Approved: February 18, 2002
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Stephen Morris at 10:35 a.m. on January 29, 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
Debra Hollon, Kansas Legislative Research Department
Martha Dorsey, Kansas Legislative Research Department
Audrey Nogle, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Assistant Revisor of Statutes
Judy Bromich, Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Connie Hubbell, Secretary, Department on Aging
Shelby Smith, The Shelby Smith Group, Public Affairs Consultants
Laura Howard, Assistant Secretary, Health Care Policy, Department of Social and Rehabilitation Services

Others attending: See attached list

Chairman Morris called the Committee's attention to the discussion of:

SB 387 – State finance, state general fund ending balance requirement, maximum amount of expenditures and demand transfers

Senator Huelskamp moved, with a second by Senator Schodorf, to amend **SB 387** to require that if the required ending balance is not met when the Legislature adjourns sine die, members of the Legislature would be notified in writing by the Director of the Kansas Legislative Research Department. Motion carried on a voice vote.

Senator Huelskamp moved, with a second by Senator Barone, a conceptual amendment regarding **SB 387** to take a dollar amount equal to the 7.5 percent or the 5.5 percent and that either that percent or that dollar amount would be the ending balance requirement for the next fiscal year, whichever is greater. Motion failed on a voice vote.

Senator Jackson moved, with a second by Senator Salmans, to recommend **SB 387** favorably for passage as amended. Motion carried on a roll call vote.

Chairman Morris opened the public hearing on:

SCR 1614 – Encouraging decreased dependence on public moneys to finance long-term care

Staff briefed the Committee on the resolution.

Connie Hubbell, Secretary, Department on Aging, spoke in favor of **SCR 1614** (Attachment 1). Secretary Hubbell mentioned in her testimony that this resolution was drafted in response to the directive from the Kansas Department on Aging (KDOA) begin a campaign to educate and make Kansans aware of the cost of long-term care, and to encourage them to consider the purchase of long-term care insurance at an age when it is affordable.

Committee questions and discussion followed. The Chairman thanked Secretary Hubbell for her appearance before the Committee. There being no further conferees to come before the Committee, the Chairman closed the public hearing on **SCR 1614**.

Senator Feleciano moved, with a second by Senator Schodorf, to amend **SCR 1614** on page 1, line 25, to add the word "once" before the words "were fatal" and recommend **SCR 1614** favorably for passage as amended. Motion carried on a roll call vote.

Chairman Morris opened the public hearing on:

SCR 1613 – Joint rules subject matter of appropriation bills

Norman Furse, Revisor of Statutes, explained the resolution (Attachment 2).

Shelby Smith, The Shelby Smith Group, Public Affairs Consultants, spoke in favor of **SCR 1613** (Attachment 3). Mr. Smith explained that provisos in appropriations bills should be restricted to the mechanics of appropriations, for example authorizations for the transfer of money from one fund to another, increases or decreases in expenditure limitations, authorizations for certain state officials to draw warrants, or reappropriation of unencumbered balances in certain funds, etc. He mentioned that simply, the constitutional mandate – one subject in a bill – must be respected. Mr. Smith also distributed copies of Separation of Powers II (Attachment 4).

Committee questions and discussion followed. Chairman Morris thanked Mr. Smith for his appearance before the Committee. There being no further conferees to appear before the Committee, the Chairman closed the public hearing on **SCR 1613**.

Senator Feleciano moved, with a second by Senator Barone, to recommend **SCR 1613** favorably for passage. Motion carried on a roll call vote.

Chairman Morris welcomed Laura Howard, Assistant Secretary, Health Care Policy, Department of Social and Rehabilitation Services. Ms. Howard addressed requests for additional information arising from Consensus Caseload Estimates (Attachment 5). A copy of a chart titled, "Medicaid Expenditures by Service Category" was distributed (Attachment 6).

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for January 31, 2002.

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.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE January 29, 2002

NAME	REPRESENTING
Pam Scott	Ks Funeral Directors Assn
Alice Barnes	DPS
Sky Westerlund	KNASW
Lynaia South	JJA
Bob Williams	Ks Pharmacists Assoc
Marsha Strahm	CWA of Ks.
Natalie Bright	Via Christi Health System
Denise Apt	USA / USD 500
Sally Finney	Ks. Public Health Assn.
Carolyn Middendorf	Ks St Ns Assn
Mark Tallman	KASB
John Federico	Federico Consulting

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE January 29, 2002

NAME	REPRESENTING
Duane Goossen	DOB
Scott Brunner	DOB
Sarah Adams	Keys for Networking, Inc.
Elaine Schwartz	KDOA
[illegible]	KDOA
Marilyn Jacobson	SRS
Laura Howard	SRS
Janet Schalansky	SRS
Scott Heidner	KAIFA
Hillary Hayes	Federico Consulting
[illegible]	K4A
Steve Solomon	The Farm, Inc.
Marianne [illegible]	SRS
Cassidy Shively	SRS
Gina McDonald	KACIL
Sidney G. Hays	KACIL
Shannon Jones	SILCK
Susan Kannarr	KS Health Institute
Sheli Sweeney	Ks Dept on Aging
Kirk Lowry	Topeka Independent Living Res. Center
Bob Harder	UMC-KS
Dale Huffman	Families Together

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Senate Ways and Means Committee
January 29, 2002

Report on Senate Concurrent Resolution 1614

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

Senate Ways and Means
1-29-02
Attachment 1

PRESENTATION TO THE SENATE WAYS AND MEANS COMMITTEE
BY
SECRETARY CONNIE HUBBELL
KANSAS DEPARTMENT ON AGING
January 29, 2002

Good morning, Mr. Chairman and members of the committee. Thank you for this opportunity to present testimony regarding Senate Concurrent Resolution 1614. This resolution was drafted in response to the directive from the Kansas Legislature that the Kansas Department on Aging (KDOA) begin a campaign to educate and make Kansans aware of the cost of long-term care, and to encourage them to consider the purchase of long-term care insurance at an age when it is affordable.

Our nation's current long-term care financing system steers people toward impoverishment and reliance on Medicaid. A fundamental shift from Medicaid to private long-term care insurance is a sensible and compassionate way to meet the nation's long-term care needs. It can help protect Americans from financial ruin as they grow older and ease the fiscal burden on states and the federal government. Long-term care insurance can become a large part of the planning process for growing older with dignity, security, and independence. This trend, if realized, could potentially decrease dependence on public monies that finance long-term care for seniors in Kansas.

With the passage of Senate Concurrent Resolution 1614, the Kansas Department on Aging (KDOA) will expand our education and awareness efforts to encourage younger Kansans to start early saving for their elder years and to purchasing long-term care insurance when feasible.

Long-term care is a risk worth insuring against. The risk is largely unpredictable early on because conditions that frequently lead to a need for long-term care, such as the onset of dementia or stroke, often are not foreseeable in youth. However, when an individual has purchased long-term care insurance, the risks and costs of long-term care are spread across a wider population, making the costs for one individual needing long-term care far more affordable.

Those who need long-term care can rarely pay for it out of their own pockets. Nursing home care is expensive, with a nationwide average of $40,000-$50,000 a year and in Kansas an average of $36,500 or $100 per day. That figure is certain to increase. Kansas seniors must spend their life savings and contribute all their income before Medicaid pays for their care. Private insurance pays for only 7 percent of long-term care services (1996), with Medicare paying for 11 percent, while Medicaid pays for 38 percent of long-term care services for elders, with the remaining 56 percent being private pay.

Long-term care insurance can play an important role in helping to provide protection against the cost of long-term care and the expenditure of a lifetime of savings. Long-term care insurance is risk insurance that protects assets--the same way a homeowner's policy protects a house or car insurance protects a car.

The first enhancement to the Department's continuing education and awareness efforts will be to correct some assumptions about retirement and long-term care that hinder people from planning for their elder years and long-term care. We will provide Kansans the information they need to make the right choices for their elder years.

Some of these assumptions include:

- **I will never need long-term care**. Anyone, no matter what their age or state of health, may need long-term care services at some point in their life. Yet 72 percent of Americans say that they are unable to pay for long-term care. Currently, 5.8 million people aged 65 or older need long-term care and this number will increase as more people survive heart attacks, cancer, strokes, and other ailments that once were fatal.
- **Social security will be enough**. According to economists, Social Security will provide only about 25 percent of the income needed in retirement. Persons who rely solely on Social Security income in their elder years will more than likely be living in poverty.
- **It is too late to start saving or to buy long-term care insurance.** Even if an individual gets a late start at saving or the purchase of long-term care insurance, any planning and preparation will make retirement more comfortable and secure. Even up to the ages of 55, 60 and 65, it can make sense for people to purchase long-term care insurance to protect their assets.
- **My children will take care of me**. Since people are living longer and spending more time in retirement, children will be hard-pressed to pay for their own retirement, mortgages, and college tuition for their children as well as supporting their elderly parents. In addition, families are many times unable to care for an elder parent or family member because of the need for two-earner households, changes in the nuclear family such as divorce and remarriage, and the fact that children may not live close to their parents.
- **My health insurance or Medicare will pay for long-term care.** Medicare will pay for rehabilitation at a long-term care facility after a hospitalization, and then only for 100 days. Private health insurance coverage does not cover the cost of long-term care. Because Medicare does not cover the cost of nursing home care, assisted living, residential health care, or other long-term care, the primary source of private financing of long-term care is the income and savings of the elderly and their families, or Medicaid. The national caseloads for Medicaid have grown in the past few years and are projected to increase annually.

The second enhancement of KDOA's education and awareness efforts will be to provide guidelines to help answer some of the questions surrounding the purchase of long-term care insurance. The most important question we can help answer is "Who should purchase long-term

care insurance?"

Some guidelines are:

- Determine your resources. People who have $50,000 or more in assets to protect may benefit from purchasing long-term care insurance.
- Purchase early. People should consider buying long-term care insurance when they are between 50 and 60 years old, when they can save on the cost of premiums.
- Purchase inflation protection. Long-term care costs will increase, so buy insurance that increases as costs rise.
- Buy a tax-qualified plan. This means that any payments made by your insurance company for your care can be paid directly to your provider and not taxed to you.
- Purchase a plan that is tailored to meet the individual's needs, e.g. daily benefit cap, benefit length, elimination period (deductible), training for family members who want to provide care, survivorship benefits, fixed term premium payments.
- Decide if it is more feasible to purchase long-term care insurance for one or both spouses, depending on health status, age, and other factors.
- Purchase a policy that provides care in your choice of setting, whether that is in-home services, assisted living or nursing home care.
- Shop for a qualified company with the best price. The top 10 out of 180 companies that sell long-term care insurance sell approximately 70 percent of the policies. Make sure the company you choose is not undercapitalized and is rated highly by industry rating services, such as Standard and Poor's.

A properly selected long-term care insurance policy will allow a policyholder to protect their life savings from depletion if long-term care is needed. An added benefit of the purchase of long-term care insurance is the shifting of financing of long-term care from the public sector to the private sector.

Mr. Chairman and members of the committee, thank you for the opportunity to discuss the importance of educating Kansans on the purchase of long-term care insurance, and the Department's support of Senate Concurrent Resolution 1614. I will now stand for questions.

Session of 2002

Senate Concurrent Resolution No. 1613

By Legislative Budget Committee

12-14

A CONCURRENT RESOLUTION relating to the joint rules of the Senate and House of Representatives for the 2001-2002 biennium.

Be it resolved by the Senate of the State of Kansas, the House of Representatives concurring therein: That the following joint rules of the Senate and the House of Representatives for the 2001- 2002 biennium be amended by the addition of a new rule to read as follows:

Joint rule 6. Appropriation bills. An appropriation bill may contain only provisions which relate to the allocation and expenditure of moneys. Provisions which are not germane to the subject of the allocation and expenditure of moneys shall not be included in appropriation bills. Appropriation bills may not change or amend existing laws on subjects other than the allocation or expenditure of moneys.

Senate Ways and Means
1-29-02
Attachment 2

QUOTES FROM KANSAS SUPREME COURT DECISIONS RELATING TO APPROPRIATION BILL CONTENTS

CASE LAW BASIS FOR CONCURRENT RESOLUTION LANGUAGE:

(2) Section 16 of Article 2 of the Kansas Constitution, as originally adopted, provided that "No bill shall contain more than one subject ..." That section was amended in 1974, and now provides that "No bill shall contain more than one subject, except appropriation bills ..." In our opinion, the amendment was not intended to grant to the legislature carte blanche to include in appropriation bills measures wholly unrelated and not germane to the subject of the allocation and expenditure of moneys. We hold that the legislature had no power to include an amendment to the school district equalization act in Senate Bill 470, an appropriation measure. Section 77 is therefore unconstitutional and of no force or effect.

STATE EX REL. STEPHAN V. CARLIN, 630 P.2d 709, 229 Kan. 665 (Kan. 1981)

HISTORICAL BACKGROUND AND KANSAS SUPREME COURT INTERPRETATION OF KANSAS CONSTITUTIONAL PROVISION IN SECTION 16 OF ARTICLE 2 OF THE KANSAS CONSTITUTION:

Since statehood, Section 16 of Article 2 of the Constitution of [**257] this State has read: "No bill shall contain more than one subject ..." To that phrase was added in 1974: "(E)xcept appropriation bills and bills for revision or codification of statutes." The question squarely presented here is this: Is the legislature granted authority by the 1974 amendment to include in an appropriations bill, without limitation, any subject[*673] which it wishes to address? May it include therein subjects entirely foreign to appropriations? We think not. The Citizens' Committee on Constitutional Revision, in its 1969 report, quoted by the Governor in his veto message, said at p. 26:

"Section 16. The proposed change in this section is designed to conform to present actual practice relative to bills for appropriations ..." (Emphasis added.)

The actual practice is evidenced by a review of the appropriation bills enacted by the legislature at the time of and immediately prior to the revision. See, for example, 1969 Laws, Chapters 12 through 46, and 1968 Laws, Chapters 11, 12, 194, 195, 196, 197, 220, 232, 240, 267, 268, 362 and 412. Examination of those chapters discloses no attempt by the legislature to include within those appropriation bills amendments to general legislation, wholly unrelated to the setting apart of state funds and the authorization of the expenditure thereof for specific purposes. The primary content is language appropriating specific sums of money for specific purposes; authorizing the transfer of sums of money from one fund to another; increasing or decreasing expenditure limitations; directing certain state officials to draw warrants; and reappropriating unencumbered balances in certain funds.

A word of caution should be added. We are not here called upon to approve, nor are we here approving, everything included within the 1968 and 1969 appropriation bills. We merely examined them to determine the then current legislative practice, and to determine whether amendments to diverse and unrelated sections of the statutes were customarily and regularly included therein. We find that they were not.

Section 77 of Senate Bill No. 470 does not appropriate state funds; it does not establish expenditure limitations on state funds; it does not authorize the transfer of state moneys from one fund to another. It does fix budget limitations for school districts. It bears no more relationship to the appropriation of state funds [**258] than do statutes fixing the budget limitations of cities, counties, or other taxing districts, or various other statutes which could be cited. Clearly, it adds a second subject to the bill.

STATE EX REL. STEPHAN V. CARLIN, 631 P.2d 668, 230 Kan. 252 (Kan. 1981)

THE KANSAS SUPREME COURT'S CONCLUSION IN THE STEPHAN V. CARLIN CASE:

Appropriation bills may direct the amounts of money which may be spent, and for what purposes; they may express the legislature's direction as to expenditures; they may transfer funds from one account to another; they may direct that prior unexpended appropriations lapse. But we hold that under Section 16 of Article 2 of the Constitution, appropriation bills may not include subjects wholly foreign and unrelated to their primary purpose: authorizing the expenditure of specific sums of money for specific purposes. Section 77 of Senate Bill 470 violates Section 16 of Article 2 of the Constitution, and is unconstitutional.

STATE EX REL. STEPHAN V. CARLIN, 631 P.2d 668, 230 Kan. 252 (Kan. 1981)

Prepared by Norman J. Furse, Revisor of Statutes

LEGISLATIVE RULES RELATING TO APPROPRIATIONS

HOUSE RULES

Rule 902. Appropriation Bills. Bills containing more than one item of appropriation shall be referred to the standing committee on appropriations, except that bills introduced by the committee on appropriations may be referred to the committee of the whole House.

Rule 2101. Germaneness. Amendments to bills and resolutions shall be germane to the subject of the bill or resolution. The principal test of whether an amendment is germane shall be its relationship to the subject of the bill or resolution, rather than to wording of the title thereof. The amendment must be relevant, appropriate, and have some relation to or involve the same subject as the bill or resolution to be amended. For the purposes of this rule the subject matter of any appropriation bill is the spending and appropriating of money and any amendment which changes the amount of money spent in any state agency or program is germane to any appropriation bill.

Any member, upon recognition by the presiding officer, may request a ruling upon the germaneness of any amendment to a bill or resolution. All rulings upon the question of germaneness shall be made by the chairperson of the House Committee on Rules and Journal. At the time of making such ruling, the chairperson shall state the reasons or basis for such ruling. Appeals from rulings of the chairperson may be taken upon the motion of any member. Such appeals shall be in order at the time of the making of the ruling and shall take precedence over any question pending at the time the chairperson makes such ruling. Appeals from the ruling of the chairperson shall be debatable only by the member making the motion to amend which is the subject of the ruling, the member carrying the measure sought to be amended, the Majority Leader or a member designated by the Majority Leader and the Minority Leader or a member designated by the Minority Leader. Debate upon the ruling of the chairperson shall be limited to the question of the germaneness of the proposed amendment. At the conclusion of debate the presiding officer shall inquire: "Shall the chairperson's ruling be sustained?"

Rule 2903. Resolutions; Limitations. (a) Appropriations shall not be made by resolutions.
(b) Resolutions do not require approval of the Governor.

Rule 3905. Appropriation Bills. All bills making an appropriation shall be printed and distributed at least 48 hours before such bills are considered by the House.

SENATE RULE

Rule 32. Reference of Bills and Resolutions. All bills shall be referred or rereferred to appropriate standing committees or the committee of the whole by the President. Upon the day of its introduction or upon the next legislative day the President shall refer every bill and each concurrent resolution to be referred to the appropriate standing committee or the committee of the whole. Bills or resolutions prefiled under K.S.A. 46-801 et seq. and amendments thereto may be referred by the President to the appropriate standing committee or the committee of the whole at any time subsequent to the prefiling of such bill or resolution with the secretary of the senate. Bills introduced by committees, if germane to the purpose and scope of the committee, may be referred to the Committee of the Whole; otherwise to the appropriate standing committee. All bills making an appropriation shall be referred to the Committee on Ways and Means. The President may refer a bill or resolution to two or more standing committees jointly, or separately, in such order as the President may direct, and such bill or resolution, when so referred, shall be considered by the committees in joint meeting, or by each of the committees separately in the order named in the reference, and when the reference is made jointly, the chairperson of the committee named first shall be chairperson of the joint committee.

JOINT RULES

Joint Rule 3.

(f) Conference committee reports; subject matters which may be included; report not subject to amendment; house which acts first on report; copies of reports; reports considered under any order of business. Only subject matters which are or have been included in the bill or concurrent resolution in conference or in bills or concurrent resolutions which have been passed or adopted in either one or both houses during the current biennium of the legislature may be included in the report of the conference committee on any bill or concurrent resolution except in any appropriations bill there may be included a proviso relating to any such item of appropriation. A conference committee report shall not be subject to amendment. The original signed conference committee report shall be submitted to and acted upon first by the house other than the house of origin of the bill or concurrent resolution. Copies of each report shall be made available to all members of the house considering the same not later than the time of consideration of the report, except when such report is that members of the committee are unable to reach agreement or is a recommendation to accede to or to recede from all of the amendments of the second house. The affirmative vote of 2/3 of the members present in the house at the time of consideration of the report shall be sufficient to dispense with distribution of copies of the conference committee report to all members of that house. Reports of conference committees may be received and considered under any order of business.

Joint Rule 4.

(k) Bill consideration deadline; exceptions. No bills shall be considered by the Legislature after April 7, 2001, during the 2001 regular session and after April 13, 2002, during the 2002 regular session except bills vetoed by the Governor, the omnibus appropriation act and the omnibus reconciliation spending limit bill provided for under K.S.A. 75-6702 and amendments thereto. This subsection (k) may be suspended for the consideration of a specific bill or bills not otherwise exempt under this subsection by the affirmative vote of a majority of the members then elected (or appointed) and qualified in the house in which the bill is to be considered.

MEMORANDUM

RE: Appropriation Bill Drafting Standards

FROM: Norman J. Furse, Revisor of Statutes

DATE: July 2, 2001

I. **Kansas Constitutional Provisions.**

A. Section 24 of article 2 of the Constitution of the State of Kansas reads as follows: "No money shall be drawn from the treasury except in pursuance of a specific appropriation made by law."

B. The authority of the governor to veto less than an entire act is limited by section 14(b) of article 2 of the Constitution of the State of Kansas to "items of appropriation of money" when a single bill contains several such items. (State ex rel. Stephan v. Carlin, 230 Kan. 252, syl. 2.)

C. The phrase "items of appropriation of money" as used in section 14(b) of article 2 of the Constitution of the State of Kansas means the designation of specific sums of money which the legislature authorizes may be spent for specific purposes. (State ex rel. Stephan v. Carlin, 230 Kan. 252, syl. 1.)

D. Section 16 of article 2 of the Constitution of the State of Kansas states, in part, that no bill may contain "more that one subject, except appropriation bills and bills for revision or codification of statutes."

II. **What May Be Included In Appropriation Bills.**

A. Appropriation bills may:

(1) Direct the amounts of money which may be spent and for what purposes;

(2) express the legislature's direction as to expenditures;

(3) transfer moneys from one account or fund to another;

(4) direct that prior unexpended appropriations lapse;

(5) establish expenditure limitations of state funds;

(6) increase or decrease expenditure limitations;

(7) direct certain state officials to draw warrants;

(8) reappropriate unencumbered balances in certain funds.

B. See State ex rel. Stephan v. Carlin, 230 Kan. 252, 257, 258.

III. What Appropriation Bills May Not Include.

A. Appropriation bills may not include "subjects wholly foreign and unrelated to their primary purpose: authorizing the expenditure of specific sums of money for specific purposes." (State ex rel. Stephan v. Carlin, 230 Kan. 252, 258.)

B. The legislature may not include in appropriation bills "measures wholly unrelated and not germane to the subject of the allocation and expenditure of moneys." (State ex rel. Stephan v. Carlin, 229 Kan. 665, 666.)

C. The legislature has no power to "include an amendment to the school district equalization act" in an appropriation bill. (State ex rel. Stephan v. Carlin, 229 Kan. 665, 666.)

D. It follows that an appropriation bill may not change or amend existing laws on subjects other than the "allocation and expenditure of moneys."

IV. Bill Drafting Standards.

A. Appropriation bill provisions must relate to the allocation and expenditure of moneys. See State ex rel. Stephan v. Carlin, 230 Kan. 252, last paragraph on p. 257.

B. The test is whether the appropriation bill language satisfies any of the provisions of II,A, above.

B. An appropriation bill may not change or amend existing laws on subjects other that the allocation and expenditure of moneys.

C. Appropriation bills may not include an amendment to the school district equalization act.

the SHELBY SMITH group
PUBLIC AFFAIRS CONSULTANTS

Outline of Testimony

Shelby Smith

OVERUSE OF PROVISOS IN APPROPRIATION BILLS
SENATE Concurrent Resolution No. 1613
January 14, 2002

Background

The Special Committee on Judiciary concluded "the Legislature should be vigilant of the potential for abuse in the whole separation of powers arena." The committee came to this conclusion after hearings on an amendment to the Kansas Constitution, an amendment similar to the clause in the U.S. Constitution prohibiting members of the Legislative Branch from holding, during their terms in office, a position in either the Executive or Judicial Branch of government.

To date, only the power of gubernatorial veto has restrained in any way the legislature's **CONSTITUTIONAL** abuses of the doctrine of separation of powers. After Governor Graves vetoed 80 of the 188 provisos in the Omnibus Appropriations Act of 2001, Senate President Dave Kerr answered the wake-up call with a request for an interim study. The Legislative Coordinating Council agreed. The Legislative Budget Committee recommends a Joint Rule with only 2 dissenting votes.

Legislative micromanagement lies at the heart of the problem with its ramifications of inefficiency and political corruption. With provisos, there are no hearings, no debate. They are used to circumvent the regular legislative process. Lew Ferguson's final story as AP's Topeka correspondent for 29 years was dedicated to the constitutional problem of separation of powers in Kansas in his article, "The Scandal Time Bomb is Ticking."

Conclusions and Recommendation

The issue is power, the misuse of power, the separation of powers – a debate justified upon the highest grounds of public policy. Power can be defined as the ability to enforce conformity through force, fear, purchase, or persuasion. It's absolutely wrong when legislators wear the three hats of appropriating officer, administrative officer, and purchasing agent.

Provisos in appropriations bills should be restricted to the mechanics of appropriations, for example, authorizations for the transfer of money from one fund to another, increases or decreases in expenditure limitations, authorizations for certain state officials to draw warrants, or reappropriation of unencumbered balances in certain funds, etc. Simply, the constitutional mandate – **ONE SUBJECT IN A BILL** – must be respected. There must be no substantive legislation in appropriation bills, only provisions which relate to the allocation or expenditure of monies, if we are to maintain our clean political culture, and commitment to constitutional law.

Attachment: Separation of Powers II, August 2001

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Senate Ways and Means
1-29-02
Attachment 3

Shelby Smith

Ad Astra....

Senate Ways and Means
1-29-02
Attachment 4

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SEPARATION OF POWERS II

August 2001

I. Eleven Years Later: Kansas' Political Culture Has Lost Its Innocence

In December 1990, I wrote *The Insider's Chronicle*, a history of the Kansas Department of Administration, a time in which I was concerned about legislators' involving themselves in the procurement process for computers. By the time I wrote *Separation of Powers* in December 1997, the legislature had begun widespread neglect of the walls built to separate political power. Ill-defined oversight committees were micromanaging programs and hamstringing the efficient operations of state agencies. Legislators served, inappropriately, on state governing bodies, and the constitutional two-subject rule all but abandoned in appropriation bills through the misuse and abuse of provisos.

To be forewarned ought to be forearmed, particularly when the first forewarnings are now more than 200 years old. Thomas Jefferson's *Notes on Virginia* forewarned that all the powers of government, legislative, executive, and judicial result to the legislative body, and the concentration of these governmental powers in the legislature is not the elective government we fought for. The pragmatic James Madison prophesized in the Federalist Papers that the legislative department can with great facility mask their intrusion under complicated and indirect measures and draw everything into their impetuous vortex, where they ought not to be involved.

II. Governor's Separation of Powers Vetoes

Madison would appreciate Governor Graves' separation of powers vetoes in the 2001 Omnibus Appropriation Bill. The vetoes forcefully call to our attention the constitutional

prohibition of two subjects in a bill (the inclusion of substantive legislation in an appropriations bill), and of the constitutional divide on the appropriate role of legislative oversight committees.

Regarding that role, the Governor wrote, "The ongoing creation and extension of joint committees by the Legislature is encroaching on the executive functions of government in violation of the Separation of Powers Doctrine." Four years ago, in my 1997 paper, I identified five causes behind the legislature's growing disregard for constitutional ear-marking of powers for the three coequal branches of government, with a specific reference to interim legislative committees prescribing details, micromanagement in ways that the Kansas constitution would never allow.

Regarding the two-subject rule, the Governor's Veto message reads, "The Kansas Supreme Court has held that the Constitution of the State of Kansas, Art. 2, Sec. 16 prohibits inclusion of substantive legislation in an act of appropriation." Since statehood our constitution has insisted that "no bill shall contain more than one subject." The provision was written to forestall the pernicious practice known as "log-rolling," – a last minute legislative tactic wherein new and unrelated issues not debated by either house sneak into a bill on a rider, frequently a proviso in an appropriations bill. Historically, such a proviso was considered a "corrupt combination" on issues that could not pass if they stood on their separate merits.

A definitive judicial review of the issue is seen in *Robert T. Stephan, Attorney General vs. John Carlin, Governor*, 230 Kan. 252 (1981) a case involving Section 77 of the Omnibus Bill prescribing budget limitations to the School District Equalization Act. The Kansas Supreme Court found the budget limitations unconstitutional because it was "not an item of appropriation of money." Flatly, the inclusion of a non-appropriation provision in an appropriation bill violates

Article 2, Section 16 of the Kansas Constitution. Substantive law in an appropriation bill is just absolutely wrong.

But now the legislature's history-making thirteen-day wrap-up session has broken the record for addenda and unconstitutional qualifiers. Fortunately, the epidemic did not go without notice. The 188 provisos in the Omnibus Appropriations Act of 2001 eclipsed the 1997 count of 154. Governor Graves vetoed 59 provisos. Senate President Dave Kerr answered the wake-up call with a request for an interim study. The Legislative Coordinating Council responded with the approval of a study on the overuse of provisos in appropriation bills.

The biggest problem in the real world is no hearings, no debate, the proviso is embedded in a conference committee report, most legislators know nothing about them, and the undue influence of an individual legislator often times has ramifications far beyond what is intended. It gets back to micromanagement, this mucking around in such details is ridiculous, it is everywhere – not only in appropriation bills.

III. UPDATE

Evidence from the past two sessions of the legislature demonstrates that, when the rhetorical camouflage is removed, Kansas is treading a path to disaster. Accommodations for deal-making, undue influences, conflicts of interest, and gross inefficiencies in the workings of state government are upon us. Corruption beckons at every turn as legislators step across a constitutional line into appointed positions to which they were not elected.

LAST YEAR

Senate Bill No. 668 would have established the Kansas Business Health Partnership, whereby four legislators would serve on a cabinet-level committee whose role is to develop and approve requests for proposals (RFPs) for the purchase of health insurance for low-wage employees of small employers. Three disturbing aspects: (1) the legislature is organizing and mandating an executive branch cabinet committee; (2) SB 668 is the product of legislative leadership, the chairpersons of three committees, the Senate Financial Institutions Committee, the Commerce Committee, and the Public Health Committee; and (3) most disturbing, legislators would have once again involved themselves in the procurement process.

Although heavily criticized by legislators, the granddaddy of all ill-defined oversight committees, the Joint Committee on Corrections and Juvenile Justice Oversight, continues today its assumed role to run the Juvenile Justice Authority. This heavy handed micromanagement has gone on uninterrupted and unchallenged since August 1997.

THIS YEAR

Senate Bill No. 57 (Sec. 78[c]) goes into considerable detail about construction of a maximum security building at the Topeka juvenile facility: "a secured commons area...on the east end of the campus...which shall include food and medical services and a visitors center." And it goes on from there. When an appropriations bill dictates which end of a building must house certain services, it has gone too far. There must be recognition for management flexibility if we have any interest in cost effectiveness.

The January 2001 Legislative Post Audit Report on the Kansas Department of Commerce and Housing, on Kansas Inc., and on the Kansas Technology Enterprise Corporation (KTEC)

reveals that four members of the legislative committee conducting the audits serve on the boards of the organization being audited. It's now the accepted thing, the trendy thing to do in Topeka, this shoving of representatives and senators onto governing boards, creating in effect a shadow government far beyond the bounds of our constitution.

A committee bill, Senate Bill No. 315, put a brazen luster on legislative hubris. This bill would have transferred two percent of the state's gaming revenues to the Kansas Community Reinvestment Special Revenue Fund, with seventy-five percent allocated for grants awarded equally in each of the state's senatorial districts, and the remaining twenty-five percent distributed among house districts. The problem, a very significant problem, arises in the approval process: a mandate that all grant applications be submitted to the senator or representative of the district where the project or service is to be located for that legislator's approval of the grant. In this example of legislative trampling on the separation of powers, our representatives and senators have made themselves entitled aristocracy, dispensing public largesse in a spoils system of nineteenth-century proportions.

Here in Kansas is Oklahoma's formula for elected officials interrupting their terms of office with prison sentences. In the book "Bad Times for the Good Old Boys," it details a system of kickbacks from suppliers to county commissioner from 1979 to 1984 resulting in 220 convictions of commissioners in 60 of the state's 77 counties. The formula for this political corruption scandal was elected officials serving in the capacity of appropriating officer, purchasing agent, and adminstrative officer.

House Bill No. 2593 creates the Great Plains Tobacco Settlement Financing Corporation (GPTSFC) as an affiliate of the Kansas Development Finance Authority with a board of directors consisting of three members of the House of Representatives and three members of the Senate.

The GPTSFC was to be created for the purposes of issuing bonds secured by tobacco settlement assets, entering into contracts, and administering contracts thereto. Clearly, these legislative directors would have assumed an executive role that is fundamentally misplaced.

House Bill 2508 and Senate Bill 195 drag legislative micromanagement into the arena of social services. The house bill codifies a federally mandated centralized collection and distribution process for child support payments. However, it adds legislative direction regarding specific contract requirements, mandates the use of standardized forms and records, one an eight-column masterpiece. It establishes a Central Payment Center Oversight Commission to advise SRS on a wide range of matters related to center operations. The senate bill opens certain child-care records to any member of the Senate Ways and Means Committee, or the House Appropriations Committee in a closed or executive meeting. However, two-thirds of the members of either committee can authorize further disclosure of these confidential records.

A number of provisos in House Bill No. 2283 directed SRS to take specific actions or report back to various committees. Several of those required the agency to report back to the SRS Transition Oversight Committee. Although, legislation that would have extended that Committee's life did not pass, and the Governor vetoed a proviso that would have continued it, nevertheless, some of the provisos that had been directed to the SRS Transition Oversight Committee have been redirected to other committees; and SRS has simply been asked to report back on the others during the 02 legislative session. The micro onslaught continues unashamed in the face of failed legislation and a Governor's veto.

Another proviso in this bill dictates that the joint committee on health care oversight shall interact with the federal government agencies responsible for health care reform.

It is hard to fathom the necessity for the kind of language found in the omnibus bill for new Department of Revenue positions to increase revenue collections. Subsection (c) spells out exactly what the department is to do, right down to "not less than 76 state officers and employees and contract personnel." What happens if the department can not find 76 individuals to hire within a year? Why not just add the money and the positions?

The first meeting of the restructured Legislative Educational Planning Committee (LEPC) on July 23, 2001 forecasts a course of action usurping the rightful role of the Kansas State Board of Education and micromanagement of that body. Additionally, once again we see legislators involving themselves in procurement, this time professional services, the hiring of a consultant to study the cost of a suitable education for Kansas children. The day-long meeting from 10:15am to 5:20pm dealt with the writing of a Request for Proposal (RFP), the details of advertising, negotiations, approval by LCC, signing of a contract, and monitoring by the Post Audit Committee. This program is designed to be managed by 3 legislative committees and 30 legislators.

In reviewing Senate Substitute for House Bill No. 2067, it's difficult to determine if the bill contains three subjects or five subjects. The conference committee added new Sections 4 & 5 detailing requirements and restrictions on KDHE's pregnancy maintenance grants.

Some additional examples: All leases of office space in nonstate – owned buildings for more than two years or for more than 10,000 square feet shall first be referred to the joint committee on state building construction before executing the lease; the Secretary of Administration shall submit to the joint committee on state building construction progress reports on each phase of all capital improvement projects including administrative costs for design, planning, moving expenses, lost rents, and first-year rent differentials; the Kansas Development

Finance Authority shall issue no bonds for a Capitol Complex Parking Garage without approval of the State Finance Council; the Legislative Educational Planning Committee shall develop a goal for the percentage of students who enter kindergarten meeting the school readiness indicator, and develop another goal for the percentage of students who do not need remediation based on the 4th and 5th grade assessment results.

NOW TO ADDRESS BRIEFLY JUDICIAL / LEGISLATIVE CONFLICT.

Senate Bill 49 and House Bill 2179 (identical bills) were introduced at the request of the Chief Justice of the Kansas Supreme Court to allow the judicial branch to submit its budget directly to the legislature without reductions or adjustments by the Governor. The goal was not to get around the legislature approving all budgets. The judicial branch is the only branch with no direct say on what its budget should be. Senate Bill 49 received a hearing in the Senate Ways and Means Committee, but was never put to a vote. House Bill 2179 did not earn even a hearing in the House Appropriations Committee.

House Bill 2508 creates the 17-member Central Payment Center Oversight Commission. Among the commission's duties is reviewing any abuse of judicial discretion that might occur in ordering direct parent-to-parent payment of child support. Four members of the legislature will serve as ex-officio members of the commission. Review of alleged abuse of judicial discretion is a standard of review in appellate cases. It is not a question for appeal to a commission that includes politically elected lawmakers.

Enough said, I believe, regarding legislative restraint and respect for co-equal branches of government, and the evidence of abuse of legislative overstepping in the 2001 session.

IV. GOVERNING BODIES

In my testimony on November 1, 2000 before the Special Committee on the Judiciary, I identified 70 assignments of legislators to state boards and commissions. In truth, 110 appointments prevailed at the time – 88 by legislative mandate and 22 by gubernatorial discretionary appointment. All told, these assignments involved 31 different state bodies.

Democracy is a fragile latticework of checks and balances, a three-part system of power involving the executive, legislative, and judicial branches. Contrary to current practice in Topeka, the legislature was never designed to administer the state of Kansas. Unfortunately legislators today, as 11 years ago, seem more interested in the micromanagement of state agencies, and in the manipulation of programs of their own devising rather than concentrating on results. In so doing, they have divided authority and responsibility; they have crippled cost effective management. I do not wail alone.[1]

The legislature rationalizes procedural requirements as necessary for accountability. Lost in the wilderness of this misguided intrusiveness is the compromise of their legitimate role as overseers. When legislators serve on the governing boards of state bodies, oversight is compromised, a lobbyist legislator roams Topeka.

In matters involving the separation of powers, innocent intentions go astray, abuse wears a well-meaning face, but a decieving smile leers at our beloved Kansas.

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[1] President Taft's Commission on Economy and Efficiency (1912); President Roosevelt's Commission on Administrative Management (1937); Governor Carlson's Little Hoover Commission Report (1950); and then again in the late 1960s, the study by Kansas Select Committee to Investigate Efficiency and Economy in State Government.

V. CONCLUSIONS AND RECOMMENDATIONS

It is absolutely wrong when legislators wear the 3 hats of appropriating officer, purchasing agent, and administrative officer. The issue is power. The fallout is inefficiency and an invitation for political corruption.

To date, only the power of gubernatorial veto has restrained in any way the Kansas legislature's abuses of the Separation of Powers doctrine. It's time for some direct and modest remedies. I respectfully propose for consideration the following:

Submit to the voters a long overdue constitutional amendment, to wit:

> A PROPOSITION to amend section 5 of article 2 of the constitution of the state of Kansas, relating to qualifications and eligibility of members of the legislature.
>
> > **"5. Eligibility and disqualification of members.** No member of congress and no civil officer or employee of the United States or of any department, agency, or instrumentality thereof shall be eligible to be a member of the legislature. No member of the state legislature shall be eligible for or hold any office, membership or employment in the executive or judicial branches of state government, but nothing herein shall prevent a legislator from serving on a study group that has only advisory powers. Any member of the legislature who accepts any appointment or election contrary to the foregoing shall be disqualified as a member of the legislature."
> >
> > Sec. 2. The following statement shall be printed on the ballot with the amendment as a whole:
> >
> > *"Explanatory statement.* The purpose of this amendment is to disqualify any member of the state legislature who is employed by, or is appointed or elected to any office or position in the executive or judicial branches of state government from serving as a member of the state legislature, except in the case of study groups that have only advisory powers.
> >
> > "A vote for this proposition would disqualify any state legislature who is appointed, elected, or employed in the executive or judicial branches of government during such legislator's term of office, except in the case of study groups that have only advisory powers.

> "A vote against this proposition would retain the current qualifications for members of the state legislature which qualifications do not include a prohibition against a state legislator's appointment, election, or employment within the executive or judicial branches of state government."

Support for an enforcement clause came from their eminence: Harold Herd, *Distinguished Jurist in Residency* at Washburn University Law School, former Kansas Supreme Court justice, and state senator; Dr. H. Edward Flentje, director and professor of the Hugo Wall School of Urban and Public Affairs at Wichita State University, and former Kansas secretary of administration; and Burdett Loomis, professor of political science at the University of Kansas before the 2000 Special Committee on Judiciary.

Secondly, reactivate the University of Kansas Institute for Kansas Legislators with its much-needed educational curriculum on the organization of state government, the process, the budget, and the roles of the three co-equal branches of government.

Thirdly, consider a statute or a joint rule limiting provisos in appropriation bills to matters which accomplish the mechanics of appropriations, i.e. authorizations for the transfer of money from one fund to another, increases or decreases in expenditure limitations, with authorizations for certain state officials to draw warrants, or the reappropriation of unencumbered balances in certain funds. This eliminates unconstitutional substantive legislation in appropriation bills.

We must heed history's warnings. The people of Kansas deserve nothing less. The issues on James Madison's mind still apply.

Acknowledgement:

A special thank you to Linda Ronco for her advice and assistance on this project.

Shelby Smith: Chairman, House Assessment and Taxation Committee; Lt. Governor; Pro Bono Secretary, Department of Human Resources; Secretary, Department of Administration

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Senate Committee on Ways and Means

Request for Additional Information Arising From Consensus Caseload Estimates
January 29, 2002

Janet Schalansky
Secretary

Senate Ways and Means
1-29-02
Attachment 5

The Secretary of SRS met with the Senate Committee on Ways and Means on January 16, 2002 to review the consensus caseload increases projected for FY 2002 and FY 2003. Several members of the Committee requested additional information about the consensus caseload. This is in response to those requests.

Consensus Caseload Estimating Process

In my testimony of January 16, 2002, I explained the consensus caseload estimating process. As you may recall, the consensus caseload estimates are done twice each year. The first estimate occurs in the fall. The second occurs in the spring. On a monthly basis, SRS reviews caseload projections involving a larger set of caseload populations. The purpose of the caseload consensus estimates is to: (1) ensure that the executive and legislative branches reach a consensus of the caseload estimates; (2) improve the accuracy of estimates by incorporating objective estimations; and (3) identify the base caseload expenditure level from which policy changes may be made. Six SRS populations are included in the consensus caseload estimating process. They are: Foster Care, Adoption, Temporary Assistance for Families (TAF), General Assistance (GA), Nursing Facilities for Mental Health (NfsMH), and Regular Medical Assistance.

The consensus caseload estimating process is extremely valuable in eliminating disagreements about what the base expenditures levels for critical entitlement programs will be. Reaching consensus on base expenditure levels for entitlement programs allows the agency, the Governor, and the Legislature more time to evaluate these programs and adjust them, as needed, to improve their effectiveness.

All parties involved in the process are committed to achieving the best base expenditure estimates possible. No party wants to grossly underestimate base expenditures, because this creates unwanted surprises later in the appropriations process. However, neither do the parties want to over estimate the base expenditures, because every dollar set aside for entitlement programs not used by the program is a dollar that could have been used elsewhere in state government.

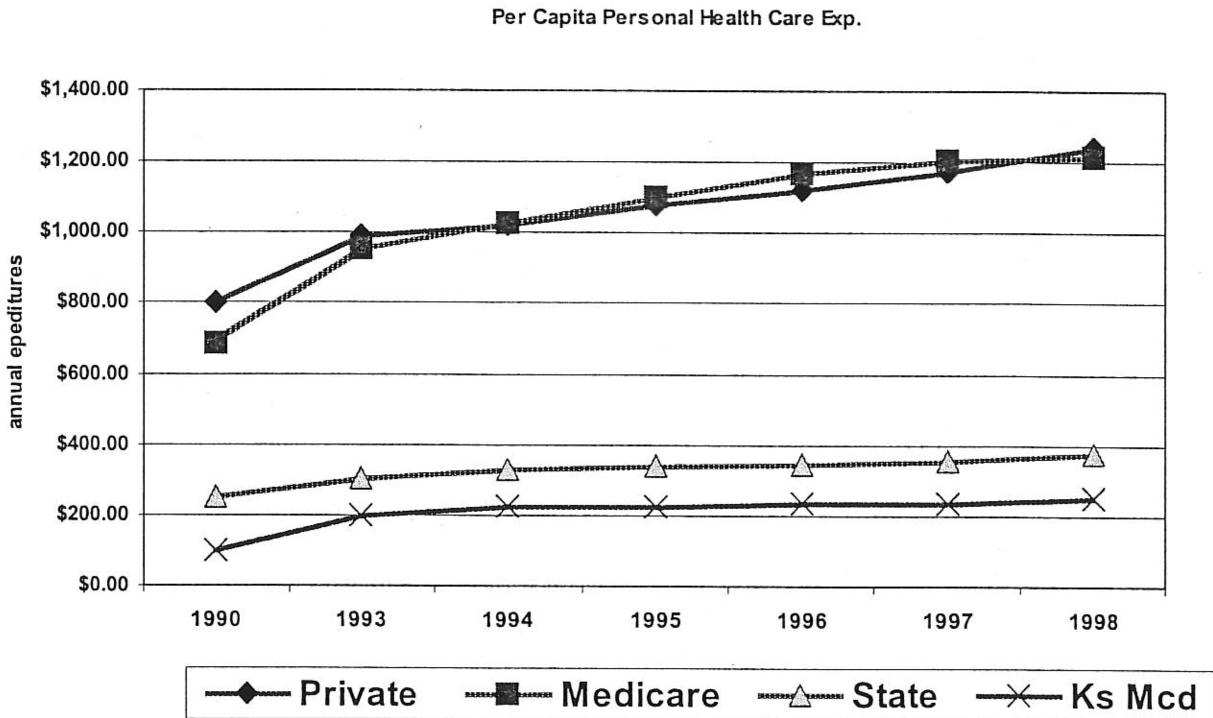
While the consensus estimating process is a very reliable one, even small errors lead to major budget adjustments. For example, a one percent error in the Regular Medical Assistance caseload would be regarded as an extremely precise estimate. Yet a one percent error equals a $9 million dollar budget error. Consequently, relatively small estimation changes from the twice-annual consensus caseload estimating process give rise to large funding adjustments during the budget process.

Finally, this year more funding is needed to increase the approved Regular Medical Assistance budget to meet the consensus caseload estimate than would have typically been needed to meet increases reflected in the consensus caseload estimating process. This is because the 2001

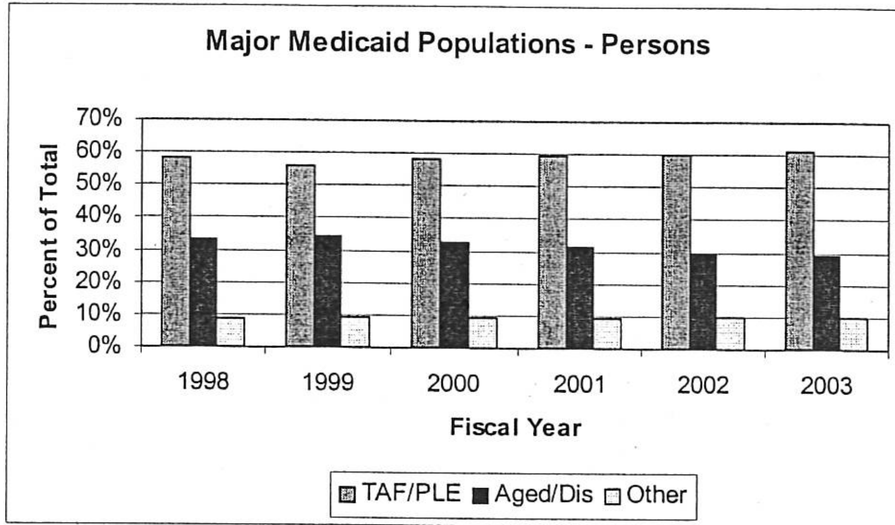
legislature reduced the amount appropriated for Regular Medical Assistance $11.25 million all funds ($4.5 million SGF) below the spring 2001 FY 2002 consensus caseload estimate. This causes the FY 2002 consensus caseload increase to appear larger than it is.

1. **How have Medicaid cost trends in Kansas historically compared to growth in other state's Medicaid programs, cost, commercial health plans, and the state employee plan?**

This chart shows the per capita payments for personal health care services by payment source for 1990, and 1993 through 1998. The chart compares average annual payments per consumer for private (commercial) insurance, Medicare, Kansas Medicaid, and all other state Medicaid programs. Personal health care services include physician, inpatient, outpatient, pharmacy, and dental services, and medical equipment. According to these statistics, the average payment for individuals has increased each year for all payment sources. Medicare and commercial payments are higher and have increased more than Medicaid. In addition, Kansas Medicaid has lower per person expenditures but the growth trend closely mirrors the national Medicaid average. These data are from the Center for Medicare and Medicaid (formerly HCFA) data tables found at www.hcfa.gov/stats.

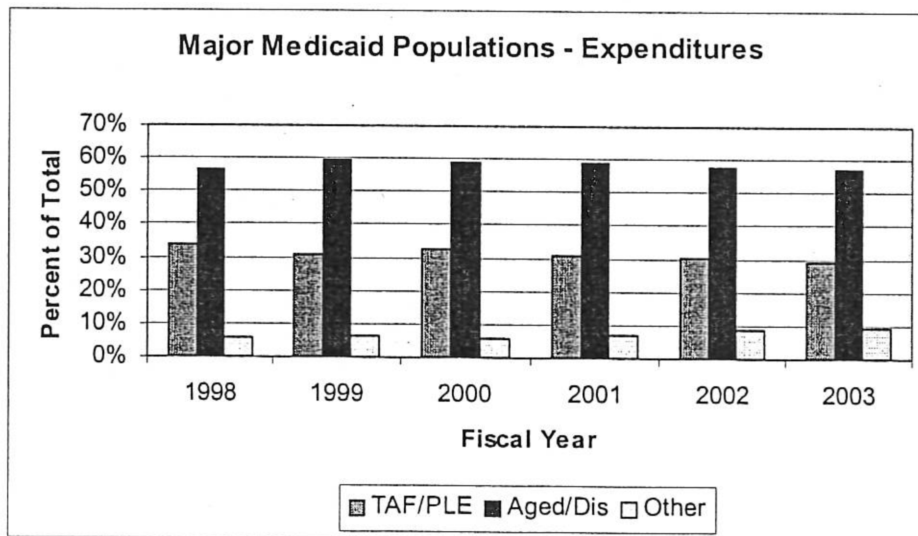


2. **<u>Please provide prior years of the population and expenditures related to Regular Medical Assistance</u>**



With the introduction of HealthWave in FY 1999, there has been a significant increase in the TAF & PLE populations. Aged & Disabled has increased from 58,525 in FY 1998 to a projected 64,380 persons in FY 2003. As a percentage of total persons served this results in a smaller percentage of total persons as shown in the chart above.

Other populations include QMB, MediKan, Medically Needy Family, Foster Care and all other.



Growth in expenditures has occurred for all populations. Aged & Disabled has increased from $266,647,000 in FY 1998 to a projected $506,915,000 in FY 2003. During the same time period TAF & PLE increased from $160,900,000 to $256,515,000. Despite the large change in total expenditures by the Aged & Disabled, their percent of total expenditures has slightly declined from FY 1999 due to the growth in the number of persons on TAF & PLE.

3. Why are FY 2003 consensus caseload percentage increases for Foster Care, TAF, GA, and Regular Medical lower than recent projected increases?

Foster Care

The moderate increases in costs for FY 2002 and FY 2003 reflect the stability now a part of the foster care system. In prior years, increases in costs included actions taken to remedy financial problems experienced by the various contractors. Currently, all contractors are operating with the rates negotiated. Therefore, the change in costs for FY 2003 reflects increased rates negotiated during the bid process. This increase of approximately 3% is mitigated by a declining number of foster children to be served.

Temporary Assistance for Families. The increase in the TAF caseload was based on the projected increase in the unemployment rate. The next table compares the projected caseload increase to the projected change in the unemployment rate. The relative change in the unemployment rate for Fiscal Year 2002 (8.1%) is lower than 2003 (7.5%). Therefore, the TAF caseload increase in 2003 was projected to be lower, corresponding to the lower rate of increase in the unemployment rate.

Fiscal Year	Average Monthly Persons	Pct Chg	Unemploy-ment Rate	Pct Chg
2001	31,788		3.7%	
2002 est	34,544	8.7%	4.0%	8.1%
2003 est	37,338	8.1%	4.3%	7.5%

General Assistance. The increase in the General Assistance caseload was based on rising unemployment and the assumption that the current rate of growth cannot continue indefinitely. The next table compares the projected caseload increase to the projected change in the unemployment rate. The relative change in the unemployment rate for Fiscal Year 2002 (8.1%) is lower than 2003 (7.5%). Therefore, the GA caseload increase in 2003 was projected to be lower, corresponding to the lower rate of increase in the unemployment rate. Also considered was the unprecedented growth rates of 17-18 percent during 2001 and 2002, in contrast to the slightly negative trend in prior years. The consensus assumed that a sustained increase at this rate into 2003 would be unlikely.

Fiscal Year	Average Monthly Persons	Pct Chg	Unemploy-ment Rate	Pct Chg
2001	2,616		3.7%	
2002 est	3,060	17.0%	4.0%	8.1%
2003 est	3,480	13.7%	4.3%	7.5%

Regular Medical

Total Regular Medicaid Expenditures

Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
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%	$333	6.6%	$885,000,000	12.0%
Proposed Cuts					-$22,401,000	
GBR '03	221,400	5.1%	$325	3.9%	$862,599,000	9.2%

The highlighted part of the graph reflects corrected figures from the testimony presented on January 16, 2002. See attachments A through D.

The increase in TAF/PLE populations is comprised primarily of increases in children who enroll as a result of the out reach initiatives carried out for the SCHIP. Medicaid continues to experience about 1.2 eligibles for each SCHIP eligible child. Cost growth for this population remains low since they are low utilizers of medical services.

TAF/PLE	Persons	% Change	Ave. Cost	% Change	Total Cost	% Change
FY 01	117,464	6.8%	$152	1.0%	$213,642,083	8.0%
FY 02 Est	127,060	8.2%	$158	4.1%	$240,620,000	12.6%
FY 03 Est	135,320	6.5%	$158	0.1%	$256,515,000	6.6%

While the population growth for the Aged and Disabled has been low during the last three years their rate of utilization and the cost of services has increased dramatically. The percent of per person cost increase from FY 01 to projected FY03 is over 20% during the same time period the TAF/PLE per person cost rose only 3.9%.

Aged/Dis	Persons	% Change	Ave. Cost	% Change	Total Cost	% Change
FY 01	61,928	1.3%	$544	11.0%	$404,257,552	12.4%
FY 02 Est	63,120	1.9%	$603	10.8%	$456,740,000	13.0%
FY 03 Est	64,380	2.0%	$656	8.8%	$506,915,000	11.0%

Within the other population category are children in foster care and adoption services, persons on MediKan, dually eligible persons and individuals brought back into the program because of CMS enforcement of 1931 rules. Included in Other, MediKan, accounts for a total of $12,500,000 in FY 01 and projected expenditures of $17,500,000 in FY 2002 and $21,700,000 in FY 2003.

Increases in MediKan are almost equally divided between growth in persons and growth in utilization and pricing.

Other	Persons	% Change	Ave. Cost	% Change	Total Cost	% Change
FY 01	18,607	8.9%	$219	29.0%	$48,955,057	40.5%
FY 02 Est	20,550	10.4%	$277	26.6%	$68,430,000	39.8%
FY 03 Est	21,700	5.6%	$309	11.5%	$80,540,000	17.7%

The chart below lists the three major service cost drivers in the regular medical budget. While Medicaid has been able to slow the rate of growth in pharmacy from previous highs of over 18% the very size of the expenditure means that even at 7.7% growth the actual dollar increase is nearly $15 million dollars. This growth seems to be largely due to pricing since utilization is projected to remain stable. Some of this pricing is a result of shifting from lower cost drugs to more expensive newer and potentially more effective medications. The growth in mental health is due almost entirely to a price increase. Ninety per cent of this increase is comprised of federal funds and does not result in an increase in general fund dollars. Home health growth is the result of increased utilization and not in growth in population. This growth has occurred with in the HCBS population.

	Pharmacy	Percent Change	Mental Health	Percent Change	Home Health	Percent Change
FY 01	$188,580,000	11.6%	$36,490,000	51.5%	$39,310,000	23.1%
FY 02 Est	$203,100,000	7.7%	$53,500,000	46.6%	$50,610,000	28.7%
FY 03 Est	$220,000,000	8.3%	$56,700,000	6.0%	$61,310,000	21.1%

The projected rate of growth in FY 2003 is estimated to be 12%, down 2.9% from FY 2002 which projects a growth rate of 14.9%. As noted earlier, caseload changes are the result of three variables: population change, utilization patterns, and pricing. A significant price change that impacts both FY 2001 and FY 2002 is the increase in mental health reimbursement. This change represents an attempt to maximize the Federal share of the costs and involves very few state dollars, less than 10% of total. These pricing changes will have been fully implemented by the end of FY 2002, thus, pricing is expected to remain stable during FY 2003.

While caseload estimating has projected a 12% increase in FY 2003, the Governor's budget reduces this growth to just over 9%. These reductions will be accomplished by managing pricing and appropriate utilization of those service categories that have witnessed the most rapid growth. This will result in a reduction of $22.4 million dollars from the FY 2003 projected caseload growth.

Below is a list of the program changes to be implemented:
Pharmacy: Beginning in FY 2003, the dispensing fee will be reduced from $4.50 to $4.00 per prescription. The ingredient fee will be reduced from AWP-10% to AWP-12%. The consumer co-pay will be raised from $2.00 to $3.00 and consumers will be reminded that this is a liability they must pay. Utilizing a clinical advisory panel Medicaid will create and implement a voluntary preferred formulary and work with physicians to gain compliance with the formulary.

Home Health: A review of home health claims has revealed that approximately 80% of the services provided to persons receiving HCBS services is provided by skilled nurses even when the service does not require skilled nurse level of care. Medical Policy has already instituted a pricing change which requires home health agencies to bill in smaller incremental units (15 minutes rather than one hour) and beginning July 1, 2002, persons receiving waiver services will need to obtain prior authorization to receive home health services.

Mental Health: Although the increase in mental health cost is primarily due to an increase in federal share, some reductions in mental health are planned. This includes limiting payments to CMHCs for residents of Nfs/MH because these are services considered a part of the daily rate paid to the NFMH. This will reduce the rate paid for mental health services to the FY 2002 level for persons on MediKan. And, seeking a parental contribution for children receiving SED waiver services.

MediKan: Beginning July 1, 2002, persons receiving MediKan will not be able to stay on the program beyond 24 months.

In an effort to maximize federal funds, the agency has converted several non-traditional medical services into Medicaid matchable services. These include behavior management and local education services. In the case of local education services this was done with no expenditure of additional state funds since the education agencies certify that they have the state funds available. These types of expansions have resulted in higher Medicaid expenditures, but have also resulted in additional federal matching funds being returned to Kansas.

4. What are the optional and mandatory populations eligible for Medicaid?

The following briefly summarizes the mandatory and optional coverage groups for whom Kansas provides Medicaid funded health care. A more comprehensive and technically complete list is included in attachment G. In addition to defining the population within the group, Medicaid rules also specify a level of eligibility for coverage. This specific level of coverage is usually selected by the State from an allowable range of incomes. The minimal level of coverage must be provided, or Medicaid funding may be sacrificed. If an optional group is selected, the conditions of the coverage group often depend upon a minimal level of coverage as well. These required levels are also included below:

MANDATORY COVERAGE GROUPS	OPTIONAL COVERAGE GROUPS
Temporary Assistance for Families (TAF) - Must cover families at 34% FPL ▸ Low-income families with children, eligible at TAF income levels ▸ Families moving from TAF to work ▸ Families moving from TAF to child support	**HCBS waivers** - The protected income level cannot be lower than the medically needy standard: ▸ Expanded coverage through higher protected income level of $716.00 per month ▸ Required disregard of parental income and resources

Poverty Level Eligibles - PLE - Must cover pregnant women and children of specific ages at 1989 levels
▸ Pregnant Women up to 150%
▸ Children at the following levels
  ▸ birth to one year up to 150%
  ▸ one to five years up to 133%
  ▸ six to eighteen up to 100% FPL
	Medically Needy - Minimal protected income level is $475/month; through a spenddown, persons contribute to the cost of care:
	▸ Pregnant women and children
	▸ Elderly, disabled and blind persons

Foster Care/Adoption Support - Must cover children in custody under IV-E: ▸ foster care ▸ adoption ▸ juvenile justice	**Women with Breast or Cervical Cancer** - Must cover at level of the FREE to Know program ▸ Uninsured persons up to age 65 ▸ Income level is currently 250% FPL
Supplemental Security Income Recipients - Must cover all SSI recipients ▸ Persons who are disabled or blind ▸ Persons who are elderly	**Working Healthy** - Must cover persons with disabilities with incomes up to 300% of FPL
Medicare Savings Plans (QMB/LMB) - required to cover Medicare premiums and other cost sharing	**MediKan Coverage** - State funded group for persons who are receiving General Assistance or seeking federal disability benefits

5. How does Kansas Medicaid eligibility compare to other states?

Please see Attachment F for a detailed chart of this comparison.

6. What are the optional and mandatory services required by Medicaid

The following table compares adult Medicaid beneficiaries only. It is inappropriate to include children in these comparisons because federal regulations of Early Periodic Screening, Diagnostic, and Treatment (EPSDT) preclude significant reduction or elimination of medically necessary services for children. Kansas, like other states provides EPSDT coverage for children to age 20.

Federally Mandated Services[1]	State Option Services
• **Emergency Medical Services for Alien Individuals** • **Family Planning Services and Supplies** • **Home Health Services** • **Inpatient General Hospital Services** • **Laboratory and X-Ray Services** • **Medical Transportation** • **Outpatient General Hospital Services** • **Physician Services.** This includes pregnancy related services, and some physician extender (i.e., nurse-midwife and nurse practitioner) services.	• **Alcohol and Drug Abuse Treatment** • **Attendant Care for Independent Living** • **Audiological Services** • **Behavior Management** • **Community Mental Health Center and Psychological Services** • **Dental Services.** Limited to KAN Be Healthy consumers (children), except for medically necessary extractions. • **Durable Medical Equipment, Medical Supplies, Orthotics, and Prosthetics** • **Early Childhood Intervention** • **Health Clinics** • **Home or community-based services** • **Hospice Services** • **Inpatient Psychiatric Services.** For individuals under age 21 • **Intermediate care facility (ICF/MR) services** • **Local Education Agencies** • **Local Health Department Services** • **Nursing Services (ARNP)** • **Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.** • **Prescribed Drugs** • **Podiatric Services** • **Respiratory care for ventilator-dependent individuals.** • **Services for Special Disorders** • **Targeted Case Management for Assistive Technology** • **Vision Services**

[1] Federal rules require that when services are reduced or eliminated, they must be reduced or eliminated for all adults covered by Medicaid. However, federal rules for Early Periodic Screening, Diagnostic, and Treatment do not allow for significant reduction or elimination of medically necessary services for children.

Each service is provided only when medically necessary to the beneficiary. In addition, each provided service must be defined in the Kansas State Plan.

7. How do Kansas' Medicaid benefits compare to surrounding states?

Comparison of Most Commonly Provided Optional Services for Adults in the Kansas Medicaid and Medicaid of Surrounding States

Optional Services	Kansas	Colorado	Missouri	Nebraska	Oklahoma
Dental Services	Very limited	Very limited	Yes	Yes	Limited
Clinic services.	Yes	Yes	Yes	Yes	Yes
Pharmacy	Yes	Yes	Yes	Yes	Yes
Optometrist services and eyeglasses.	Limited	Limited	Yes	Yes	Limited
Transportation services.	Yes	Yes	Yes	Yes	Yes
Rehabilitation and physical therapy services.	Limited to 6 months of rehabilitative care only	Limited to 30 visits per diagnosis per year	Yes	Yes, but limited to restoration of lost function due to illness or injury	Yes
Audiology	Yes	Limited to hearing aids for congenital & traumatic injury hearing loss	Yes	Yes	
Durable Medical Equipment (DME)	Yes	Limited	Yes	Yes	Yes
Transplants	Limited	Limited	Yes		
Podiatry	Yes		Yes	Yes	Yes

8. A. How does the Kansas Medicaid Program compare with the State Employee Program?

B. How does the Kansas Pharmacy Program compare to the State Employee Pharmacy Program?

Medicaid and the State Employees' Health Plans differ in terms of costs and benefits.

Medicaid

Costs: Co-payments and Deductibles

Medicaid coverage includes no deductibles, with the exception of covered populations with a "spenddown" requirement. Federal regulations allow the use of minimal co-payments, but only for certain services and populations.

- *Services* exempt from co-payments include those provided by public health departments, maternity centers, hospices, local education agencies, contract managed care organizations, and Indian Health Centers.
- *Beneficiaries* exempt from co-payments include beneficiaries under 18 years of age, breast and cervical cancer eligibles, persons in an adult care home or receiving home and community based services, persons enrolled in a capitated managed care program, and persons in a state psychiatric facility under age 22 or over 64 years old.
- Co-payments limits are set at the following: $.50 for services costing $10.00 or less up to $3.00 for services costing $50.01 or more.

State Employee Health Plan

Deductibles for the State Employees Health Plan are set by contract negotiation, and are affected by the benefits offered and the premiums charged. The State HMO option and the indemnity option provide examples of co-payments and deductibles for comparison:

- Premier Blue (HMO): $200 annual per person deductible, $400 per family. A $10 co-payment applies to most physical health services, with higher costs for prescription drugs, outpatient mental health services, and durable medical equipment.
- Kansas Choice (Indemnity): $300 annual per person deductible, $600 per family. Coinsurance of 20% of costs applies to most physical health services, with higher costs for prescription drugs, outpatient mental health services, and durable medical equipment.

Benefits

- Federal law or regulation requires that Medicaid offer many of the benefits it offers. Services required for Medicaid that are not often found in commercial plans include: over-the-counter medications for children (KAN Be Healthy or EPSDT covered beneficiaries), disposable medical supplies, case management services, non-ambulance medical transportation for children, enabling services, and Secretary-specified (Secretary of Health and Human Services) services. Some services require prior authorization and have limitations, but all medically-necessary services must be provided.

- The State Employees' Health plans offer some services, such as home health and hospice care, with annual or lifetime limitations. Additional or extended services are not generally offered or provided.

See Attachment E for side by side comparison.

Kansas Pharmacy Program

The pharmacy programs of Kansas Medicaid and the State Employees Health Plan also differ. The state employees group health plan offers a retail prescription program through Advance PCS, a pharmacy benefit management company. The prescription program for the state employees has a drug formulary, which is a list of quality, cost-effective drugs chosen by a committee of physicians and pharmacists. The retail prescription program contracts with participating network pharmacies.

In comparison, as a result of the Omnibus Budget Reconciliation Act (OBRA '90) legislation, Kansas Medicaid is required to have an "open drug formulary". The OBRA '90 legislation mandated the drug rebate system and required coverage of all products rebated by manufacturers, with a few exclusions (i.e., drugs for cosmetic purposes, infertility drugs, drugs for weight loss or gain, over-the-counter medications, benzodiazepines, and barbiturates).

Most commercial health insurance plans, including the state employees plan, are allowed to utilize cost control measures such as tiered co-pays, formularies, generic substitutions, step-therapy and prior authorization. Kansas Medicaid is limited to the use of prior authorization for a small number of drugs, to assure appropriate utilization of the drug. However, for a drug to be placed on prior authorization, it must go through the rules and regulations as dictated by K.A.R. 30-5-64.

In addition, it is important to note the following about Kansas Medicaid:

- Kansas Medicaid collected $35 million in rebates from drug manufacturers in FY 2001. The money received from rebates goes into the SRS fee fund, which does not reduce the overall cost of the Medicaid prescription drug program, but does reduce the overall Medicaid costs to the State. Some commercial plans may contract with specific drug manufacturers to receive incentives for using a certain amount of their products.

- Kansas Medicaid has implemented several strategies to help control pharmacy costs, including:
  - 34-day supply limitation
  - Early refill editing
  - Maximum Allowable Cost (MAC) pricing set by the State
  - Single statewide dispensing fee currently set at $4.50
  - Long Term Care (LTC) credits and returns
  - Prior authorization for specific medications
  - Point-of-sale (POS) systems enhancements
  - Drafted a request for proposal for a pharmacy benefits manager

- Federal Upper Limit (FUL) pricing
- Mandated use of generics unless physician indicates otherwise

Please see Attachment E.

9. That other programs does SRS manage that are caseload related and how are the costs in those programs controlled?

Programs Not in Consensus Caseload

The FY 2003 GBR (existing resources) for SRS totals $2.1 billion (all funds). Almost 60% of these total expenditures are part of the consensus caseload estimating process. Expenditures for services that are directly related to caseloads, but are not included in the consensus caseload estimating process total $420 million, or 20% of total SRS expenditures. These include Child Care Assistance, HealthWave, Adoption Support, Family Preservation, Vocational Rehabilitation, Intermediate Care Facilities for the Mentally Retarded (ICFsMR), and the Medicaid waivers for persons with Physical Disabilities (PD), persons with Developmental Disabilities (DD), and persons with Head Injuries (HI).

In many instances, expenditures in many of these programs are contained by limiting access to services, creating waiting lists or making policy changes to regulate the fiscal growth of each program.

10. Are there Medicaid waivers the State might be able to take advantage of?

The federal government offers states many waivers, none of which allow states to reduce services to already served populations. The following are the various waivers states may use to expand services to unserved populations.

Health Insurance Flexibility and Accountability (HIFA) 1115 Waiver
In August 2001, Health and Human Services Secretary Tommy Thompson launched the Health Insurance Flexibility and Accountability (HIFA) initiative to make it easier for states to submit Medicaid and SCHIP 1115 waiver requests and to have those requests considered promptly. The HIFA initiative allows states to design benefit packages which expand health care coverage to low-income individuals through Medicaid and State Children's Health Insurance Program (SCHIP) demonstrations. The initiative gives states more tools and flexibility to coordinate state Medicaid and SCHIP programs and offers a simpler application for states that commit to reducing the number of people who lack health insurance. Kansas does not have excess SCHIP funds available to expand health care coverage to unserved populations.

For example, in December 2001, Secretary Thompson announced approval of a proposal submitted by Arizona through a 1115 HIFA waiver to expand health coverage to more than 25,000 residents who did not previously have access to regular medical care. Arizona was the first state to receive HIFA waiver approval under the Bush administration's new streamlined approach to make it faster and easier for states to expand coverage.

1915(b) Waivers:
Referred to as "Freedom of Choice" waivers, these waivers allow states to waive (1) state wideness, (2) comparability of services, and (3) freedom of choice. They are limited in that they apply to existing Medicaid eligible beneficiaries, authority under this waiver cannot be used for eligibility expansions. Reasons states use 1915(b) waiver:

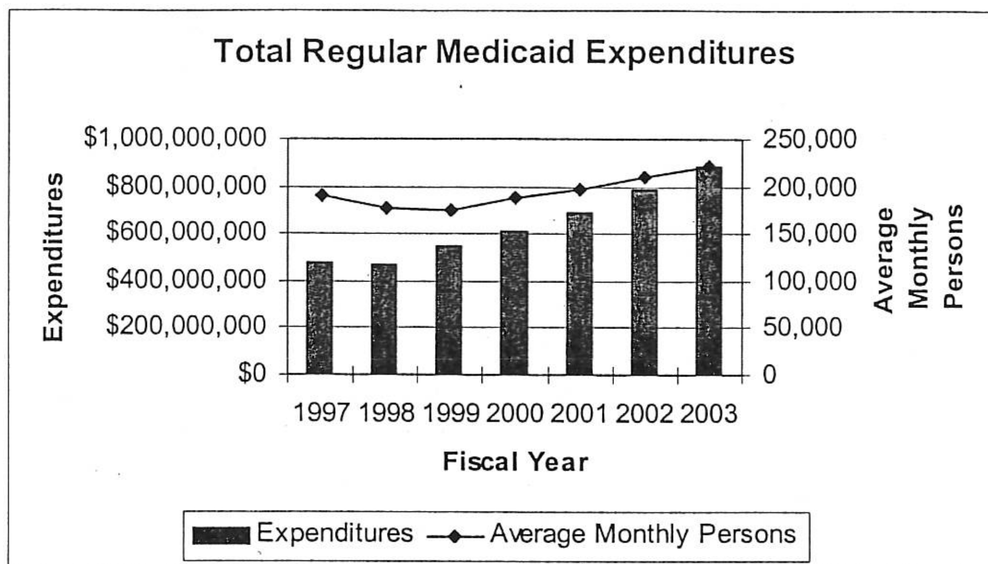
- To mandatorily enroll beneficiaries into managed care programs;
- To create a carve-out to deliver specialty care, for example: managed behavioral health;
- To create programs that are not available statewide;
- To provide an enhanced service package – this allows a state to provide additional services to medicaid beneficiaries via savings from a managed care program.

A 1915(b) waiver cannot negatively impact beneficiary access, quality of care of services, and must be cost effective (cannot cost more than the Medicaid program would have cost without the waiver).

1915(c) Waivers:
Referred to as "Home and Community-Based Services waivers, these waivers afford states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation.

Research and Demonstration Waivers: 1115 waivers

These waivers provide HHS with broad authority to authorize experimental, pilot, or demonstration projects which, are likely to assist in promoting the objectives of the Medicaid statute. This authority provides flexibility for the provision of services which are not otherwise matchable and allows for the expansion of eligibility for those who would otherwise not be eligible for the Medicaid program. The HIFA waiver described above is an 1115 waiver.

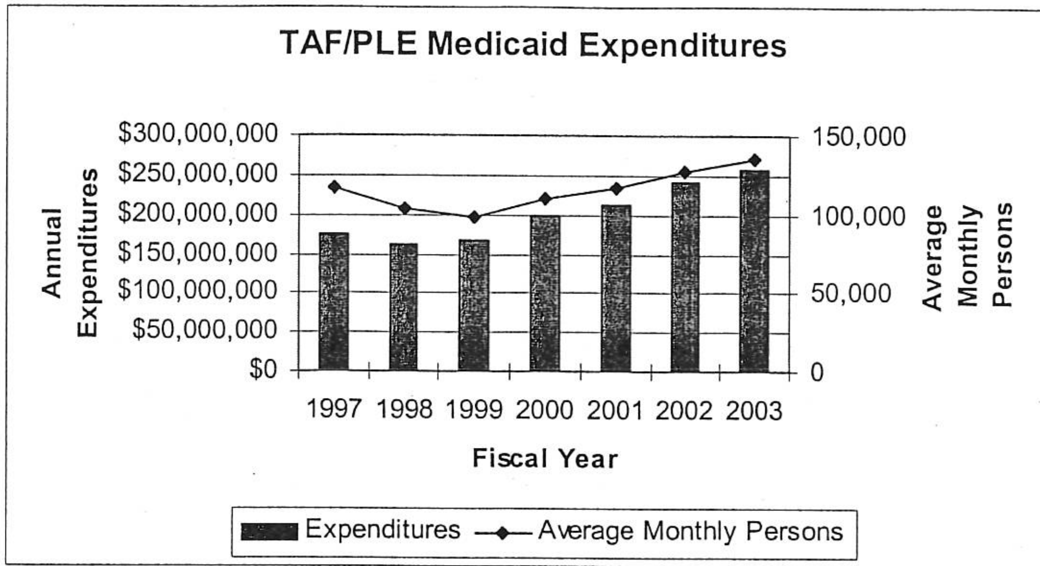


Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
1997	189,582		$209		$475,930,000	
1998	177,579	-6.3%	$221	5.8%	$471,556,744	-0.9%
1999	173,998	-2.0%	$261	17.8%	$544,327,399	15.4%
2000	188,250	8.2%	$269	3.1%	$607,216,000	11.6%
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%	$333	6.6%	$885,000,000	12.0%
Proposed Cuts					-$22,401,000	
GBR '03	221,400	5.1%	$325	3.9%	$862,599,000	9.2%

In reviewing the testimony presented on January 16, 2002, it was noted that there were some errors in the FY 2003 figures. The highlighted part of the above graph are the corrected figures.

Attachment A

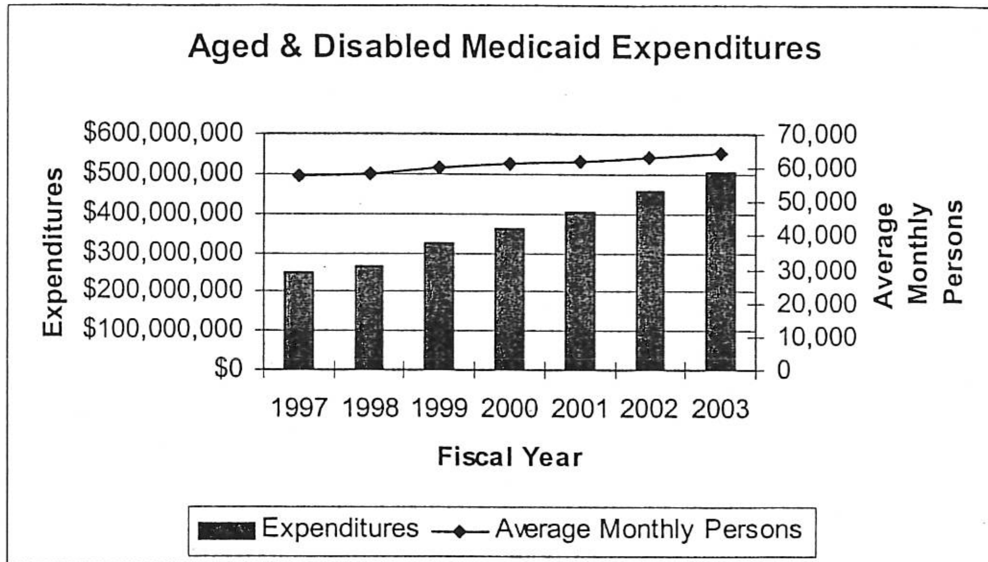
Response to Request for Additional Information About
Consensus Caseload Estimates



Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
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	127,060	8.2%	$158	4.1%	$240,620,000	12.6%
2003	135,320	6.5%	$158	0.1%	$256,515,000	6.6%

In reviewing the testimony presented on January 16, 2002, it was noted that there were some errors in the FY 2003 figures. The highlighted part of the above graph are the corrected figures.

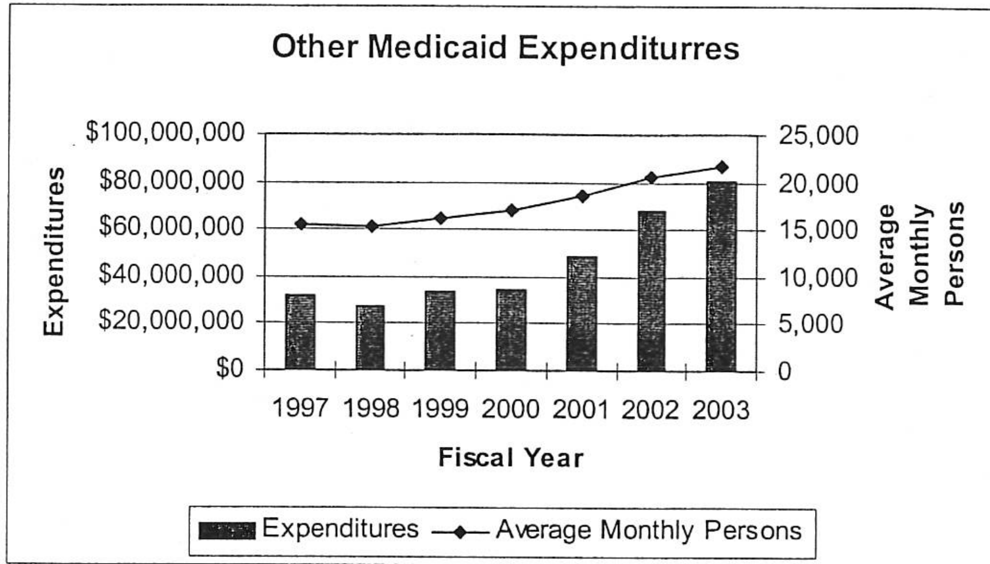
Attachment B



Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
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%	$656	8.8%	$506,915,000	11.0%

In reviewing the testimony presented on January 16, 2002, it was noted that there were some errors in the FY 2003 figures. The highlighted part of the above graph are the corrected figures.

Attachment C



Fiscal Year	Average Monthly Persons	Percent Change	Average Cost per Person per Month	Percent Change	Expenditures	Percent Change
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%	$309	11.5%	$80,540,000	17.7%

In reviewing the testimony presented on January 16, 2002, it was noted that there were some errors in the FY 2003 figures. The highlighted part of the above graph are the corrected figures.

Attachment D

Comparison of Medicaid to State Employee Health Plan Options

Benefits	Medicaid	Premier Blue	Kansas Choice
Inpatient hospital	Covered when medically necessary, subject to $48 copayment for nonpregnant adults, if provided under fee-for-service delivery model. [Note: copayment limits set by federal law.]	Upon satisfying $200 annual deductible per person/ $400 per family, covered in full for unlimited general days when using a contracting hospital.	In-network deductible of $300 per person/ $600 per family. In-network coinsurance of 20% of allowable charges - maximum of $2,000 per person/ $4,000 per family. Unlimited hospital days subject to deductibles and coinsurance.
Outpatient hospital	Covered when medically necessary, subject to $3.00 copay per visit for nonpregnant adults, if provided under fee-for-service delivery model.	Covered in full, with $10 copay per visit.	Covered subject to deductibles and coinsurance.
Physician services	Physician or mid-level practitioner are covered when medically necessary, subject to $2.00 per visit copay for nonpregnant adults, if provided under fee-for-service delivery model.	A $10 copay for each office call for medical/ surgical services, except for immunizations for children under the age of 72 months.	Covered subject to deductibles and coinsurance.
Surgical services	Covered when medically necessary, subject to $3.00 copay per visit for nonpregnant adults, if provided under fee-for-service delivery model.	Additional $100 coinsurance applies for outpatient surgery.	Unlimited hospital days subject to deductibles and coinsurance.
Clinic services	Covered when medically necessary, subject to $2.00 or $3.00 copay per visit for nonpregnant adults, if provided under fee-for-service delivery model.	A $10 copay per visit.	Covered subject to deductibles and coinsurance.
Prescription drugs	Covered when medically necessary subject to $2.00 copay per prescription for nonpregnant adults, if provided under fee-for-service delivery model.	20% of prescription cost for generic medications, 30% for formulary medications: 50% of the cost for nonformulary medications, or $60 for special case medications. Up to a 60-day supply may be obtained.	20% of prescription cost for generic medications, 30% for formulary medications: 50% of the cost for nonformulary medications, or $60 for special case medications. Up to a 60-day supply may be obtained.

Benefits	Medicaid	Premier Blue	Kansas Choice
the-counter medications	The following therapeutic classes of drugs are covered for **KAN Be Healthy** participants: antihistamine combinations, decongestants, cough and cold, vitamins and multi-vitamins.	Not covered.	Not covered.
Laboratory and radiological services	Covered when medically necessary, subject to $3.00 copay per visit for non pregnant adults, if provided under fee-for-service delivery model.	Covered subject to $10 copayment per visit.	Covered subject to deductibles and coinsurance.
Prenatal care and prepregnancy family planning services and supplies	Covered when medically necessary. This coverage includes prenatal health promotion and risk reduction when enrolled in a HMO.	Covered subject to $10 copayment per visit.	Covered subject to deductibles and coinsurance.
Inpatient mental health services	Covered when medically necessary. This coverage includes psychiatrists, psychologists, Community Mental Health Center services, partial-hospitalization and mental health prescriptions. Prior authorization is required.	Coverage for up to 60 days per plan year, when medically necessary for evaluation and treatment of mental illness and for rehabilitation for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization.	Coverage for up to 60 days per plan year, when medically necessary for evaluation and treatment of mental illness and for rehabilitation for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization.
Outpatient mental health services	Covered when medically necessary. This coverage includes psychiatrists, psychologists, Community Mental Health Center services, partial-hospitalization and mental health prescriptions. These services are limited to 32 hours a year unless the client participates in **KAN Be Healthy** and then the client is allowed 40 hours of service.	Visits 1 - 3 are covered at 100%, visits 4 - 25 have a $25 copayment, and additional visits are covered at 50% of allowable charge.	Limited to 25 outpatient visits per plan year. Each visit after first three are subject to a $25 office copayment.
Disposable medical supplies	Covered when medically necessary.	Not covered.	Not covered.

Benefits	Medicaid	Premier Blue	Kansas Choice
[illegible]ble medical equipment and [illegible] medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).	Durable Medical Equipment is covered when it is ordered by a qualified health provider and is needed for life support, employment or a child. Audiology and hearing services include the fitting and dispensing of hearing aids (every 4 years) and appropriate accessories (up to 6 hearing aid batteries per month--monaural or 12 per month--binaural). Vision services are covered, including a complete eye exam every four years (**KAN Be Healthy** participants every year). Eyeglasses are covered and contact lenses are covered when medically necessary. Eye prosthesis are covered when ordered by a health care provider. $3.00 copayment may apply to nonpregnant adults, if provided under fee-for-service delivery model.	Covered at 80% up to $5,000 in covered charges per person per plan year. One eye exam for refraction per covered person per year subject to $10 copayment. [Supplemental vision insurance can be purchased.]	Covered subject to deductibles and coinsurance. Benefits limited to $2,500 per person per plan year. Annual eye exam for refraction covered subject to coinsurance. Eyeglasses and contact lenses are not covered except for initial purchase following cataract removal. [Supplemental vision insurance can be purchased.]
Home and community-based health services and home health services.	Home and community based services are covered within these special children populations: technology assisted children, developmentally delayed children, head injury children (age 18-55), physically disabled children (age 16-64), and severely emotionally disturbed children. Home health aide services include skilled nursing services, and attendant care services are covered when medically necessary.	Home health, private duty nursing and home hospice care is covered in full.	Home health care and home hospice care is covered in full, subject to a maximum annual benefit of $2,500 per person for home health care and $5,000 maximum lifetime benefit per person for home hospice care.
Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school or other setting).	Covered when medically necessary.	Home health, private duty nursing and home hospice care is covered in full.	Home health care and home hospice care is covered in full, subject to a maximum annual benefit of $2,500 per person for home health care and $5,000 maximum lifetime benefit per person for home hospice care.

Benefits	Medicaid	Premier Blue	Kansas Choice
tion	Only when it is necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	Covered as any other inpatient or outpatient medical service, subject to deductibles and copayments.	Covered as any other inpatient or outpatient medical service, subject to deductibles and copayments.
Dental services	Covered dental services include dental medical history, oral hygiene exam, dental developmental exam, oral lesions, periodontal exam, dental caries, education, fluoride treatments, cleaning, x-rays, oral surgery, orthodontia, and space maintainers. Dental services for adults are limited to extractions, and are subject to a $3.00 copay per visit.	Supplemental dental insurance can be purchased which covers diagnostic, preventive, ancillary, and regular restorative services without a deductible. Other services covered subject to deductibles and copayments. Inpatient services involving oral care are covered as other inpatient services.	Supplemental dental insurance can be purchased which covers diagnostic, preventive, ancillary, and regular restorative services without a deductible. Other services covered subject to deductibles and copayments. Inpatient services involving oral care are covered as other inpatient services.
Inpatient substance abuse treatment services	Alcohol and drug abuse services are covered for medical detoxification only.	Coverage for up to 60 days per plan year, when medically necessary for evaluation and treatment of mental illness and for rehabilitation for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization.	Coverage for up to 60 days per plan year, when medically necessary for evaluation and treatment of mental illness and for rehabilitation for diagnosis and treatment of abuse or addiction to alcohol or drugs upon authorization.
Outpatient substance abuse treatment services	Alcohol and drug abuse services are covered when it is medically necessary through community based services.	Visits 1 - 3 are covered at 100%, visits 4 - 25 have a $25 copayment, and additional visits are covered at 50%.	Limited to 25 outpatient visits per plan year. Each visit after first three are subject to a $25 office copayment.
Case management services	Provided.	Unable to find in the information.	Unable to find in the information.
Care coordination services	Provided.	Unable to find in the information.	Unable to find in the information.

Benefits	Medicaid	Premier Blue	Kansas Choice
'cal therapy, occupational ...apy, and services for individuals with speech, hearing, and language disorders	Physical therapy services are covered when they are restorative for each injury or acute episode for a maximum of six months from the date of the first therapy. Occupational services are covered when they are restorative for each injury or acute episode for a maximum of six months from the date of the first therapy. Speech services are covered when they are restorative for each injury or acute episode for a maximum of six months from the date of the first therapy. $1.00 copay per visit may apply to nonpregnant adults, if provided under fee-for-service delivery model.	Covered subject to $10 copayment per visit.	Covered subject to deductibles and coinsurance.
Hospice	Hospice services are covered when ordered by a health care provider.	Home health, private duty nursing and home hospice care is covered in full.	Home health care and home hospice care is covered in full, subject to a maximum annual benefit of $2,500 per person for home health care and $5,000 maximum lifetime benefit per person for home hospice care.
Well child check-ups including immunizations	Covered when medically necessary. **KAN Be Healthy** extended services are available.	Covered subject to $10 copayment per visit.	Covered subject to deductibles and coinsurance.
Premiums for private health care insurance coverage	An option that is used when the private health care package is more affordable than Medicaid.	N/A	N/A
Medical transportation	Covered when it is medically necessary. Non-ambulance medical transportation can be provided to **KAN Be Healthy** participants. $3.00 copayment may apply to nonemergency trips for nonpregnant adults, if provided under fee-for-service delivery model.	Covered subject to $10 copayment.	Covered subject to deductibles and coinsurance.
Enabling Services	Medicaid requires that enabling services be provided by HMOs.	Unable to find information	Unable to find information

Benefits	Medicaid	Premier Blue	Kansas Choice
[illegible] ther health care services or [illegible] specified by the Secretary and not excluded under this section.	Medicaid requires that contract HMOs provide health care services or items specified by the Secretary that are not excluded by the contract.	N/A	N/A

ELIGIBILITY COMPARISON BY STATE

	MANDATORY GROUPS - States must cover certain populations. Some states have different minimal requirements than Kansas because coverage levels for certain groups were frozen at different points over the past several years. In most instances, the level of coverage at the time had to be maintained.							
	Category	**Minimal Requirements/ KS Options**	**Kansas**	**Nebraska**	**Missouri**	**Iowa**	**Oklahoma**	**Colorado**
1.	Family Medical under 1931 - (TAF)	AFDC rules in effect 07-16-96	TANF Limit- 34% FPL	TANF Limit-45% FPL	100% FPL	TANF Limit- 35% FPL	TANF Limit- 25% FPL	TANF Limit- 31% FPL
2.	Transitional Medical - ineligible for 1931 due to excess earnings	Required to cover first 6 months	Up to 12 months	Up to 24 months	Up to 48 months	Up to 12 months	Up to 12 months	Up to 12 months
3.	Extended Medical - ineligible for 1931 due to child or spousal support	Required to cover 4 months	Yes - 4 months	Yes	Yes	Yes	Yes	Yes
4.	Pregnant Women	Kansas frozen at 150%	150% FPL	185% FPL	185% FPL*	200% FPL	185%FPL (150)**	133% FPL*^
5.	Newborns under 1 year	Kansas frozen at 150%	150% FPL	185% FPL	185% FPL*	200% FPL	185% FPL(150)**	133% FPL*^
6.	Children under 6	133% FPL	133% FPL	185% FPL	133% FPL*(185)	133% FPL	185% FPL(133)**	133% FPL*^
7.	Children under 19	100% FPL	100% FPL	185% FPL	100% FPL*(185)	133%	185% FPL(100)**	100%
8.	SSI Recipients and deemed recipients	No options for Kansas - SSI is 76% FPL	yes	yes	*** 80% FPL	yes	*** more restrictive	yes
9.	Medicare Cost Sharing (QMB/LMB)	No options for Kansas	yes	yes	yes	yes	yes	yes
10.	Protected Groups	No options for Kansas	yes	yes	yes	yes	yes	yes

Attachment F

	Category	Minimal Requirements/ KS Options	Kansas	Nebraska	Missouri	Iowa	Oklahoma	Colorado
11.	IV-E Foster & Adoption Support Children	KS expanded, see 15 below	yes	yes	yes	yes	yes	yes
12.	SOBRA - Coverage for non-citizens	No options for Kansas	yes	yes	yes	yes	yes	yes
	OPTIONAL GROUPS							
13.	Home and Community Based Services (HCBS) Waivers	Optional. If an obligation is determined, must not be < 1 person med needy standard	Standard is $716.00 for all waivers	Standard is $716.00 for all waivers, except assisted living - 1 person SSI FBR ($545/month)	For most waivers, standard is $952.00	300% SSI limit for all waivers ($1635). Not elig if income > than this limit.	Standard is $259 + $325 allowance for spouse	300% SSI limit for all waivers ($1635). Not elig if income > than this limit
14.	Katie Beckett Kids		no	yes	yes	yes	04-01-02	yes
15.	Reasonable Classifications of children < 21	Optional, but many persons would be picked up in other groups	All children in custody Children in institution Adoption sbsdy	Adoption sbsdy	FC children in PLE group Some temp absent kids Adoption sbsdy	Children in institution Some temp absent kids Adoption sbsdy	All children < 21 in custody Adoption sbsdy	All children < 18 in custody Adoption sbsdy
16.	Chafee/ Foster Care Independence Act		no	unknown	no	no	unknown	no
17.	Optional SSI State Supplement	States are required to cover 1972 converts only	conversion only	yes, expanded	conversion only	yes, expanded	yes, expanded	yes, expanded
18.	Aged-blind-disabled Poverty Level Group	Levels between SSI and 100% FPL	no	100% FPL Asset Test- $4000 - 1 hh $6000 - 2 hh	no	no	100% FPL	no

	Category	Minimal Requirements/ KS Options	Kansas	Nebraska	Missouri	Iowa	Oklahoma	Colorado
19.	Special Institutional Level for NF coverage	If chosen 300% is maximum	300% SSI	no	no	300% SSI	300% SSI	300% SSI
20.	COBRA Eligibles		no	no	no	no	no	no
21.	Institutional Hospice		no	no	yes	no	no	no
22.	HMO for < min period		no	unknown	no	no	yes	yes
23.	Breast and Cervical Cancer (BCC)	Minimal levels provided	yes	yes	yes	yes	no	no
24.	Tuberculosis		no	no	no	no	yes	no
25.	Working Disabled (BBA or TWIAA)		July, 2002	yes	April, 2002	yes	no	no
26.	Medically Needy pregnant women, children, caretakers, aged, blind, disabled	Yes. If chosen pregnant women and children < 18 must be included	pw, children, aged, blind, disabled $475- 1 hh $475- 2 hh person	all groups $392 - 1 hh $392 - 2 hh Resource Test: $4000 - 1 hh $6000 - 2 hh	No, SPNDWN*** aged, blind, disabled, 80% FPL or $573 - 1 hh $750 - 2 hh	all groups $483 - 1 hh $483 - 2 hh	Same groups as Kansas,** $291 - 1 hh	no
	OTHER OPTIONAL GROUPS/POLICIES							
27.	Continuous Eligibility (kids)	Periods up to 12 months	12 months	12 months	no	no	12 months	12 months
28.	Presumptive Eligibility	Optional, PW, kids, BCC only	no	PW, kids, BCC	PW, BCC	PW, BCC	PW	PW
29.	SCHIP	Yes. Medicaid MOE	200% FPL	185% FPL	300% FPL*	185% FPL	185% FPL**	185% FPL

Notes:

*Missouri has utilized a Medicaid expansion program for children up to 300% FPL, but imposes nominal cost sharing on families over 185% and expanded cost sharing on families over 225%

**Oklahoma is currently implementing program cuts that would reduce eligibility levels to 150% for PW and newborns, 133% for children under 6, 100% for children under 19, eliminate the medically needy program and eliminate RX coverage for QMB eligibles

***Missouri and Oklahoma are 209(b) states able to set more restrictive criteria. Missouri does not have a medically needy program, but does apply spenddown rules to other groups through 209(b) status

*^Colorado had differing eligibility levels at the time the freeze was implementing, thus setting the minimal threshold below that of Kansas.

Medicaid Eligibility Groups - Mandatory & Optional

Healthcare coverage through Medicaid is available only to certain groups of individuals. The Medicaid program must cover certain mandatory groups and has the option to cover many other groups. In most cases, the authority to cover a population also specifies certain eligibility requirements, or allows the state to set the limit within a specific range. In some cases, new federal rules have been put in place that freeze current levels of coverage, thus creating differing minimum standards that each state may be required to provide.

The methodologies (policies and procedures) to determine countable income and resources are those generally the most closely related cash assistance program for the specific population. For the aged, blind and disabled the rules of the SSI program are used; for families and children, rules in the Aid to Families with Dependent Children (AFDC) program on July 17, 1996 are used.

MANDATORY GROUPS - States are required to cover the following groups of individuals:

Temporary Assistance for Families/1931 - Covers low income families with children at Temporary Assistance for Families (TAF) income levels. The level varies by household size, location and living arrangement but is about about 34% FPL. Due to welfare reform changes which 'delinked' Medicaid from cash assistance, families do not have to be TAF recipients. This group is also called 1931, due to the section of the Social Security Act which now contains the authority to provide coverage to this group. The minimal level of coverage are the rules in place for the AFDC program on July 16, 1996. Kansas could reinstate a resource test, slightly reduce the level of the earned income disregard or impose work-related penalties for adults. In addition, deprivation requirements could also be brought back to the program. There is much room for liberalization of this program as well.

Transitional Medical (Trans-Med): Provides ongoing medical coverage after termination from the TAF/1931 group because of employment. Persons must be covered under TAF/1931 at least three of the last six months to qualify. States are required to cover six months of transitional coverage and may cover an additional six months. There is an optional gross income test (185% FPL) and states may also charge premiums for this coverage.

Extended Medical: Provides four months additional medical for families losing eligibility under the TAF/1931 group due to receipt of spousal or child support. Like Trans-Med, persons must be receiving TAF/1931 at least three out of the last six months.

Pregnant Women - Kansas is required to cover women up to 150% FPL because of an eligibility level freeze in 1989, although other states may only cover up to 133% FPL. Women must also be covered through a postpartum period, which is defined as the second month following the month of birth. A resource test may also be put in place for this group.

Children - Certain targeted children must be covered under the Medicaid program. The level of

coverage is dependent upon the age of the child. Kansas has the ability to require a resource test. Coverage is provided at the minimum levels allowed by Medicaid:

- Infants born to Medicaid eligible women are covered through the month of the child's first birthday. Other newborns must be covered up to 150% FPL.

- Children ages one to five in families up to 133% FPL must be covered.

- Children ages six to eighteen up to 100% FPL must be covered.

SSI Recipients - Persons receiving Supplemental Security Income (SSI) are covered. In addition, specified groups of deemed SSI recipients, such as person ineligible for an SSI payment due to employment and certain protected children who failed to meet the new federal disability definition in 1996 are also included in the mandatory population. Kansas cannot further restrict coverage to this group because of the level of coverage we were providing at the time certain options became available. Some of our neighboring states, such as Missouri and Oklahoma, are able to provide more restrictive coverage.

Qualified Medicare Beneficiary and Low-Income Medicare Beneficiary - Qualified Medicare Beneficiaries (QMB) are persons with income below 100 percent of the federal poverty level. Low-Income Medicare Beneficiaries are persons with income up to135 percent of the poverty level. These programs provide for Medicare cost sharing expenses only, primarily reimbursement of the Medicare Part B premium. These groups are required and Kansas cannot further restrict coverage.

Protected Groups- These required programs are for persons who would otherwise be eligible for SSI except for increases in Social Security benefits. Some examples include the Pickle Program for persons losing SSI because of a COLA increase, the Adult Disabled Child program for person losing SSI because of receipt of Social Security and Early Widows and Widowers losing SSI because of receipt of widows or widowers benefits. These are required groups and Kansas cannot further restrict coverage.

Foster and Adoption Services and JJA - States are required to cover children receiving adoption support and foster care under IV-E. Generally, the AFDC rules in place on July 16, 1996 establish the IV-E eligibility thresholds. Kansas also provides coverage for all children in custody and children receiving adoption subsidy payments. If the optional coverage were not provided most children would be covered through a poverty level or other group

Coverage of Emergency Services for Non-Citizens: Although technically not a group, coverage is required for this population. Coverage of emergency services for any individual who, except for the citizenship/alienage requirements, would otherwise be eligible is required.

<u>OPTIONAL GROUPS</u>: States have the option to provide to other groups of persons. Kansas provides coverage under some of these groups, but there are many other options for expanded coverage. Eligibility criteria are generally set by the state within an allowable range provided for

in the enabling legislation or other rules in effect for the population. This document summarizes some of the groups Kansas has opted to cover.

Home and Community Based Services Waivers (HCBS) - HCBS are 1915(c) waivers available to states as alternatives to nursing facility or hospital care. States are able to target specific groups with these waivers, and may choose the groups that will be covered under a particular waiver. Kansas allows provides coverage to persons on the waivers who would be otherwise eligible under institutional rules, such as those meeting the Spousal Impoverishment criteria. Higher protected income limits are also allowed. The income limit for persons served through the waiver is $716 per month compared with the medically needy program standard of $475. The persons served through waivers are not required to spend this higher income on the cost of their waiver or medical health care costs.

In addition, children served through the waivers are not subject to deeming of parental income and resources. In other words, children are evaluated on their own income and resources. In this way children who are eligible for institutional placement may receive waiver funded services and Medicaid funded health care.

Reasonable Classifications - A state may provide coverage for certain broad groups of children under 21 under this provision. Kansas provides coverage for the expanded foster care and adoption support programs noted above, as well as some non-disabled children in medical institutions by establishing a reasonable classification.

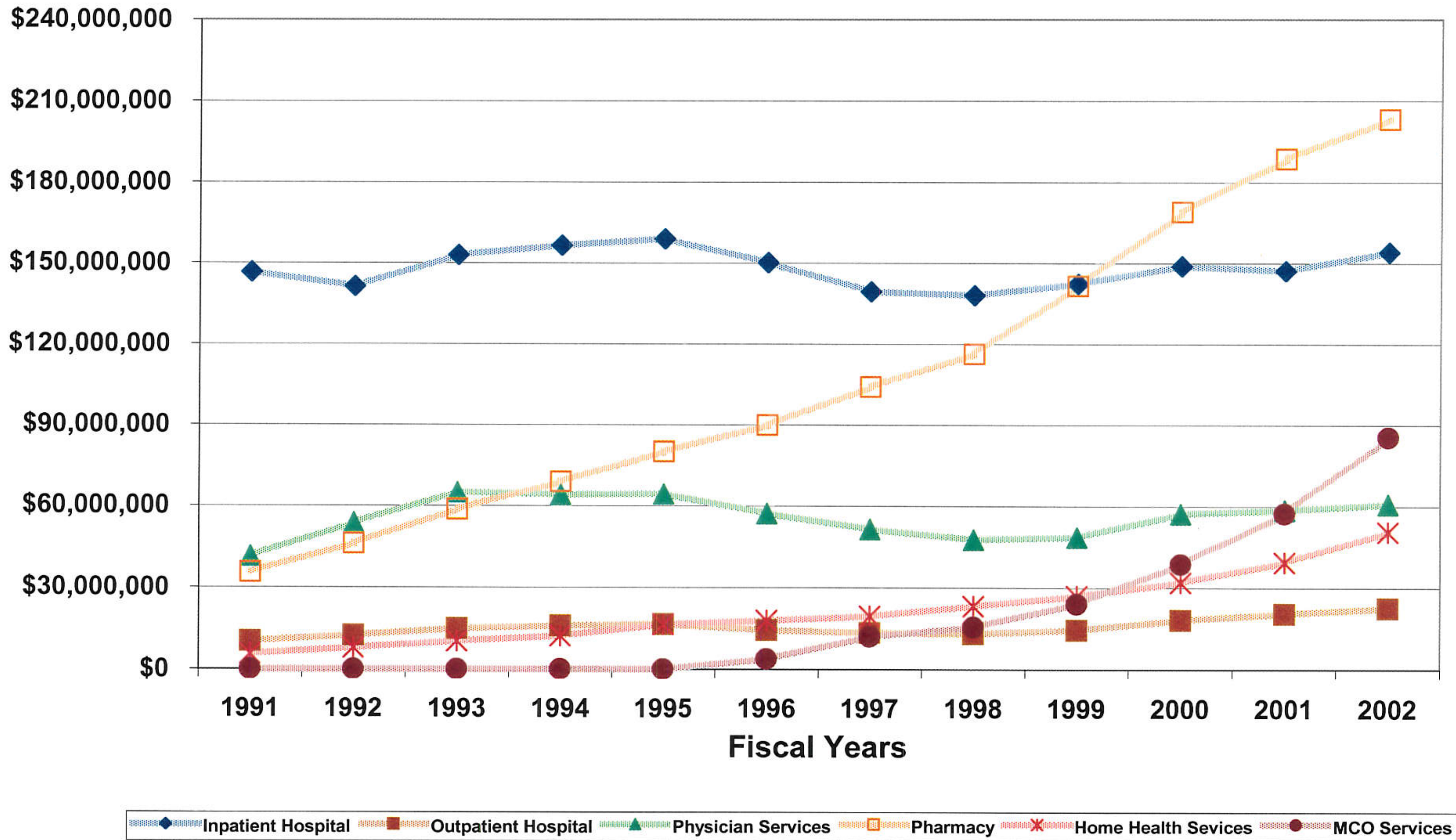
Special Institutional Level/Nursing Facility Coverage - Although states are required to provide nursing facility coverage to persons falling into other covered groups, a special income level is used, in conjunction with the medically needy program, to cover other nursing facility residents. A combination of these two groups allows Kansas to cover persons with medical costs in excess of their countable income. An income level of 300% of the one person SSI benefit is currently used, or $1635 a month. If only the income cap were used, eligibility may be obtained by depositing monthly income into a special trust, called a Miller Trust. This would effectively circumvent the income cap. The **protected income standard** for nursing facility coverage is currently $30.00/month. This amount may be increased but not decreased. Spousal Impoverishment, transfer of property and trust fund availability cannot be adjusted, as we currently utilize the most restrictive rules allowed.

Breast and Cervical Cancer Coverage - Uninsured women under 65 diagnosed with breast and cervical cancer through the FREE to Know program, operated by the Kansas Department of Health and Environment, are covered under this group. FREE to Know currently covers women to 250% FPL. Eligibility requirements for this group cannot be further restricted, but coverage of the group may be eliminated.

Working Disabled - This group allowable under the authority provided in the Ticket to Work and Work Incentives Improvement Act (TWWIIA) is scheduled to be implemented July 1, 2002 and is fully optional. There are no substantial options for coverage restrictions given the current plan in development.

Continuous Eligibility - This provision provides children twelve months of medical coverage without regard to family income changes. The option may be eliminated or the current twelve month period reduced.

Medically Needy - This program provides coverage to additional persons who may have too much income to qualify under other mandatory or optional groups. Persons obtain coverage by meeting a spenddown, which is much like an insurance deductible. The amount of the spenddown is determined by comparing countable income against a standard. The medically needy program is fully optional and States may choose to cover only certain portions of the population. There are 6 potential populations that may be covered: pregnant women; children; caretaker-relatives; aged; blind; and the disabled. Although a state may choose which of these populations to cover, a medically needy program must minimally cover children under 18 and pregnant women. Different eligibility levels for each population can be reached by utilizing provisions newly available to states, but there are minimum standards. For the aged, blind and disabled populations Kansas currently utilizes the minimum standard for resources ($2000 for a single and $3000 for a couple) and for income ($475.00/month). For families and children, no resource test is used but the minimum income standard is used. Kansas does not cover caretaker-relatives. Any changes in the current medically needy program could impact other Medicaid populations. Eligibility levels under some groups, such as HCBS and NF, would be impacted if the medically needy program were eliminated.



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Attachment 6