is current and followed, and verifying that only Medicaid covered services are included in requests to the Health Care Financing Administration for federal matching funds. In some situations, states are required to cover certain services by federal regulations. Often, this coverage is for medically necessary services which were not being provided. Such has been the case in the provision of services for AIDS recipients and transplantations, including follow-up care. Federal regulations mandate categories of eligible recipients and medical services that must be covered. States may be more restrictive in coverage than federal regulation limitations, but cannot be more lenient. To be eligible for medical assistance, persons must meet specified criteria of being aged, blind, disabled, or be eligible through Aid to Families with Dependent Children. They must also meet income and resource guidelines. Those not eligible for federal assistance may have been eligible for MediKan services through eligibility for state General Assistance.

Medicaid is an entitlement program with a federal match for all expenditures meeting federal guidelines at a percentage based on state per capita income. The current match rate for services provided is 55% federal and 45% state funds.

Federal regulations mandate that certain services must be covered to participate in Medicaid. Other services may be covered if included in the state plan. MediKan services are those provided to eligible recipients and paid for from all state funds.

Categories of services covered by Medicaid and MediKan are:

FY 1988

MEDICAID	MEDIKAN
Mandated Categories of Service:	All services are optional.
Inpatient Hospital-surgery is limited to non-elective procedures. Stays must be medically necessary. Alcohol & drug treatment limited to three admissions per lifetime, and 25 days of stay per admission.	**Inpatient Hospital**-surgery is limited to non-elective procedures. Stays must be medically necessary. Alcohol & drug treatment limited to three admissions per lifetime, and 25 days of stay per admission. All admissions for diagnostic work-up are non-covered.
Outpatient Hospital - reduced to MediKan service limitations.	**Outpatient Hospital** - surgery and other procedures must be medically necessary. Emergency room use must be for an emergency. Limited by identified procedures. Reimbursement is based on the lower of the usual & customary charge or the established range maximum.

ATTACHMENT 2
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MEDICAID	MEDIKAN
Physician - reduced to MediKan service limitations.	**Physician** - non-elective surgery only. Office visits are limited to 12 per year. New procedures are not covered.
Home Health - same as MediKan.	**Home Health** - covered without limitations.
Family Planning - same as MediKan.	**Family Planning** - covered without limitations.
Laboratory and Radiology - same as MediKan.	**Laboratory and Radiology** - covered without limitations.
Skilled Nursing Facilities - same as MediKan.	**Skilled Nursing Facilities** - covered without limitations.

Optional Categories Covered at the State's Discretion:

MEDICAID	MEDIKAN
Community Mental Health Centers - reduced to MediKan service limitation.	**Community Mental Health Centers** - covered with limitation on procedures which are identified individually. Increased to 32 hours of psychotherapy per year, limited to all categories of providers providing psychotherapy.
Psychology - reduced to MediKan service limitations.	**Psychology** - increased to 32 hours of psychotherapy per year limited to all categories of providers providing psychotherapy.
Ambulatory Surgery Centers - same as MediKan.	**Ambulatory Surgery Centers** - limited to non-elective surgery.
Prescribed Drugs - reduced to MediKan level with a formulary having limited drug coverage with same criteria as MediKan.	**Prescribed Drugs** - limited to a formulary with many non-covered drug categories. Reimbursement is at a State maximum allowable cost limitation. Generic substitution required. Some drugs covered only for lowest bidder.
Dental - reduced to MediKan limitations.	**Dental** - only oral surgery is covered. No extractions are covered.
Local Health Departments - same as MediKan.	**Local Health Departments** - coverage of EPSDT, prenatal risk reduction, new born home visits, family planning services & treatment of STD.
Durable Medical Equipment & Orthotics and Prosthetics - reduced to MediKan service limitations.	**Durable Medical Equipment & Orthotics and Prosthetics** - covered with severe limitations.
Chiropractic - same as MediKan.	**Chiropractic** - limited to 12 office visits per year.
Podiatry - same as MediKan.	**Podiatry** - limited service coverage, including surgery provided in the office or in an adult care home.
Optometric Services - eye exams limited to 1 every 4 years. Medical eye condition treatment is covered.	**Optometric Services** - not covered except for medical eye conditions for adults.
Audiological Services - covered with limitations.	**Audiological Services** - not covered.

Attendant Care for Independent Living - same as MediKan.
Medical Transportation - emergency & limited non-emergency services covered.
Intermediate Care Facilities (Including general, mental retardation, and mental health.)*
Home and Community Based Services - covered
Co-payment - $1 physician, dental, drugs, psychology, chiropractic, ambulance & vision. $3 outpatient hospital & ambulatory surgery. $25 inpatient hospital admission (except surgery). Exceptions: Those under age 18, Adult Care Home residents, those in the Home and Community Based Services programs, & those receiving family planning pregnancy and emergency services. All co-payments are also applied to Medicare covered services.

*This includes coverage of swing beds in general hospitals and heavy care in these facilities.

Attendant Care for Independent Living - personal care services. Maximum 12 hours daily.
Medical Transportation - emergency ambulance with supplies is covered.
Intermediate Care Facilities (Including general, mental retardation, and mental health.)*
Home and Community Based Services - covered
Co-payment - $1 physician, dental, drugs, psychology, chiropractic, ambulance & vision. $3 outpatient hospital & ambulatory surgery. $25 inpatient inpatient hospital admission. Exceptions: Those under age 18, Adult Care Home residents, those in Home and Community Based Services programs, and those receiving family planning, pregnancy and emergency services.

*This includes coverage of swing beds in general hospitals and heavy care in these facilities.

Approximately 10,000 medical providers are enrolled in the Kansas Medical Assistance Program to provide the covered service to eligible recipients. K.S.A. Supp. 39-708c authorizes the provision of these services. It also authorizes the Department of Social and Rehabilitation Services to contract with a fiscal agent for the processing and reimbursing of claims. Providers are to be paid at a reasonable fee for service. The Division of Medical Programs administers this system through a federally approved and federally matched Medicaid Management Information System. System changes have a 90% federal match rate and on-going system operation a 75% match rate.

To be a provider of Medicaid/MediKan services, interested persons must make application and be approved to provide a covered category of service. Reimbursement is made to the provider for covered services upon claim submission. Maximum rates for reimbursement are established by the Secretary of Social and Rehabilitation Services based on the provider's costs or the provider's usual and customary charges. Two criteria are always utilized:

1. The provider group must provide medically necessary services in an efficient and economical manner.
2. The service must be provided in the least restrictive setting in which the service can be received. Incentives are established to encourage use of the least restrictive setting.

Every effort is made to assure that: (1) other third party payors are billed first (if not, recovery of the Medicaid/MediKan reimbursement for this service is made later), (2) misutilization, abuse, and fraud are detected and appropriate action is taken, and (3) incorrect and inappropriate billings are identified and recoupments made.

LKK:plk
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Department of Social and Rehabilitation Services
Division of Medical Programs

COMPARISON OF MEDICAID-MEDIKAN LIMITATIONS
as of July 1, 1987

	All Medicaid Except EPSDT Program Participants	All MediKan
ADULT CARE HOME SERVICES	Recipient must be screened and choose ACH over HCBS. ICF, SNF, ICF/MR and ICF/MH services are covered if a recipient is over the age of sixteen and not pregnant. Recipients under the age of sixteen or those who are pregnant must receive ACH services from a state facility or swing-bed hospital. No copayment is required.	Same as Medicaid except only two months of stay are covered including the month of entrance.
AMBULATORY SURGICAL CENTER SERVICES	Nonelective surgery is the only covered service. Copayment is $10.00 per visit (copayment is $3.00 per visit, effective January 1, 1988).	Same as Medicaid.
AUDIOLOGICAL SERVICES	Exams, testing, dispensing and repairs are covered. Hearing aids are covered with prior authorization.	Noncovered.
CHIROPRACTIC SERVICES	Twelve office visits (examinations and services to treat back problems) per calendar year are covered. Copayment is $1.00 per visit.	Same as Medicaid.
COMMUNITY MENTAL HEALTH CENTER SERVICES	800 units per calendar year of outpatient psychotherapy are covered (one hour of group therapy equals four units, and one hour of individual or family therapy equals twenty units).	480 units per calendar year of outpatient psychotherapy are covered (unit definition is the same as Medicaid).
	800 units per recipient's lifetime of substance abuse treatment are covered, regardless of provider.	Same as Medicaid.
	Six hours of psychological testing every two years are covered with prior authorization.	Six hours of psychological testing every three years are covered with prior authorization.
	Five hours of admission evaluation per calendar year are covered.	Same as Medicaid.
	One hour of therapy per day for fourteen days of stay provided in an inpatient hospital setting are covered.	Same as Medicaid.
	2,080 hours per calendar year of psychiatric partial hospitalization are covered.	1,440 hours per calendar year of psychiatric partial hospitalization are covered.
	No copayment is required for any CMHC services.	Same as Medicaid.
DENTAL SERVICES	Only nonelective dental surgery is covered. Dentures are not covered. Copayment is $1.00 per office visit.	Same as Medicaid.
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, ORTHOTICS AND PROSTHETICS	Selected items to be used in a recipient's home are covered. Artificial limbs, braces and special equipment are covered. Most services require medical necessity documentation or prior authorization. Recipients must need services for school, employment, life support, or to preclude higher cost care. No copayment is required.	Coverage of these items is limited to those needed for life support. Most services require medical necessity documentation or prior authorization.
FAMILY PLANNING SERVICES	All services (counseling; physical examination; laboratory tests; surgical procedures, supplies and devices that prevent conception; and natural family planning methods) are covered if provided by physicians, local health departments or family planning clinics. No copayment is required.	Same as Medicaid.
HOME HEALTH SERVICES	Skilled nursing care; home health aide care; attendant care for independent living; and physical, occupational and speech therapy if for restoration of functions lost due to accident or illness are covered. No copayment is required.	Same as Medicaid.

	All Medicaid Except EPSDT Program Participants	All MediKan
HOSPITAL SERVICES	Inpatient: Acute medical care (intensive and coronary care, laboratory and x-ray, operating room and anesthesia, drugs, blood, oxygen, intravenous solutions, nursing services) is covered. Stays are subject to utilization review. Substance abuse treatment is limited to three admissions per lifetime, and is covered up to twenty-five days per admission. Detoxification is covered up to eight days. Nonelective surgery is the only covered surgery. Procedures to diagnose disease are covered. Rehabilitative therapy (physical, speech or occupational) is covered if physically restorative following an illness or accident. For normal deliveries, the delivery room, nursery and forty-eight hours of care are covered. Copayment is $25.00 per admission.	Same as Medicaid.
	Outpatient: Emergency care, sterilizations, diagnostic testing, radiation and chemotherapy, renal dialysis, and nonelective surgery are covered. Nonemergency visits count against the physician office visit limitation. Copayment is $10.00 per outpatient surgery ($3.00 effective January 1, 1988) and $1.00 per nonemergency visit instead of a doctor's office visit.	Same as Medicaid.
	Emergency services for illegal aliens (Program Code 72): outpatient emergency room services, forty-eight hours of subsequent inpatient stay and related physician services.	These individuals are considered to be Medicaid.
LABORATORY AND RADIOLOGY SERVICES	Laboratory tests and x-rays needed to detect and treat disease are covered. No copayment is required.	Same as Medicaid.
LOCAL HEALTH DEPARTMENT SERVICES	Selected laboratory procedures; immunizations; family planning services; prenatal risk reduction and health promotion; newborn home visits; screening, diagnosis and treatment of sexually transmitted diseases are covered. No copayment is required.	Same as Medicaid.
PHYSICIAN SERVICES	Twelve nonpsychiatric office visits and twenty-four hours of psychiatric office visits per calendar year are covered. Nonelective surgery, elective sterilization, laboratory and diagnostic x-rays are covered. Copayment is $1.00 per visit.	Same as Medicaid.
PODIATRIC SERVICES	Twelve office visits (examinations and services to treat foot problems) per calendar year and nonelective outpatient surgery are covered. No copayment is required.	Same as Medicaid.
PRESCRIBED DRUGS	Drugs and supplies on an approved listing. Copayment is $1.00 per new or refill prescription. AZT is covered.	Same as Medicaid.
PSYCHOLOGICAL SERVICES	Twenty-four hours of office visits per calendar year are covered. Psychological testing is covered up to six hours every two years with prior authorization. Copayment is $1.00 per visit.	Same as Medicaid except that psychological testing is covered up to six hours every three years with prior authorization.
TRANSPORTATION SERVICES	Ambulance transportation is covered for emergencies. Nonemergency but medically necessary ambulance trips are covered. Some require prior authorization. Copayment is $1.00 per nonemergency ambulance trip.	Ambulance transportation for emergencies is the only covered transportation service.
	Nonambulance transportation is covered with prior authorization if to receive prenatal services for pregnant women, to receive medical services which prevent placement in an adult care home or hospital, to receive medical services for HCBS recipients or adult care home residents which are not available in the home, or if to receive medical services which are only available 50 miles or more away (one way). No copayment is required.	Noncovered.
VISION SERVICES	Examinations and treatment for medical conditions of the eye are covered up to two per month. One complete eye exam every four years is covered for recipients who have not had cataract surgery. Eyeglasses are covered once every four years only if for severe medical hardship, employment or job training. Eye exams are covered as needed for post-cataract surgery recipients for one year following surgery. Copayment is $1.00 per visit.	Treatment for medical conditions of the eye is covered. Eyeglasses are not covered. Copayment is $1.00 per visit.

Note: Copayment requirements are the same for both Medicaid and MediKan recipients. Recipients under the age of eighteen, those residing in adult care homes or HCBS recipients are exempt from copayment. Services related to pregnancy, family planning or emergencies are also exempt from copayment. Copayment for ambulatory surgical center services and outpatient hospital surgeries will be $3.00, effective January 1, 1988.