Approved: February 11, 2004
Date

MINUTES OF THE SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman Pete Brungardt at 10:30 a.m. on January 21, 2004 in Room 231-N of the Capitol.

All members were present except:
Senator John Vratil- excused

Committee staff present:
Russell Mills, Legislative Research
Dennis Hodgins, Legislative Research
Theresa Kiernan, Revisor of Statutes' Office
John Beverlin, Committee Secretary

Conferees appearing before the committee:
William Minner, Executive Director, Human Rights Commission
Mike Hollar, Assistant Director, Human Rights Commission
Wayne White, Kansas Legal Services, Inc.

Others attending:
See Attached List.

Chairperson Brungardt called the meeting to order and introduced William Minner, Executive Director, Human Rights Commission.

Mr. Minner presented an overview of the Human Rights Commission (Attachment 1).

Upon the completion of his testimony, Mr. Minner introduced Mike Hollar, Assistant Director of the Human Rights Commission, to finish the department overview (Attachment 2).

Mr. Hollar explained his charts. He showed the decrease in the number of open cases since 1995. He then showed the decrease in the amount of processing time, from 22 months in 1995, to little more than 6 months in 2003. Mr. Hollar continued by showing that the department now does more work with fewer personnel, going from 45 positions in 1995, to 36 in 2003. He then explained the decrease in the budget of the department compared to the increase in the amount of work it has done in the same time frame. Mr. Hollar then provided the reasons for the turn around and the future of the department.

Mr. Hollar referred to the Kansas Human Rights Commission Annual Report FY 2003, during his testimony (Attachment 3).

Mr. Hollar introduced Wayne White of Kansas Legal Services, Inc.

Mr. White provided an overview of the Kansas Legal Service's Voluntary Mediation Project (Attachment 4). He explained that the program was a cost effective and fair way of reaching settlement. He added to his testimony, that as a general rule, his goal is to achieve a 25 percent mediation rate each year. Mr. White stated that for this reason, 2003 was not a good year for the program. Mr. White explained the program has achieved, in the last couple years, a settlement rate of over 50 percent.

Mr. White explained that the creation of the mediation program mandated that the program receive private funding to supplement the state funding. He further explained that the program obtains one dollar of private funding for every three dollars of state funding. He explained the funding that the program receives from the Kansas Bar Foundation.

Mr. White wanted the committee to know that the mediation settlements resulted in substantial monetary settlements. He explained the difference between a formal and an informal settlement.

Chairperson Brungardt asked the committee for questions

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.

Senator Teichman asked whether lawyers donate time to the program.

Mr. White stated that some lawyers do donate time to the program. He further stated that it was administered through the Office of Judicial Administration.

Senator O' Connor had a question concerning page 13 of the Kansas Human Rights Commission Annual Report. She wanted to know whether allegations had decreased each year, similar to the way complaints had decreased.

Mr. White deferred the question to Mr. Hollar.

Mr. Hollar answered that each complaint is made up of more than one allegation. He stated that the average is 1.5 allegations per complaint.

Senator O' Connor asked whether the settlements had a teaching effect and led to the decrease in complaints.

Mr. Minner answered that the decrease in complaints were due to aggressive education, spread of word concerning settlements, and the reforming of attitude.

Chairperson Brungardt thanked Mr. Minner, Mr. Hollar and Mr. White. He welcomed Senator Clark to speak.

Senator Clark presented testimony on the President's Task Force on Medicaid Reform (Attachment 5).

Senator Clark provided charts for the committee (Attachment 6) (Attachment 7)(Attachment 8). On the second chart, he pointed out the increase in welfare and social services expenditure compared to the increase of all other expenditures. He also provided for the committee The President's Task Force on Medicaid Reform Final Report to the 2003 Legislature (Attachment 9).

Chairperson Brungardt asked the committee for questions.

Senator O' Connor asked how many medicaid issues were in bill form before the House or the Senate.

Senator Clark answered that there was one bill that contained six provisions, Senate Bill 272, and that he would have to defer to other members of the committee concerning other bills.

Senator Barnett stated that there were two bills still in drafting stage. He said that one bill was about long-term care and tax exemptions. He stated that the other bill was directed at smoking cessation.

Senator Barnett asked how he could obtain the 18 million dollars needed to fund his bill pertaining to smoking cessation.

Senator Clark answered that the bill would have to be sold as an investment or possibly they could use the tobacco money each state received. He stated that there would be little or none SGF money available.

Senator Barnett stated that there were efforts underway to expand safety net care, obesity, and The Sunflower Foundation.

Chairperson Brungardt thanked Senator Clark and reminded the committee about the Medicaid luncheon that afternoon.

The meeting was adjourned at 11:30. The next meeting is scheduled for January 22, 2004, at 10:30 a.m. in room 231-N.

Senate Federal and State Affairs Committee

Date: Jan. 21, 2004

Name:	Representing:
Mike Hollar	KS Human Rights Commission
William Minner	KS Human Rights Comm.
David Hanson	KHRC "
Brandon Myers	KHRC
Glenn Thompson	Stand Up For KS.
Megan Dunn	Hein Law Firm
Wayne White	Ks Legal Services
Andy Shaw	Kearney & Associates
Josie Torrez	SILCK
Fred Lucky	Kansas Hosp. Assn
Kevin Robertson	Ks. Dental Assn
Sheli Sweeney	Assoc. of CMHC's
Gina McDonald	KACIL
Joyce Jackson	TILRC
Laura Walsh	Dept. on Aging
Craig Kaberline	KS Area Agencies on Aging Assn.
Barb Hinton	Post Audit
Teresa Schwab	Oral Health Kansas
Trent LeDoux	Sen Pres Off
Brad Smoot	CMH
Marie Ann Lower	CMH
Denny Nichols	CMH
Pat Hubbell	Pharma
Scott Brunner	SRS
Mary Beth Mueller MD	Physician private practice

Senate Federal and State Affairs Committee

Date: January 21, 2004

Name:	Representing:
Carolyn Middendorf	Ks St Ns Assn
Tanya Dorf	SRS
Mike Huttles	Ks. Governmental Consulting

PREPARED STATEMENT – REMARKS FROM THE EXECUTIVE DIRECTOR WILLIAM V. MINNER
JANUARY 21, 2004

TO: FEDERAL AND STATE AFFAIRS COMMITTEE, KANSAS SENATE

CHAIRMAN BRUNGARDT, RANKING MEMBER GILSTRAP AND OTHER MEMBERS OF THE COMMITTEE:

I AM VERY PLEASED TO BE HERE BEFORE YOU TODAY TO TALK ABOUT THE KANSAS HUMAN RIGHTS COMMISSION. WE HAVE MADE REMARKABLE STRIDES SINCE 1995. OF COURSE, IN 1995, THE COMMISSION HAD REACHED A CRISIS DUE TO THE LARGE BACKLOG OF COMPLAINTS THAT WERE ON FILE AWAITING INVESTIGATION, 2,768, WITH A 22 MONTH PROCESSING TIME FOR A COMPLAINANT TO AWAIT INVESTIGATION OF HIS/HER COMPLAINT. THE COMMISSION WAS THREATENED WITH SEVERE MEASURES TO INCLUDE THE COMMISSION BEING PUT OUT OF BUSINESS IF CHANGES WERE NOT MADE TO CORRECT INEFFICIENCIES. A MANAGEMENT TEAM AND PROGRAM WERE PUT INTO PLACE TO ADDRESS THE CONCERNS AND ISSUES RESULTING IN A COMPLETE TURNAROUND. AS OF THE END OF FY 2003 THE COMMISSION HAS AN OPEN INVENTORY OF 548 CASES.

Sen. Federal & State Affairs Comm
Date: JANUARY 21, 2004
Attachment: # 1

I BEGAN MY EMPLOYMENT WITH THE COMMISSION ON JULY 1, 1972, IN A FIELD INVESTIGATOR POSITION. I CAN STAND BEFORE YOU TODAY AND TELL YOU THAT THE KANSAS HUMAN RIGHTS COMMISSION IS EFFECTIVELY CARRYING OUT THE LAWS THE LEGISLATURE PASSED TO ADDRESS DISCRIMINATION IN KANSAS.

FOLLOWING CHANGES AND REFORMS IN THE COMMISSION IN 1995, IN FISCAL YEAR 1996, THE COMMISSION RECOVERED $400,752.0O FOR COMPLAINANTS. IN FY YEARS 1997, 98, 99, 2000, 2001, 2002 AND 2003, THE COMMISSION RECOVERED:

$ 773,824.00 (FY 97)

1,542,101.00 (FY 98)

620,103.00 (FY 99)

1,201,704.00 (FY 2000)

1,059,066.00 (FY 2001)

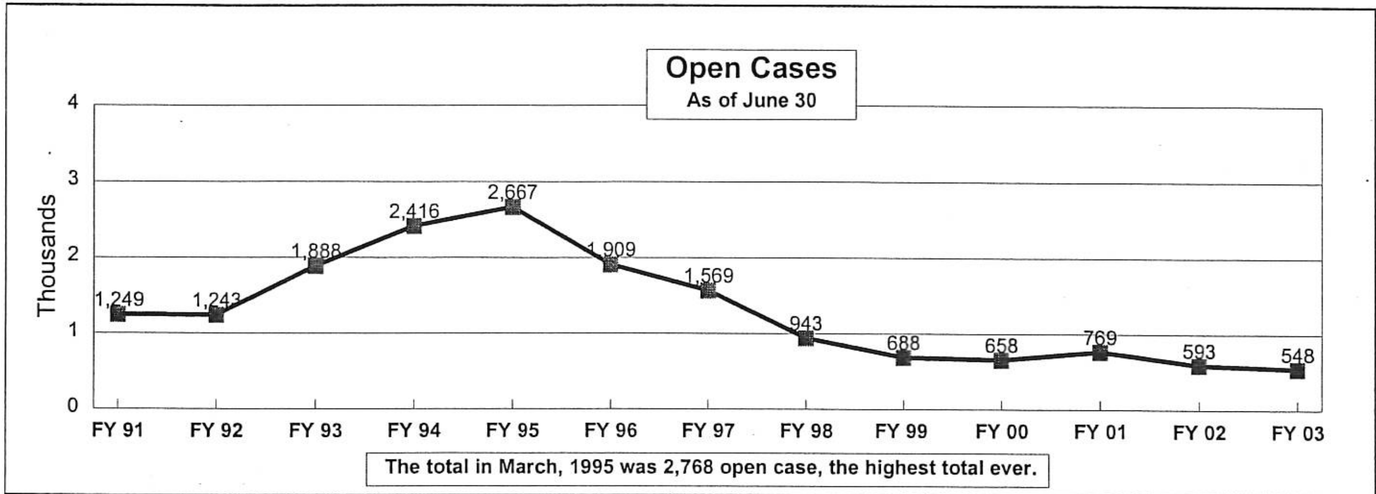
712,437.00 (FY 2002)

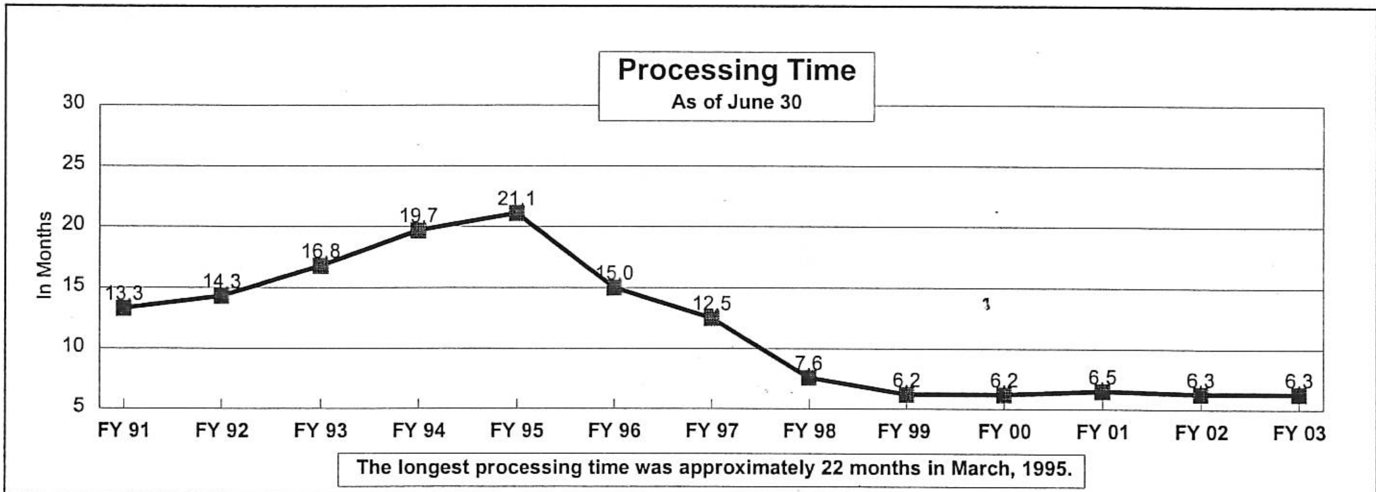
741,181.00 (FY 2003)

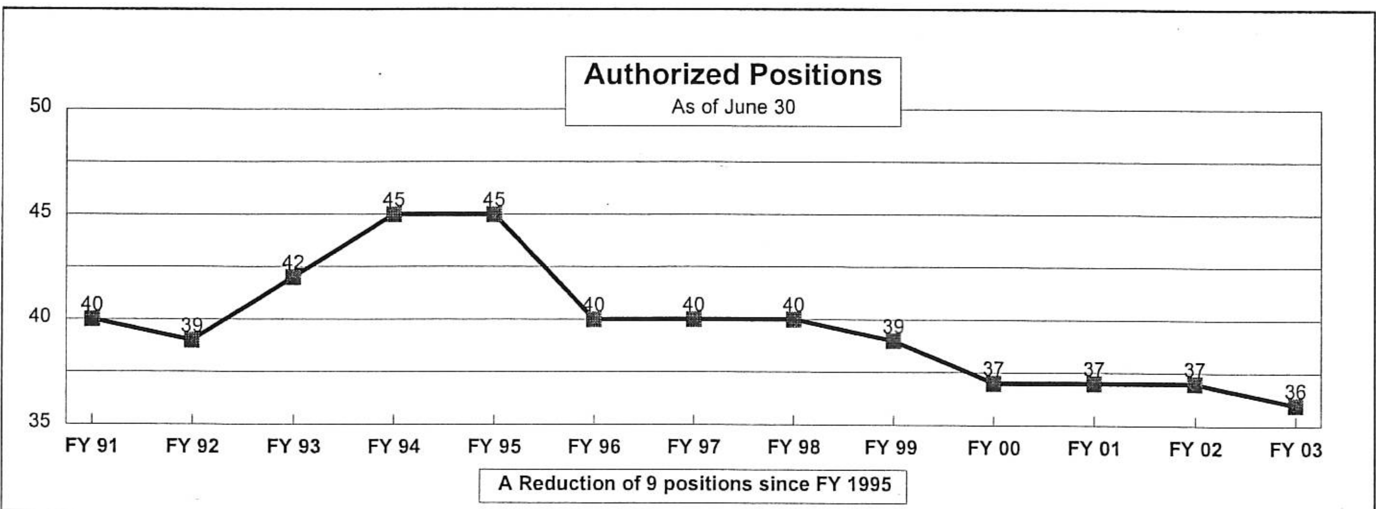
1,043,248.00 (CURRENTLY IN FY 2004)

TESTIMONY — MIKE HOLLAR

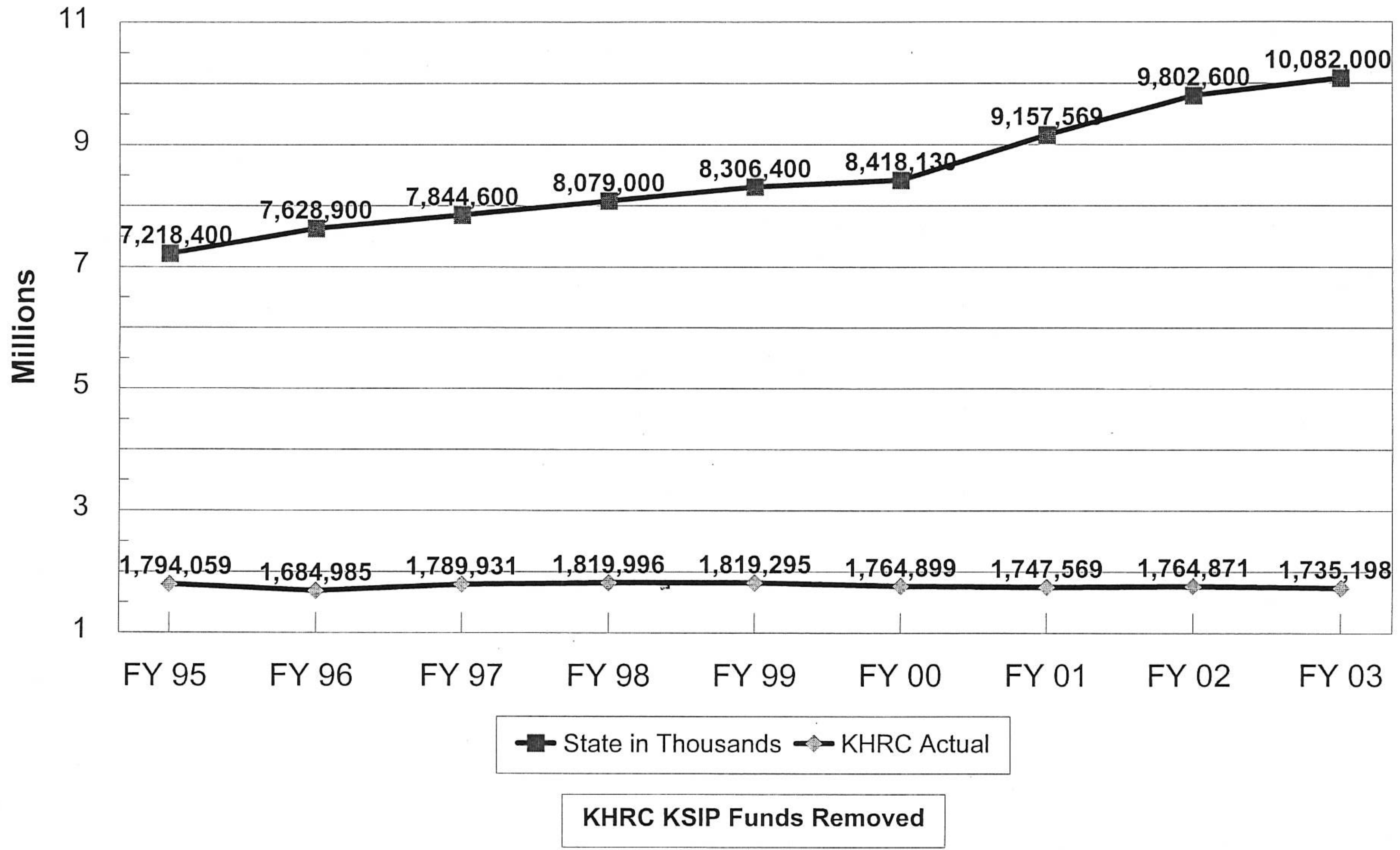
KANSAS HUMAN RIGHTS COMMISSION







Sen. Federal & State Affairs Comm
Date: JANUARY 21, 2004
Attachment: # 2



BUDGET COMPARISIONS STATE TO KHRC
FY 95 to FY 03 State increase 39.67% KHRC decrease 3.28%
Millions
11
9
7
5
3
1
7,218,400
7,628,900
7,844,600
8,079,000
8,306,400
8,418,130
9,157,569
9,802,600
10,082,000
1,794,059
1,684,985
1,789,931
1,819,996
1,819,295
1,764,899
1,747,569
1,764,871
1,735,198
FY 95
FY 96
FY 97
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03
State in Thousands
KHRC Actual
KHRC KSIP Funds Removed

Reasons for the turn around

1 All pending cases were assigned and strict accountablity maintained
2 Kansas Legal Services Mediation Program
3 Strong and continued Management involvement in all phases of Investigations
4 Streamlined Investigation Techniques to allow higher Investigator productivity
5 Increase efforts at conciliation
6 Better screening in Intake Department
7 Review EEOCs pending cases that are within KHRC jurisdiction
8 Try innovative ideas even if they end up not working
9 Statute changes: 300 day procedure and use of Pro Tem Hearing Officers
10 Drop HUD contracts as counter productive

The Future

1 Increase quality of investigations
2 Increase use of technology
3 Maintain Management involvement in all phases of investigations
4 Initiate and test new and innovative ways of doing business
5 Increase ability to provide Information/Education about the law
6 Keep the Commission Right-Sized

Kansas Human Rights Commission

PRESENTED AND REVIEWED BY-
MIKE HOLLAR

Annual Report FY 2003

Sen. Federal & State Affairs Comm
Date: JANUARY 21, 2004
Attachment: # 3

KANSAS HUMAN RIGHTS COMMISSION

2003 ANNUAL REPORT

* * * * * *

OUR MISSION AND PHILOSOPHY

The mission of the Kansas Human Rights Commission is to prevent and eliminate discrimination and assure equal opportunities in all employment relations, to eliminate and prevent discrimination, segregation or separation, and assure equal opportunities in all places of public accommodations and in housing.

The agency philosophy in accomplishing its mission is to act in accordance with the highest standards of professional conduct, ethics, efficiency, and accountability. Realizing that the principles of equality and the protection of basic human rights are the most noble of human efforts, we dedicate our activities toward that purpose, believing that eternal vigilance is the price of freedom.

Eternal vigilance is the price of freedom.

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3-3

THE COMMISSIONERS

James E. Butler
Chairman
At Large, Manhattan

David A. Hanson
Vice Chair
Law, Topeka

Brenda C. Jones
Labor, Kansas City

Beth Bradrick, Ph.D.
Labor, Pittsburg

Deborah Wheeler
Industry, Emporia

Errol Williams
Industry, Topeka

Lou Ann Thoms
Real Estate, Topeka

The Kansas Human Rights Commission enforces both the Kansas Act Against Discrimination and the Kansas Age Discrimination in Employment Act. The Kansas Act Against Discrimination provides for a seven member Commission to be appointed by the Governor subject to approval of the Senate; two representing industry, two representing labor, one who is authorized to practice law in this state, one representing real estate, and one appointed at large. The Governor designates one Commissioner to serve as Chairperson. The term of office of each member of the Commission shall be four years or until a successor is confirmed. Commissioners may, at the will of the Governor and Senate's discretion, be appointed for an additional term(s) upon completion of the initial term. The Act also requires that no more than four of the Commissioners are from the same political Party.

Contact Information

Topeka-Main Office

Landon State Office Building
900 SW Jackson - 568 South
Topeka KS 66612-1258
(785) 296-3206
Fax: (785) 296-0589
TTY: (785) 296-0245
Toll Free (888) 793-6874

Wichita

130 S Market, Suite 7050
Wichita, KS 67202-3827
(316) 337-6270
Fax: (316) 337-7376
TTY: (316) 337-6272

Dodge City

Military Plaza Offices, Suite 200
100 Military Plaza
Dodge City, KS 67801-4945
(620) 225-4804
Fax: (620) 225-4986

Independence

Independence Corporate Office, Inc.
200 Arco Place, Suite 311
Independence, KS 67301-5353
(620) 331-7083
Fax: (620) 331-7135

The Internet

http://www.khrc.net

KHRC STAFF

Name	Position
William V. Minner	Executive Director
Robert M. Hollar	Assistant Director
Brandon L. Myers	Chief Legal Counsel
Judy Fowler	Senior Staff Attorney - Wichita
Barbara Scott Girard	Staff Attorney
Jane Neave	Office Supervisor - Wichita
Bill Wright	Housing/Intake Supervisor
Jeremy R. Hall	Public Information Officer
Karen McDaneld	Office Manager
Orie Kirksey	Intake Manager
Kelly McKinley	Intake Specialist
Deborah Rhodd	Intake Specialist
Barbara Combs	Investigator - Wichita
Heidi Thaw	Investigator - Wichita
Cindy Nelson	Investigator – Wichita
Diane Roberson	Investigator - Wichita
Vamba Nzwilli	Investigator - Topeka
Kathy Prochazka	Investigator - Topeka
Jerry Ryan	Investigator - Topeka
Bryant Barton	Investigator - Topeka
Christopher Barnes	Investigator – Topeka
Paul Forese	Investigator - Topeka
Doreen Vargas	Investigator - Dodge City
Linda Dennett	Investigator - Independence
Caryl Hines	Secretary - Topeka
Carol Radcliffe	Secretary - Wichita
Linda Wenger	Secretary - Topeka
Marilyn Seeger	Secretary – Admin. Hearing Office
Sharon Williams	Secretary – Topeka
Etta James	Office Specialist - Topeka
Mary Mitchell	Office Assistant - Wichita
Sabrina Thompson	Receptionist - Topeka

History of the KHRC

The Kansas Act Against Discrimination was passed in 1953 making Kansas the twelfth state in the U.S. to have a law against discrimination. At that time the agency was called the Kansas Anti-Discrimination Commission. The Act was limited to employment practices and had no enforcement provisions.

The Act was amended in 1961 to become an enforceable law prohibiting discriminatory employment practices because of race, religion, color, national origin, or ancestry and the name of the agency was changed to the Kansas Commission on Civil Rights.

In 1963 the Act was amended to prohibit discrimination by hotels, motels, cabin camps and restaurants. In 1965 the legislature broadened the Act's coverage of employment practices and places of public accommodations. In 1967 the Commission was given the power to initiate complaints of discrimination and the power of subpoena.

Housing discrimination was prohibited by an act of the 1970 Kansas Legislature, which also increased the size of the Commission to its present seven members and gave it power to conduct investigations without the filing of a formal complaint.

The 1972 Kansas Legislature further amended the Act in three ways. The Commission was given authority to investigate complaints of sex discrimination, initiate a contract compliance program, and use hearing examiners for public hearings.

In 1974 the Legislature prohibited discrimination in employment and public accommodations because of physical handicap but limited remedies for discrimination. The law has been changed since that time to include persons with physical and mental disabilities.

In 1983 age discrimination in employment was prohibited, which made it illegal to discriminate against persons between the ages of 40-70. The Kansas Age Discrimination in Employment Act was amended in 1988 to protect persons of the age of 18 or more years against age discrimination.

The Act was amended in 1991 so as to prohibit discrimination in employment, public accommodations and housing on the basis of disability, and to also prohibit housing discrimination on the basis of familial status. The Act was also amended to change the name of the Kansas Commission on Civil Rights to the Kansas Human Rights Commission.

In 1995 two separate legislative bills amended the Act. The changes removed the statutory requirement that the Commission employ at least one full-time hearing examiner. Instead, the legislature

authorized the Commission to employ or contract for the services of hearing examiners or pro tem hearing examiners to preside over public hearings, and amended the provisions of the statute regarding the terms, appointments and confirmation of Commissioners.

In 1995, the Kansas Legislature further amended the Act to provide that a complaint may be dismissed, under certain circumstances, after pending before the Commission for at least 300 days without a finding or disposition by the Commission. That dismissal would constitute an exhaustion of administrative remedies sufficient to allow a complainant to file the matter in court.

In 1999, the Kansas Legislature amended the act to prohibit the use of genetic testing and genetic information in employment decisions.

INTRODUCTION

A professional staff under the supervision of the Executive Director conducts the daily operations of the Kansas Human Rights Commission. Staff includes an Assistant Director, fourteen investigators, four investigative supervisors, one pubic information officer, three attorneys, one intake manager, two intake workers, an office manager, and nine clerical workers. Pro tem administrative law judges conduct public hearings.

The Commission is mandated by the Kansas Legislature to prevent and eliminate unlawful discrimination, and is responsible for enforcing both the Kansas Act Against Discrimination (KAAD) and the Kansas Age Discrimination in Employment Act (KADEA). The KAAD protects persons from discrimination in employment, housing and public accommodations. Charges of alleged discrimination may be filed on the basis of race, religion, color, sex, disability, national origin, ancestry or use of genetic information in employment decisions. In addition, charges of discrimination on the basis of familial status may be filed in housing cases. The KADEA protects any individual 18 or over from discrimination in employment on the basis of age. Both laws protect those who have filed a complaint, participated in the investigation of a complaint, or opposed actions believed to be in violation of the Act(s) from retaliation for such actions. Anyone claiming to be aggrieved by an alleged unlawful practice, and who can articulate a prima facie case pursuant to a recognized legal theory of discrimination, has the right to file a complaint charging discrimination under the laws of Kansas with the KHRC.

FISCAL ALLOCATIONS

The Commission's FY 2003 total budget was $1,760,354 with funds coming from the Kansas general fund, as appropriated by the Legislature, various fee funds, from contracts with the EEOC, and from the Kansas Savings Incentive

Program (KSIP). The comparative portions and dollar appropriations are as follows:

General Funds	**$ 1,303,836**
Fee Funds	**$ 6,597**
Federal Funds	**$ 424,789**
KSIP	**$ 25,132**
Totals	**$ 1,760,354**

COMPLIANCE AND ENFORCEMENT ACTIVITIES

Civil rights law, at both the state and federal level, has become increasingly complex in its nature and application. This is principally due to the enactment of major state and federal legislation in the past decade, which has expanded the role of the Kansas Human Rights Commission and other human rights agencies.

In 2003, for the twelfth year in a row, sex discrimination was the number one basis of complaints filed. Sex, race, disability, and age continued as the basis given for most complaints filed with this agency.

During FY 2003 KHRC closed 966 cases and recovered $741,810 for complainants. This figure does not include the value of positions or jobs, which may have been obtained by the Commission for complainants, nor does it include other non-monetary remedies.

KHRC had an open inventory of 2,768 cases in March of 1995, a record high for the agency. At the end of FY 2003 this backlog was reduced to 548 open cases.

This impressive reduction has been attributed to a combination of statutory, procedural and organizational changes implemented over the last seven fiscal years, and the addition of innovative programs such as the Kansas Legal Services mediation project, investigator accountability, and streamlining administrative procedures.

During the fiscal year the agency also reduced the average processing time for cases filed with the Commission from approximately 22 months in FY 1995 to approximately 6 months currently.

MONITORING COMPLIANCE

The Commission is a party to written agreements, which resolve complaints of alleged discrimination filed with the agency. A Commission representative is assigned to monitor the terms and conditions of these agreements, as well as Commission orders.

CONTRACT COMPLIANCE

The Commission is empowered to review equal employment opportunity data of companies throughout the state who have entered into a contract with the State of Kansas, a Kansas municipality or

other political subdivision in the state. A contractor and its subcontractors are obligated to observe the provisions of the Kansas Act Against Discrimination.

The Commission is empowered to investigate these state contractors to insure that entities receiving money from contracts with the state have equitable work forces and employment practices.

THE COMPLAINT PROCESS

Kansas law provides that any person who claims to be aggrieved by an unlawful practice in the areas of employment, housing, or public accommodations, and can articulate a prima facie case pursuant to a recognized legal theory of discrimination (based on race, religion, color, sex, disability, ancestry, national origin, age and use of genetic information in the area of employment only, familial status in the area of housing only, and retaliation) may file a complaint with the KHRC.

Employment and public accommodation complaints must be filed within six (6) months from the last alleged discriminatory act. Housing complaints must be filed within one year of the last date of incident.

KHRC's intake department is located in the Topeka office and is responsible for drafting complaints filed with the agency. Staffed by an intake manager and two intake specialists. The intake department also provides inquirers with referrals to other agencies (for issues outside of KHRC's jurisdiction), and answers questions regarding KHRC's compliance and enforcement policies.

A complaint may be filed personally or by attorney. An individual may write, telephone or come in to one of the Kansas Human Rights Commission's offices to begin the filing process. If the complaint falls within the Commission's jurisdiction, a formal complaint may be submitted. The Intake workers are available to assist in drafting a complaint based on information provided by the complainant. The complaint must be signed, verified and notarized before it can be officially filed with the Commission. Forms and information about filing a complaint of discrimination may be obtained at any area office or the Commission web page.

There were over 5000 inquiries to KHRC's intake department and over 500 other inquiries during FY 2003. Many inquiries were outside of KHRC's jurisdiction or beyond the six month timely filing limit and were referred to the Equal Employment Opportunity Commission or other agencies.

The Commission offers a third-party mediation program statewide through Kansas Legal Services. Mediation services offer a possible alternative to complete investigation.

When mediation services are not selected by one of the parties, or when mediation services fail, a complaint may be sent for full investigation.

The Commission is responsible for investigating all complaints filed. It is also responsible for conciliation of cases where the investigating commissioner has indicated there is probable cause to credit allegations of the complaints.

During a full investigation a field investigator will interview the complainant, review relevant documents, conduct interviews with witnesses, and summarize the case for the investigating commissioner. The investigator's role is that of a fact finder. The investigator does not determine the outcome of the case, but rather gathers and presents the facts to a commissioner for determination. All information discovered throughout the course of the investigation is confidential and is gathered in an objective and impartial manner.

Depending upon the information obtained during the investigative process, the investigating commissioner makes a determination of either "Probable Cause" or "No Probable Cause". If the Commission finds "Probable Cause", then an attempt will be made to reach a written settlement between complainant and respondent. If conciliation efforts fail, the case may be scheduled for a public hearing.

THIRD-PARTY MEDIATION PROGRAM

Under this program KHRC contracts with Kansas Legal Services to offer a voluntary procedure in which the parties to discrimination complaints filed with KHRC may attempt to mediate and resolve their controversies short of having KHRC investigate and process the complaint.

This program was begun on a limited basis in FY 96. Beginning FY 97, the program was expanded to offer mediation services statewide. Twenty-five percent of the program costs are funded with private funds.

KHRC's third-party mediation procedure has been an effective means of resolving complaints to date. In FY 2003, a total of 727 cases were referred to mediation. Of that number, 150 mediations were completed, with another 39 under consideration by the parties involved or pending. At the end of the FY 2003 another 20 mediations were scheduled, but not completed. A total of 80 mediations resulted in case settlements.

OFFICE OF ADMINISTRATIVE HEARINGS

The Office of Administrative Hearings (formerly Office of Administrative Law Judge) performs the adjudicatory functions of the KHRC. By

statute, public hearing proceedings (administrative trial proceedings) are commenced pursuant to the provisions of the Kansas Administrative Procedure Act. The Kansas Human Rights Commission Pro Tem Hearing Examiners preside over public hearing proceedings.

At the beginning of Fiscal Year (FY) 2003, two (2) cases were pending in the Office of Administrative Hearings. Thereafter, during FY 2003, three (3) additional cases were forwarded to the Office of Administrative Hearings for commencement of public hearing proceedings. A Pro-tem Hearing Examiner was assigned in all three (3) cases. In FY 2003, there were no public hearings, other conference/hearing or administrative closures.

During FY 2003, the Office of Administrative Hearings conducted pre-hearing conference in four (4) cases, and issued seventeen (17) other orders addressing such matters as pre-hearing procedural issues, potential dispositive matters, and discovery issues.

A public hearing was not required in one case and settlement proceedings are currently pending and awaiting finalization.

In summary, during FY 2003, no cases closed in public hearing, and five (5) cases are still pending in the Office of Administrative Hearing.

PUBLIC INFORMATION PROGRAM

In addition to its enforcement and compliance activities, the Commission is also required by law (KAAD) to inform the public about civil rights laws, what constitutes discrimination and how acts of discrimination can be avoided.

The Kansas Human Rights Commission's public information program sponsors, develops, and conducts a vast amount of training across the State. This is done through seminars and conferences that are open to the public, on-site training and presentations for private businesses, municipalities, and college-level classes, and the constant development of its web site.

During fiscal year 2003, the agency conducted seminar and training sessions throughout the State, training public and private organizations, civic groups, neighborhood organizations, realtors, landlords and schools.

KHRC's information services are provided free of charge to individuals across the state. Civil rights topics most often requested included issues relating to sexual harassment, disability, fair housing, and the investigative process.

In addition to information and training, the Agency creates and maintains Commission publications. During FY 2003, the agency distributed thousands of

posters, brochures, and pamphlets and fielded hundreds of telephone inquiries. Publications of the Kansas Human Rights Commission include its Annual Report, its Rules & Regulations, the Kansas Act Against Discrimination and Kansas Age Discrimination in Employment Act (KAAD/KADEA) booklet, and brochures on Employment, Discrimination in Hiring, Fair Housing, and the publication of the Commission's quarterly newsletter, *Spectrum.* On March 25, Governor Kathleen Sebelius proclaimed April 2003 as Kansas Fair Housing Month. The proclamation was presented to the Fair Housing Project Team, which consists of representatives from various organizations, including KHRC staff.

The KHRC is holding its 9th Annual Employment Law Seminar in October of 2003. Employers from the around the state are expected to attend.

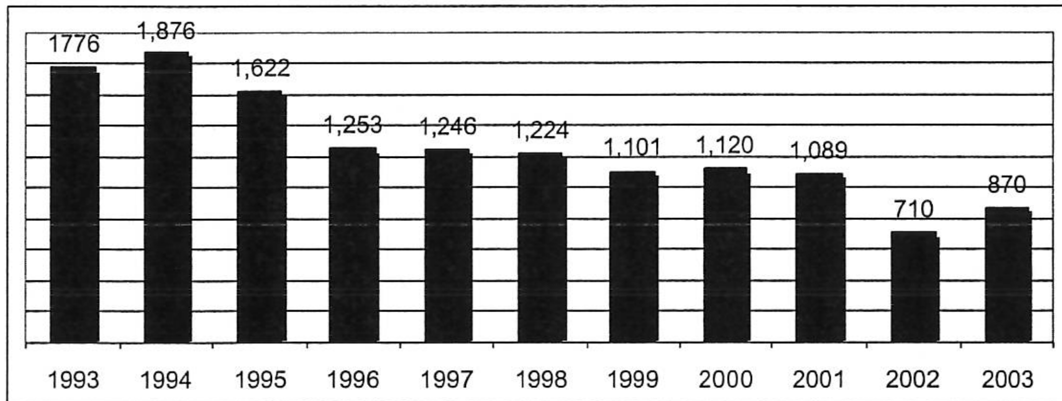
During FY 2003, the Commission continued to update and improve its informational web site. The site not only provides information on the Kansas Human Rights Commission, its Commissioners and the law it is empowered to enforce, but it has links to other state human rights organizations and various civil rights related web sites. The web page address is www.khrc.net

STATISTICAL DATA

COMPLAINTS FILED FY 2003

AREA	COMPLAINTS
EMPLOYMENT	832
HOUSING	5
PUBLIC ACCOMMODATION	33
TOTAL CHARGES FILED	870

COMPLAINTS FILED YEAR TO YEAR 1993 - 2003



ALLEGATIONS FILED FY 2003

Category	Number
EMPLOYMENT	1149
HOUSING	7
PUBLIC ACCOMMODATION	36
TOTAL ALLEGATIONS FILED	1192

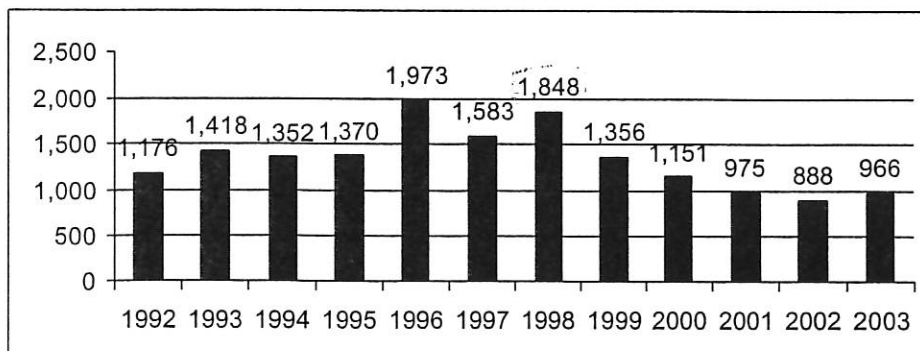
CASES RESOLVED FY 2003

Category	Number
Employment	917
Housing	7
Public Accommodation	42
Total Cases Closed	966

In FY 2003 the Commission resolved 966 cases and recovered a total of $741,810 for complainants. This figure does not include the value of positions or jobs that may have been obtained by the Commission for complainants, nor does it include other non-monetary remedies.

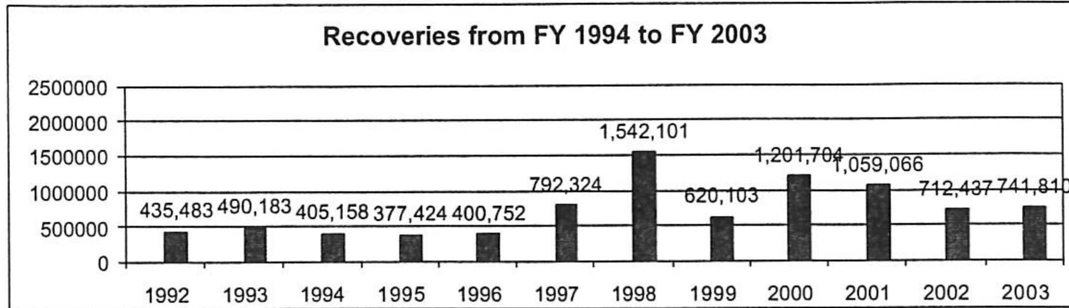
RESOLVED CASES FY 2003	TOTALS
RESOLVED CASES WITH RECOVERY:	
Satisfactory adjustment-mediation	80
Satisfactory adjustment-settlement	76
Satisfactory adjustment-conciliation	16
Pre-hearing settlement	0
CASES WITHDRAWN BY COMPLAINANT WITH BENEFITS	18
CASES CLOSED WITHOUT RECOVERY:	
Unsuccessful Conciliation	0
No probable cause determined by KHRC	536
Hearing determination of no violation	0
ADMINISTRATIVE CLOSURES AND WITHDRAWALS	147
TOTAL CASES RESOLVED	966

CASES RESOLVED YEAR TO YEAR



RESOLVED CASES AND MONETARY RECOVERY

2003	966	$ 741,810.00
2002	888	$ 712,437.00
2001	975	$1,059,066.00
2000	1151	$1,201,704.00
1999	1356	$ 620,103.00
1998	1848	$1,542,101.00
1997	1583	$ 773,824.00
1996	1,973	$ 400,752.00
1995	1,370	$ 358,556.00
1994	1,352	$ 405,158.00
1993	1,418	$ 490,183.00
1992	1,176	$ 435,483.37
1991	1,115	$ 307,900.00
1990	1,206	$ 285,171.16
1989	1,107	$ 199,014.18
1988	1,083	$ 253,955.93
1987	1,367	$ 171,549.16
1986	1,177	$ 192,000.89
1985	1,119	$ 303,383.00
1984	1,035	$ 182,714.14
1983	1,278	$ 86,969.67
1982	1,351	$ 201,959.21
1981	849	$ 160,715.62
1980	570	$ 67,588.00
1979	570	$ 71,174.00
1978	588	$ 87,178.00
1977	697	$ 55,332.89
1976	903	$ 59,966.67



The figures above do not include the value of positions that may have been obtained by the Commission for complainants, nor does it include other non-monetary remedies.

ALLEGATIONS OF UNLAWFUL EMPLOYMENT PRACTICES

Employment discrimination complaints totaled 832, approximately 95.6% of all complaints filed with the agency.

BASIS	*NUMBER OF ALLEGATIONS*
Sex	**266**
Race	**203**
Disability	**147**
Age	**156**
Retaliation	**262**
National Origin	**77**
Religion	**22**
Color	**16**
Genetic Testing	**0**
*Totals	**1149**

*Totals exceed the actual number of complaint documents filed since many complaints contain multiple allegations.

DISTRIBUTION OF ALLEGATIONS OF UNLAWFUL EMPLOYMENT PRACTICES FY 2003

Allegation	Count
Benefits	17
Constructive Discharge	84
Demotion	37
Discharge	491
Discipline	91
Harassment	158
Hiring	36
Layoff	27
Maternity	22
Promotion	36
Reasonable Accommodation	35
Recall	1
Reference Unfavorable	6
Reinstatement	9
Retirement- Involuntary	2
Sexual Harassment	85
Suspension	22
Terms & Conditions	136
Training	4
Union Representation	5
Wages	28
*Total	1333

*Totals exceed the actual number of complaint documents filed since many complaints contain multiple allegations.

RESPONDENTS IN EMPLOYMENT CASES FY 2003

Respondent	Count
Private Employers	755
Governmental	31
Educational	34
Unions	7
Total	827

DISTRIBUTION OF ALLEGATIONS OF UNLAWFUL EMPLOYMENT PRACTICES
(Year to Year Comparison)

	2003	2002	2001	2000	1999	1998	1997	1996
Apprenticeship	0	0	0	0	0	0	0	0
Assignment	0	0	0	0	0	0	1	0
Benefits	17	7	37	55	19	51	66	37
Constructive Discharge	84	59	102	201	163	243	183	135
Demotion	37	20	0	61	41	66	54	49
Discharge	491	392	492	766	630	864	924	870
Discipline	91	90	88	158	96	159	200	174
Exclusion	0	0	0	0	2	0	0	4
Harassment	158	93	156	543	197	357	247	243
Hiring	36	29	60	81	105	144	105	116
Intimidation	0	0	0	0	1	0	3	1
Involuntary Retirement	0	0	0	7	14	6	0	16
Layoff	27	23	27	72	37	29	61	49
Maternity	22	29	19	12	12	52	35	53
Promotion	36	36	82	129	109	130	137	123
Reason Accommodation	35	27	56	171	168	155	141	133
Recall	1	3	2	8	13	21	33	45
Reference Unfavorable	6	4	2	7	0	16	1	2
Reinstatement	9	2	4	1	12	22	16	12
Retirement-Involuntary	2	0	0	0	0	0	0	0
Sexual Harassment	85	96	144	300	230	317	242	275
Suspension	22	33	27	94	82	97	10	76
Terms & Conditions	136	71	326	498	427	799	877	771
Training	4	3	6	54	17	50	33	12
Union Representation	5	1	5	14	21	23	9	8
Wages	28	27	24	191	100	149	153	105
Other	0	1	1	66	136	0	126	0

ALLEGATIONS OF UNLAWFUL HOUSING PRACTICES

Housing discrimination complaints totaled 5, less then 1% of all complaints filed with the agency in FY 02.

BASIS OF COMPLAINT:	HOUSING
Race	1
Disability	0
Familial Status	0
Sex	0
Retaliation	0
Ancestry	0
Religion	2
National Origin	4
Color	0
*Totals	7

***Totals exceed the actual number of complaint documents filed since many complaints contain multiple allegations.**

DISTRIBUTION OF ALLEGATIONS OF UNLAWFUL HOUSING PRACTICES FY 2003

Eviction	1
Refusal to Rent	0
Terms & Conditions	1
Harassment	2
Sexual Harassment	0
Denied Loan	0
*Totals	4

UNLAWFUL HOUSING PRACTICES
(YEAR-TO-YEAR COMPARISON)

	2003	2002	2001	2000	1999	1998	1997
Terms & Conditions	1	4	5	10	3	3	13
Refusal to Rent or Sell	1	3	2	2	3	10	6
Brokerage/Finance	0	1	0	6	0	0	0
Accommodations	0	0	0	0	2	0	2
Eviction	1	3	8	8	3	17	6
Unfavorable References	0	0	0	0	0	0	0
Design/Construction	0	0	0	0	0	0	0
Retaliation/Coercion	1	0	0	4	0	2	1
Harassment	2	4	4	0	0	0	0
Sexual Harassment	0	1	0	1	1	1	0
Other	0	0	0	0	3	0	0

*Totals may exceed the actual number of complaint documents filed since many complaints contain multiple allegations.

ALLEGATIONS OF UNLAWFUL DISCRIMINATION IN PUBLIC ACCOMMODATIONS

Public accommodation complaints totaled 33, approximately 4% of all complaints filed with the agency during FY 2002.

BASIS OF COMPLAINT:	PUBLIC ACCOMMODATIONS
Race	23
Disability	8
Sex	4
Ancestry	0
Color	0
National Origin	1
Retaliation	0
*Totals	36

*Totals exceed the actual number of complaint documents filed since many complaints contain multiple allegations.

TYPES OF UNLAWFUL PUBLIC ACCOMMODATION CASES

CATEGORY	Number
Unequal Service	11
Denial of Service	15
Denied Accessible Parking	5
Harassment	14
*Total	45

TYPES OF UNLAWFUL PUBLIC ACCOMMODATION CASES (YEAR-TO-YEAR COMPARISON)

Category	2003	2002	2001	2000	1999	1998	1997	1996
Unequal Service	11	8	15	27	42	35	17	26
Denial of Service	15	23	18	14	15	13	20	15
Denied Accessible Parking	5	0	1	0	0	0	0	0
Harassment	14	19	15	0	0	0	0	0
*Totals	45	50	49	41	57	48	37	41

RESPONDENT IN PUBLIC ACCOMMODATION CASES

TYPE OF RESPONDENT	Number
Retail	11
Eating Establishment	10
Finance	2
Hotel Industry	1
Amusement	1
Services	8
*Total	33

*Totals exceed the actual number of complaint documents filed since many complaints contain multiple allegations.

BASIS OF COMPLAINT *versus* AREA IN WHICH COMPLAINT WAS ALLEGED

BASIS	EMPLOYMENT	HOUSING	PUBLIC ACCOM.
SEX	266	0	4
RACE	203	1	23
DISABILITY	147	0	8
RETALIATION	262	0	0
AGE	156	-	-
GENETIC TESTS	0	-	-
NATL ORIGIN	77	4	1
RELIGION	22	2	0
COLOR	16	0	0
FAMILIAL STATUS	-	0	0
*TOTAL	1149	7	36

*Totals exceed the actual number of complaint documents filed since many complaints contain multiple charges.

DISTRIBUTION OF CASES BY CITY FY 2003

CITY	EMP	PA	HSG	CITY	EMP	PA	HSG
Abilene	3			Hays	6		
Andover	2			Haysville	3		
Arkansas City	1			Herington	1		
Atchison	3			Hesston	1		
Augusta	2			Holcomb	1		
Baldwin City	1			Holton	1		
Bonner Springs	1			Horton	1		
Burlington	2			Hugoton	1		
Caney	1			Humboldt	1		
Chanute	2			Hutchinson	17		
Cheney	1			Independence	9		
Cherryvale	1			Iola	4		
Clay Center	3			Jetmore	1		
Coffeyville	3			Junction City	10		
Columbus	6			Kansas City	58	2	
Council Grove	1			LaCrosse	1		
De Soto	1			Lakin	1		
Derby	2			Lansing	1		
Dodge City	26		1	Larned	1		
Easton	1			Lawrence	22	2	
Edwardsville	2			Leavenworth	5	1	
El Dorado	4	1		Leawood	6		
Elkart	1			Lenexa	29	2	
Ellsworth	1			Liberal	7		1
Ellwood	2			Louisburg	1		
Emporia	6			Manhattan	4		
Erie	1			Marion	1		
Eudora	1			McPherson	10		
Fairview	1			Merriam	6	2	
Fort Dodge	1			Moundridge	1		
Fort Riley	2			Mulvane	1		
Garden City	10			Neodesha	2		
Goddard	1			Ness City	1		
Goodland	1			New Century	3		
Grandview Plaza	1			Newton	5		
Great Bend	4			Norton	1		

DISTRIBUTION OF CASES BY CITY FY 2003

CITY	EMP	PA	HSG	CITY	EMP	PA	HSG
Olathe	17	3		Salina	11		
Onaga	2			Shawnee	6		1
Osawatomie	1			Shawnee Mission	10		1
Ottawa	5			South Haven	1		
Overland Park	76	3		South Hutchinson	2		
Paola	1			Stilwell	1		
Parsons	6			Topeka	119	2	1
Phillipsburg	1			Valley Center	1		
Pittsburg	4			Wamego	1		
Prairie Village	2	1		Waterville	1		
Rantoul	1			Wellington	2		
Rossville	1			Wichita	207	14	
St. Mary's	1						

TESTIMONY OF WAYNE A. WHITE
KANSAS LEGAL SERVICES, INC.
(785) 233-2068
Wednesday, January 21, 2004

Hearing Before the
SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
Chairman: Senator Pete Brungardt
Statehouse Room 231-N

I appreciate the opportunity to report on the progress of the Kansas Human Rights Commission/Kansas Legal Services Voluntary Mediation Project. I have provided several documents for your information.

1) **Summary of Service for Fiscal Year 2001, Fiscal Year 2002, Fiscal Year 2003 and an Estimate for Fiscal Year 2004.**
   This document summarizes the number of referrals, mediations, settlements, the budget and cost per settlement for the project.

2) **Project Report for Fiscal Year 2004 through December 31, 2003 and a complete report for Fiscal Year 2003.**
   These reports give you more detail regarding the outcomes, the types of complaints handled and the location of service provided.

3) **Satisfaction Survey Results.**
   This page summarizes results of satisfaction surveys provided to program participants. I believe these satisfaction surveys are evidence of a high degree of customer/taxpayer satisfaction.

The Kansas Bar Foundation has provided Kansas Legal Services $38,333 to match the proposed budget of $115,000 in State General Funds for the mediation program. This continues the tradition of one dollar of private match for each three dollars of state funding provided for the project. The Kansas Bar Foundation continues to be a strong supporter of this program.

The Kansas Human Rights Commission/Kansas Legal Services Voluntary Mediation Project results in substantial settlements. Many of these settlements result in monetary awards to complainants. During Fiscal Year 2003, mediation resulted in $125,298 in formal settlements and an additional $285,160 in informal settlements, for a total of $410,458 in total settlements. During the first six months of Fiscal Year 2004, mediation has resulted in formal settlements of $126,757 with an additional $789,340 in informal settlements, for a total in six months of $916,097.

Sen. Federal & State Affairs Comr
Date: JANUARY 21, 2004
Attachment: # 4

KANSAS HUMAN RIGHTS COMMISSION/KANSAS LEGAL SERVICES MEDIATION PROJECT

SUMMARY OF SERVICE FOR FY 2001, FY 2002, FY 2003
AND ESTIMATE OF SERVICE FOR FY 2004

FY 2001

			BUDGET
REFERRALS	904	Kansas Bar Foundation	$ 36,667.00
MEDIATIONS	191	KHRC	110,000.00
SETTLEMENTS	84	Total	$146,667.00
SETTLEMENT RATE	44%		

Cost to KHRC per settlement:	$1,309.52
Total Cost per settlement:	$1,746.04

FY 2002

			BUDGET
REFERRALS	723	Kansas Bar Foundation	$ 38,333.00
MEDIATIONS	219	KHRC	115,000.00
SETTLEMENTS	99	Total	$153,333.00
SETTLEMENT RATE	45%		

Cost to KHRC per settlement:	$1,161.62
Total Cost per settlement:	$1,548.82

2003

			BUDGET
REFERRALS	727	Kansas Bar Foundation	$ 38,333.00
MEDIATIONS	150	KHRC	115,000.00
SETTLEMENTS	80	Total	$153,333.00
SETTLEMENT RATE	53%		

Cost to KHRC per settlement:	$1,437.50
Total Cost per settlement:	$1,916.66

ESTIMATE FY 2004

			BUDGET
REFERRALS	740	Kansas Bar Foundation	$ 38,333.00
MEDIATIONS	210	KHRC	115,000.00
SETTLEMENTS	109	Total	$153,333.00
SETTLEMENT RATE	52%		

Cost to KHRC per settlement:	$1,055.05
Total Cost per settlement:	$1,406.72

January 10, 2004

KANSAS HUMAN RIGHTS COMMISSION/KANSAS LEGAL SERVICES MEDIATION PROJECT

Progress Report for Fiscal Year 2004

KHRC REFERRALS RECEIVED AS OF DECEMBER 30, 2003		**370**
Employment	350	
Housing	4	
Public Accommodation	16	
MEDIATIONS COMPLETED TO DATE		**108**
Settlements	49	
Impasse	59	
MEDIATIONS WITH OUTCOME PENDING		**10**
MEDIATIONS CURRENTLY SCHEDULED		**20**
MEDIATIONS UNDER CONSIDERATION		**51**
MEDIATIONS REJECTED TO DATE		**271**
Rejected after 60 days with No Response	21	
Complainant Rejected	52	
Respondent Rejected	195	
KHRC Administrative Closure	3	
CURRENT REFERRALS PENDING WITH NO RESPONSE UNDER 60 DAYS		**32**

Referrals by Office:

Office	Employ	Housing	Pub Accom	Total
Topeka	170	3	11	184
Wichita	180	1	5	186
Totals	350	4	16	370

July 16, 2003

KANSAS HUMAN RIGHTS COMMISSION/KANSAS LEGAL SERVICES MEDIATION PROJECT

Progress Report for Fiscal Year 2003

KHRC REFERRALS RECEIVED AS OF JUNE 30, 2003		**727**
Employment	688	
Housing	6	
Public Accommodation	33	
MEDIATIONS COMPLETED TO DATE		**150**
Settlements	80	
Impasse	70	
MEDIATIONS WITH OUTCOME PENDING		**24**
MEDIATIONS CURRENTLY SCHEDULED		**20**
MEDIATIONS UNDER CONSIDERATION		**39**
MEDIATIONS REJECTED TO DATE		**553**
Rejected after 60 days with No Response	97	
Complainant Rejected	104	
Respondent Rejected	337	
Case Returned to KHRC	15	
CURRENT REFERRALS PENDING WITH NO RESPONSE UNDER 60 DAYS		**36**

Referrals by Office:

Office	Employ	Housing	Pub Accom	Total
Topeka	334	4	15	353
Wichita	354	2	18	374
Totals	688	6	33	727

Kansas Legal Services, Inc.
01/15/04

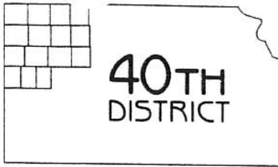
KANSAS HUMAN RIGHTS COMMISSION/KANSAS LEGAL SERVICES MEDIATION PROJECT SATISFACTION SURVEY RESULTS

2,093 Satisfaction Surveys were returned between July 1, 1996 and December 31, 2003 by people served through the KHRC/KLS Mediation Project.

	Employment	Housing	Public Accommodation	Other	No Response
Type of Discrimination Claim	1962 93.74%	26 1.24%	71 3.39%	33 1.58%	1 0.05%

	Complainant	Respondent	Complainant's Attorney	Respondent's Attorney	Other
Persons Responding to Survey	603 28.81%	886 42.33%	215 10.27%	384 18.35%	5 0.24%

	Yes	No	Other	No Response
Satisfied With Services	1748 83.52%	233 11.13%	54 2.58%	58 2.77%
Appropriate People Attended Mediation	1855 88.63%	169 8.07%	25 1.19%	44 2.10%
Issues Adequately Addressed	1708 81.61%	290 13.86%	33 1.58%	62 2.96%
Mediator Fair to Both Parties	1845 88.15%	143 6.83%	40 1.91%	65 3.11%
Recommend to Others	1761 84.14%	210 10.03%	39 1.86%	83 3.97%



Stan Clark

COMMITTEE ASSIGNMENTS

CHAIR: UTILITIES

MEMBER: ASSESSMENT & TAXATION
ELECTIONS & LOCAL GOVERNMENT
ORGANIZATIONS, CALENDAR, & RULES
RULES & REGULATIONS

Testimony before the Senate Federal and State Affairs Committee
President's Task Force on Medicaid Reform
January 21, 2004

Chairman Brungardt and members of the committee:

Chairman Brungardt has asked me to review the Task Force's recommendations on Medicaid Reform, it should be noted that three of the six senators on the Task Force (Senators Barnett, Brungardt and myself) are also members of this committee and Senators Barnett and Teichman served on the Health Issues Working Group this past summer and fall which addressed a number of items from this report.

Before getting into the report's recommendations or the basis to justify its recommendations I want you to understand my core values and the principle framework that many of these recommendations come from. I was taught from earliest childhood that I was to save 10% of all that I earn, to give 10% to charity and live on 80%. Undoubtedly the biggest challenge was the first 2 years in the Senate when my family had to change our spending habits because of the reduction in income. It is my observation that too many Americans live on 120% of their income and their decision-making is driven by short-term survival instead of long-term good. I also believe that Americans confuse the word ***compassion*** with the word ***pity.*** Hannah Arendt probably has distinguished the difference between these two terms the best of anyone. Paraphrasing her:

> *Compassion* is to be stricken with the suffering of someone else as though it were contagious. *Pity* is to be sorry without being touched in the flesh. They are not the same.
>
> *Compassion*, by its very nature, cannot be touched off by the sufferings of a whole class or mankind as a whole. It reaches only to one person. It is co-suffering. Its strength is passion itself. It can comprehend only the particular, but has no notion of the general and no capacity for generalization.
>
> *Pity* with its groups, with its focus on the abstract suffering masses, depersonalizes the sufferers and attracts rulers who find that they can concentrate their grip on power by enlarging government programs and expanding control. With this awareness you can identify how hollow their rhetoric is, how phony their false, idealistic phrases of the most idealistic pity sound the moment they are confronted with compassion. We see the emptiness in the individual in their quest and really lust for power.

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Sen. Federal & State Affairs Comr
Date: JANUARY 21, 2004
Attachment: # 5

Arendt states that the sign of Jesus' divinity clearly was his ability to have compassion with all men in their singularity without lumping them together into some such entity as one suffering mankind.

Pity, Arendt argued, is a concern for the misery of another unprompted by intimacy with, or love for, the sufferer. Compassion, by contrast, is a love directed "towards specific suffering" and concentrates on "particular persons." It can be exercised only by individuals or small groups, not by agencies or bureaus.

The type of compassion that modern liberals claim as their own peculiar virtue is really a form of pity, milder perhaps than that which lies at the heart of the socialist orthodoxies, but dangerous in its own right. David Hume called pity "counterfeited" love. It is the false compassion that results when men exercise their kindness by committee. It is the look in the eyes of the welfare clerk or the public housing official. To be pitied by another man is to stand humiliated before him; however well-intentioned programs grounded in pity may be, they always end by laying low their intended beneficiaries. Pity does not lead to a flourishing in the pitied, though it may provoke their resentment, even their rage; the act of pitying is always a kind of strength condescending to weakness. Love awakens; pity oppresses.

My "goal" is to get beyond "suffering groups;" "patient's or consumer's rights;" and all attempts to depersonalize or lump people together in the aggregate. The challenge is to unite the passions of the heart with enough reason of the mind to meet the needs with compassion. Receiving charity is always humiliating—except, perhaps when the gifts are accompanied by an affection so palpable, so real as to diminish the shaming quality of the transaction. Any assistance has to go beyond simply feeding, bathing and medicating individuals but has to heal and transform them. It is unmistakably personal, emotional and spiritual.

Medicaid is the largest health care program in America serving 51 million people at an annual cost of $280 billion which increases from 8 to 13% annually. It provides health care coverage to 1 in 4 children; pays for 37% of all deliveries; and over 50% of all mental health care. Forty-four percent of all federal grants to states are through the Medicaid program. Seventeen percent of the dollars spent for health care in America is paid by Medicaid. Medicaid today serves 11 million more people that Medicare. Within 5 years at current growth rates, Medicaid will be larger than the retirement benefits paid by Social Security. If State budgets would increase tax receipts by 5% annually and Medicaid costs continue to increase at their current rate, by 2020 Medicaid will consume the entire budgets of every state in the union. Doing nothing is not an option. Last fiscal year Medicaid costs in Kansas were $1,691,308,193 which is an increase of $191 million over FY2002 which saw an increase of $221 Million over FY2001.

What can be done?

Long-term Care

1. Long-term Care Insurance- Incentives have to be created to encourage individuals to purchase long-term care insurance. At a minimum, premiums for coverage have to be allowed as adjustments to gross income on the income tax like IRA's and the self employed health insurance deduction currently are. I would advocate that a refundable tax credit is preferable. We should lobby Congress to reinstate the provision that prior to 1992 allowed individuals to shield and pass on to their heirs an amount that matched the value of their long-term care insurance policy.
2. Last session this committee recommended and the Senate passed SB 272. This bill established the policy – if you have the means to pay for your long-term care, you will pay it. Personal responsibility trumps any heir's right to an inheritance or any attempt by an elder law attorney to make an individual artificially poor. The legislation:

- Made jointly owned property a countable asset in determining eligibility for a Medicaid Applicant;
- limited discretionary trusts which are created to be supplemental to any public assistance received;
- limited contracts that bear no relationship to the value of services provided or are prepaid. An example given was an agreement to pay your granddaughter $50,000 to visit you once a week for the rest of your life;
- limited contracts on prepaid professional services;
- allowed a lien to be placed on real property after the recipient has been in a nursing home for six months. Currently, Kansas law provides that SRS is to collect from an individual's estate the costs of the Medicaid services provided. But with no lien, many times the surviving spouse sells the asset and thereby outmaneuvers the state's recovery efforts; and
- expanded the list of assets that a claim may be filed against, the primary target being jointly owned property, annuities and trusts.

3. The report recommends increasing the look-back period to 60 months from the current 36 months for people that have created trusts or transferred assets to make themselves artificially poor to qualify for Medicaid.
4. The report recommends expanding our waiver program to "Cash and Counsel" or "Project Independence" similar to Arkansas and Florida. The importance of the individual or guardian planning and purchasing their long-term self-directed care services is the key. Individuals can hire and fire workers; and schedule services when they want them instead of when the care giver gets around to it. If you want a bath at 8:00 in the morning- that is what you schedule. Contrasting this with one example where on Monday the worker arrived as scheduled at 8:00am; on Wednesday she arrived at 4:00pm and Friday failed to show up. Why sit around waiting for the services! Plan, purchase, and schedule when you want the services. This allows movement towards implementing two of the core findings in Dr. William Dietz's presentation yesterday:

- Moving from a disease management agenda to a health care agenda;

- Engaging the patient in management of their health care which moves us towards improved self-behavior.

Prescription Drugs

1. Academic Detailing- the average physician prescribes 25 different medications. Generics, over-the-counter and herbal supplements offer complimentary and alternative remedies with potential dollar savings without compromising patient care.
2. Review all patients' prescriptions upon discharge from the hospital. Assess all prescriptions- those being taken before admittance to the hospital and those prescribed in the hospital- to make sure the combination of prescriptions truly contribute to the well-being of the patient.
3. Pay pharmacists $15 for every generic prescription filled and $10 for name brand prescriptions. Adopt a system similar to Alcohol Beverage Control to track the cost of drugs at the manufacturer, wholesaler and retail level. We encourage multi-state and multinational buying cartels.

Care Management

1. Different than *managed care* because *care management* is a descriptive phrase to where a trained person gives assistance to an individual who wants guidance in planning and purchasing their own medical care. It is the interaction of the individual with medical professionals and attendant care providers. Via Christi and Associates in Health LLC, both in Wichita are great examples. In my opening analogy, liken care management to *compassion* and managed care to *pity.*

Direction for the Future

1. The report recommends expansion of Medical Savings Accounts, Health Reimbursement Arrangement and with the recent Congressional passage of the Medicare bill- Health Savings Accounts to assist family with health insurance coverage. Only when we address health insurance costs and assist families in its purchase do we start to take the pressure off the Medicaid system. Medicaid has to exist as a safety net. Our State has to be an aggressive advocate for some of these health coverage options.
2. The report makes specific recommendations for advocating healthier lifestyles and moving from disease management and acute care towards well-being and health care. It asks the question: Do more health care services mean better health? A Dartmouth study for that 20 to 30% of all health care spending pays for services that do absolutely nothing to improve the quality or increase the length of our lives. Recent studies show that patients with special medical facilities nearby, large numbers of doctors and specialized medical services available do not buy the citizens better health; infact they are no more likely to receive preventive care such as flu shots or careful monitoring of their diabetes and they do not live

longer. In fact their lives are slightly shorter. The most likely explanation of the increased mortality is they spend more time in the hospital.

There are many other recommendations in this report but I have highlighted specific examples that I believe Kansas needs to champion. Can we move from *pity* to *compassion*? Can we break down the barriers between advocacy groups, legislators, service providers, administrators, agencies and bureaus? Can we become individuals working towards common goals? Or are the ideas and ideals a bunch of high sounding rhetoric and clanging cymbals? The responsibility is just as great for the wise use of health care dollars on the family with a BC-BS health insurance plan as ot is on a Medicaid recipient. We have to inject as strong dose of responsibility and there has to be tangible consequences to those choices which encourage long-term changes in our individual health and relieve the demands placed on our safety net, the Medicaid system. I believe a kind word, a loving touch and a quiet prayer can transform and heal; restore personal dignity, self respect and personal responsibility; and offer true compassion.

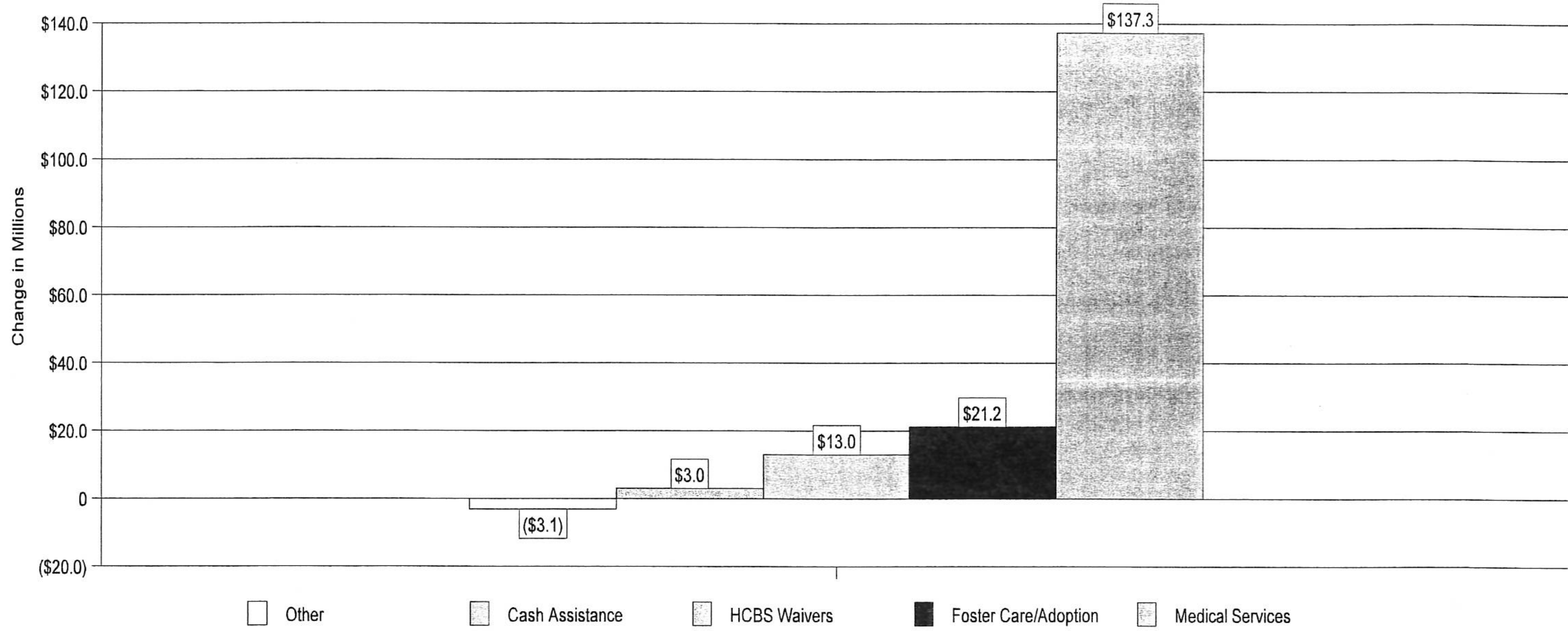
Kansas Legislative Research Department

December 8, 2003

TESTIMONY – SENATOR STAN CLARK

Sen. Federal & State Affairs Comm
Date: January 21, 2004
Attachment: # 6

Department of Social and Rehabilitation Services
Change in State General Fund Expenditures
FY 2000-FY 2004
(In millions)



Notes: Foster Care/Adoption State General Fund increase reflects the reduced availability of Temporary Assistance for Needy Families (TANF) funds for Foster Care since FY 2000 as TAF caseloads increased.

Other includes programs such as Child Care, Family Preservation, Vocational Rehabilitation, and Nursing Facilities and Grants for Mental Health and Developmental Disabilities.

Medical Services pays for services such as doctor visits, inpatient hospital, outpatient hospital, prescription drugs, and home health care for income eligible pregnant women, children, and people who are elderly or disabled.

6-2

Department of Social and Rehabilitation Services
State General Fund Expenditures
FY 2000-FY 2004
(In Thousands)

	FY 2000	FY 2004*	*Four-Year Change*	
			Dollar	*Percent*
Other	$ 209,047	$ 205,963	*$ (3,084)*	*(1.5) %*
Cash Assistance	34,361	37,338	*2,977*	*8.7*
HCBS Waivers	85,793	98,803	*13,010*	*15.2*
Foster Care/Adoption	29,798	51,038	*21,240*	*71.3*
Medical Services	211,429	348,692	*137,263*	*64.9*
TOTAL SRS Expenditures	**$ 570,428**	**$ 741,834**	***$ 171,406***	***30.0 %***

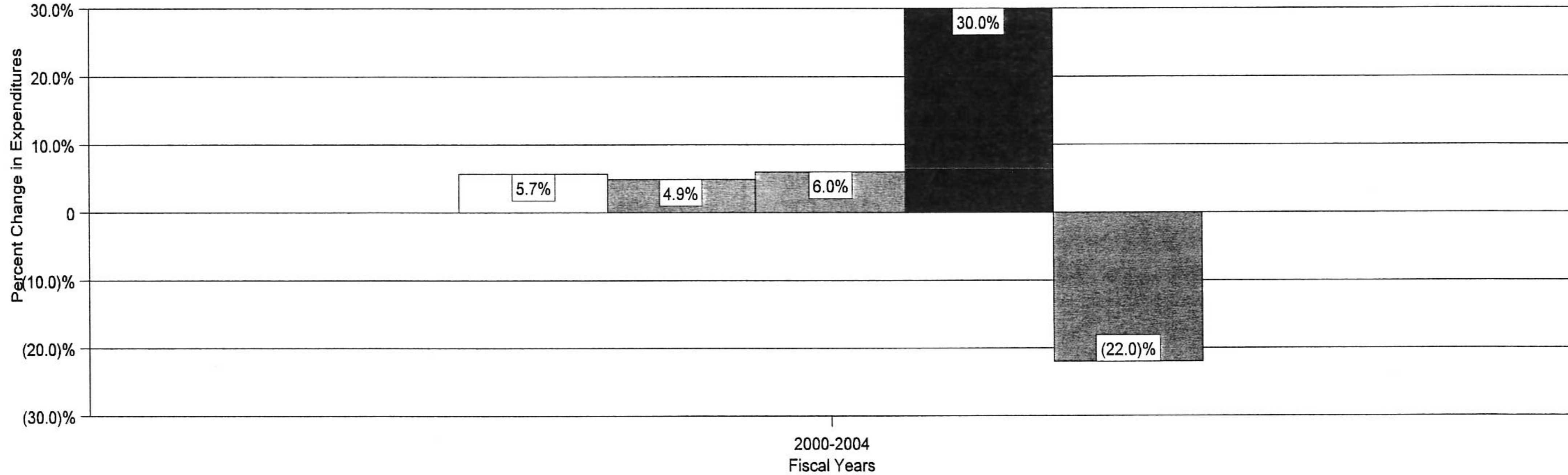
*FY 2004 reflect the amounts as approved by the 2003 legislative session.

6-2

TESTIMONY – SENATOR STAN CLARK

Sen. Federal & State Affairs Com
Date: January 21, 2004
Attachment: # 7

State of Kansas
Percentage Change in State General Fund Expenditures
FY 2000-FY 2004



Agency/Program	Percent of Approved FY 2004 State General Fund Budget
Postsecondary Education	14.5%
Elementary/Secondary Education	51.4
Department of Corrections and Facilities	4.7
Department of Social and Rehabilitation Services (state welfare and social services agency)	16.4
All Other	12.7
TOTAL	**100.0%**

State of Kansas
State General Fund Tax Receipts
FY 2000-FY 2004
(In Thousands)

	FY 2000	FY 2004*	*Four-Year Change* *Dollar*	*Percent*
Individual Income	$ 1,854,726	$ 1,855,000	*$ 274*	*0.0 %*
Corporation Income	250,123	120,000	*(130,123)*	*(52.0)*
Retail Sales	1,440,303	1,635,000	*194,697*	*13.5*
Compensating Use	209,966	220,000	*10,034*	*4.8*
Cigarette	49,125	130,000	*80,875*	*164.6*
All Other Tax Receipts	293,306	405,800	*112,494*	*38.4*
TOTAL TAX RECEIPTS	**$ 4,097,549**	**$ 4,365,800**	***$ 268,251***	***6.5 %***

*FY 2004 amounts reflect the estimates of the Consensus Revenue Estimating Group as of November 3, 2003.

TESTIMONY – SENATOR STAN CLARK

Sen. Federal & State Affairs Comm
Date: January 21, 2004
Attachment # 8

State of Kansas

PROGRAM SERVICES	Customers		Annual Expenditures	
	FY 2001	FY 2002	FY 2001	FY 2002
CASH ASSISTANCE				
(Fiscal Year Average Per Month)				
Temporary Assistance for Families	31,792	34,461	$44,731,166	$48,201,402
Number of Children in Program	22,628	24,259	N/A	N/A
General Assistance	2,616	3,160	$5,013,944	$5,929,205
Refugee Assistance	15	10	$21,155	$16,622
MEDICAL ASSISTANCE (See Note 1)				
(Fiscal Year Unduplicated)				
Medical Assistance Beneficiaries	288,015	301,377	$1,279,536,328	$1,500,654,119
HealthWave Beneficiaries	32,540		$28,567,754	
Major Categories of Service (See Note 2)				
Adult Care Home	19,547	18,498	$327,124,936	$334,868,704
Home and Community Based Services				
Head Injury	129	171	$3,607,953	$3,974,400
Technology Assisted Children	48	42	$153,088	$149,637
Mental Retardation/Developmental Disability	6,247	6,386	$176,469,200	$190,003,000
Severe Emotional Disturbance	1,553	1,675	$8,844,967	$8,545,010
Physically Disabled	4,968	4,971	$57,526,375	$60,467,730
Inpatient Hospital	38,310	35,787	$147,728,205	$161,104,317
Outpatient Hospital	98,281	92,608	$20,518,465	$21,425,242
Pharmacy	164,489	156,838	$188,124,050	$213,054,599
Physician	167,854	161,723	$58,521,644	$60,582,279
OTHER ASSISTANCE (See Note 3)				
(Fiscal Year Average Per Month)				
Food Stamps	117,241	131,726	$89,007,787	$107,186,250
Child Care	15,312	16,158	$46,648,941	$50,827,245
Employment Preparation Services	8,692	11,346	$7,263,579	$7,781,360
(Fiscal Year Unduplicated)				
LIEAP Heating	80,201	72,239	$16,275,345	$8,786,702
Rehabilitation Services	11,717	12,451	$11,217,179	$13,507,337
Burial	879	846	$466,454	$458,390
Family Preservation	18,740	16,096	N/A	N/A
Children in SRS Custody	10,282	9,825	N/A	N/A
Child Support Enforcement		308,239	$105,793,339	$107,457,005
Number of Children in Program		173,500	N/A	N/A

Statewide information includes adjustments and recoupments and may not be a summary of the county level information.

Note 1: Does not include HIPPS, Medicare Buy-In or adjustments.
Note 2: Medical consumers can be counted in more than one category of service. Major Categories of Service are not all inclusive.
Note 3: This is not an exhaustive listing of all programs available within SRS.
N/A: Not applicable.

2003

KANSAS DEPARTMENT OF SOCIAL and REHABILITATION SERVICES

Central Office:

Office of the Secretary
915 SW Harrison, Room 603 N
Topeka, Kansas 66612
(785) 296-3271

1,691,309,193

2000 STATEWIDE DEMOGRAPHICS

333,893,727

Population	2,688,418
Under 20	798,418
20-64	1,533,681
65 Plus	356,229
Male	1,328,474
Female	1,359,944

Note: 2000 demographics are not certified as the official population.

225,729,450

AREA OFFICES

Chanute
Emporia
Garden City
Hays
Hutchinson
Kansas City
Lawrence
Manhattan
Overland Park
Topeka
Wichita

ABBREVIATIONS

HIPPS: Health Insurance Premium Payment System
HCBS: Home and Community Based Services
LIEAP: Low Income Energy Assistance Program

PRESIDENT'S TASK FORCE ON MEDICAID REFORM

Final Report to the 2003 Kansas Legislature

TASK FORCE MEMBERS

Senator Stan Clark, Chair
Senator James Barnett
Senator Pete Brungardt
Senator Paul Feleciano, Jr.
Senator Tim Huelskamp
Senator Janis Lee

Representative Bob Bethell*
Representative Don Hill*

* Participated in Task Force meetings.

March 21, 2003

Sen. Federal & State Affairs Comm
Date: January 21, 2004
Attachment: # 9

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EXECUTIVE SUMMARY

The Task Force recommends the following items for immediate action:

Legislative Action Items

- Allow the state to establish a lien on the real property of Medicaid recipients.
- Change the definition of estate to include jointly-owned property.
- Prohibit property owners applying for Medicaid from specifying a percentage ownership of jointly-owned property.
- Require that discretionary trusts be considered a countable resource for public assistance.
- Limit the scope of life contracts established between Medicaid recipients and family members.
- Institute a refundable tax credit for long-term care insurance premiums.

Regulatory Action Items

- Extend the look-back period for transfers of non-trust property to five years and apply any resulting penalty period to begin with month of application.
- Adopt current federal minimum limits on the exempted value of non-business property and the value of vehicles.
- Replace the blanket exemption of all personal effects and furnishings with a $15,000 limit.
- Request a Cash and Counseling Section 1115 Waiver from the federal government.
- Install requested edits on the new Medicaid Management Information System:
  - Undertake a study of care management for multiple diagnosis and dual eligible recipients; and
  - Additional actions on completion of the edits should be pursued.
- Undertake a study of prescription drug use in Kansas nursing homes.

MEDICAID IN KANSAS: 35 YEARS AND BEYOND

INTRODUCTION

Kansas incorporated the Medicaid program into its state structure during the summer of 1967. The program began on a comprehensive basis, both from the standpoint of covering all eligible groups (both mandatory and optional) and included most of the mandatory and optional medical services.

Kansas government has kept a steady eye on the expenditures involved in the Medical Assistance Program also referred to as MAP, Title 19, and Medicaid. The executive branch, through the Division of the Budget, and the legislative branch, primarily through the standing Senate Ways and Means and House Appropriations committees, the Division of Legislative Post Audit, and more recently, through joint select committees have reviewed various aspects of the Medicaid program. These reviews have generally focused on one or two major topics. There was not always the opportunity for a comprehensive look at developments in the program.

In retrospect, the Kansas Medicaid program was probably at its best in the early days, because it was comprehensive in covering needy populations and providing medical services. Early on, controls were set in place, but even with the controls, the increasing costs of providing medical coverage continued to expand. Institutional services were controlled by various audit mechanisms. Reimbursements to hospitals were based on Medicare audits, and nursing home costs were set through audits of cost statements as submitted by the nursing homes. Especially in the instance of nursing homes, strict controls were applied by Social and Rehabilitation Services. The individual provider fees were set internally by the state agency. For example, there was a time when physicians' fees were set by a relationship to the Medicare fee schedule. That practice has been all but abandoned except in areas where a fee adjustment is mandated by the federal government. Because of the ever-increasing cost of providing health care, there have been a number of legislative studies looking at financing issues related to Medicaid. These studies were often at the same time that Social and Rehabilitation Services was looking for ways to contain costs.

By the mid-1970s, the pressure was on the Department of Social and Rehabilitation Services to, at least, rein in the spiraling costs of providing services. The state, up to that time, had not only a medical assistance program for those families just above the cash assistance level of income; it had a General Assistance and Medical Only program which provided medical assistance to the working poor. The funding for persons eligible for General Assistance and General Assistance and Medical Only was from State General Fund money. The state tried to manage the level of services within the General Assistance and Medical Only programs for about 10,000 persons. When eligible populations increased beyond this number, programs and available services tended to be scaled back, and many contend that these reductions and cutbacks have been continuous since that time.

During the 1980s, Congress mandated that certain special populations be covered through Medicaid. With the adding of new populations, there was the obvious increase in

costs. Medicaid has always been a joint effort with the federal government. The federal match for Kansas has generally been in the range of 50-60 percent, and currently the federal government pays 60 percent of the cost of Medicaid services. Even with that favorable match, when the state's medical budget is over 1.5 billion dollars, it means that the state is putting significant state dollars into funding Medical Assistance. The federal government has set the general guidelines for carrying out the Medical Assistance Program; consequently the state has not had the flexibility it would like to have in carrying out the program. Beginning in the 1980s, the federal government made it possible for the states to make significant changes in Medical Assistance through the use of waivers. Waivers have made it possible for the states to adjust the program to more nearly match what the needs are in a particular state.

One of the most significant waiver programs has been Home and Community Based Services. This program has made it possible to present a community alternative to those persons headed towards nursing home or institutional placements. The major Kansas waivers have been geared to serve the physically disabled, the developmentally disabled, and the frail elderly.* This significant change in state policy has meant the nursing home population for the disabled exceeded 14,000 persons at one time. Now that population is between 1,000 and 1,100 persons. Such a change in program philosophy has meant that hundreds of people are living independently and in the community. These services are also less expensive which is a win-win proposition for all parties concerned.

Over the last three years, the Division of Legislative Post Audit has done significant work in defining some of the critical issues related to cost containment. Through these audits there has been the opportunity to re-examine such issues as caps on the various programs, eligibility, recouping of funds, recovery of funds as it relates to long-term care, and the increased use of generic drugs. All of these audits and the audit staff have aided the Task Force in developing a better understanding of the financial issues which need our attention.

It is important to note that Medicaid is the payer of last resort. Other resources that always pay first include Medicare, private health insurance, employee group health insurance, and any other "third party" payments.

As the state looks at the Medicaid program, it may seem as if it is disjointed and expensive. In a real sense that is true because that is the way the whole medical delivery system looks at this time. The President's Task Force has had the opportunity to go beyond the casual look. It appears to the members that over the 35-year period the consumers, the consumer advocates, the providers, and the Departments of Social and Rehabilitation Services and Aging have done a good job of putting the scattered pieces together. All parties seem to be committed to working together to make the system work for those individuals eligible and needing service.

---

* Kansas has six home and community based services' waivers that serve the frail elderly (HCBS-FE), the developmentally disabled (HCBS-DD), the physically disabled (HCBS-PD), the head injured (HCBS-HI), the technology dependent (HCBS-TD), and the severe emotionally disturbed (HCBS-SED) waiver.

Kansas Senate President Dave Kerr appointed the members of the President's Task Force on Medicaid Reform on February 3, 2003, with a deadline of reporting to the President by March 17, 2003. The members are Senators Jim Barnett, Pete Brungardt, Stan Clark, Paul Feleciano, Jr., Tim Huelskamp, and Janis Lee. Members of the House of Representatives, though not officially part of the Task Force but extremely helpful, were Representatives Bob Bethell and Don Hill.

Social and Rehabilitation Services signed a contract with Don Muse which provided the Task Force with an overview of the Medicaid program. The report provided a very informative analysis and breakdown of Medicaid eligibles by maintenance assistance; age groups; and types of service (all actual Kansas numbers are included in Appendix A).

The Task Force held 17 meetings, with over 50 conferees covering the whole range of topics related to Medicaid. Nationwide, Medicaid currently covers more people and has a larger budget than the Medicare program. Within five years at current growth rates, Medicaid will be larger than the total retirement benefits paid by the Social Security Administration. By 2020, assuming current growth rates for Medicaid and 5 percent growth rates for each state budget in the United States, Medicaid will consume the entire budget of all 50 states.

There is the tug on each of our hearts to expand coverage, but hold down costs at the same time. It is evident that people have no stomach for health care reform that contains even a whiff of rationing. Though largely unspoken, there was the thought throughout the hearings: "Does more health care mean better health"? What if this assumption is wrong? Should the focus be more on quality rather than quantity? Throughout the testimony, articles, studies, and reports there is an unmistakable thread and growing body of evidence that recipients of both Medicare and Medicaid health care want more decision making responsibility. They want the system to be more patient-centered and consumer-directed so they can make their own personal health choices.

LONG-TERM CARE

Statement of the Issue

Kansas residents between the ages of 38 and 66 will, on average, face expenses that exceed income by at least $10,000 annually during their retirement years, and the projected income deficit will be more than $20,000 annually for single women. By 2031, the aggregate annual deficit for retired Kansans could be in the $700 million range. With an aging population and the need to ensure opportunity for disabled persons to remain in their own homes and in the community; the Task Force agreed this was an area which needed major attention. The elderly and disabled accounted for 94 percent of the increased long-term care costs and 70 percent of the increased medical costs from 1998 to 2000. The expenditures in the nursing home program (approximately $335 million) and the expenditures in the home and community based waiver programs (HCBS) (approximately $318 million) represent the two largest categories The Task Force is interested in continuing to support the blend of

services now being given. However, there were issues the Task Force thought should be explored.

Strategies for Action

Long-Term Care Insurance

- The Task Force recommends the Office of the Governor and the Office of the Insurance Commissioner launch a statewide public education campaign to educate the public as to the importance of buying long-term care insurance. Geared to persons in their 50s or early 60s, the campaign should encourage citizens to plan for their own long-term care.

- Long-term care insurance premiums should be deductible from Kansas Income Tax as part of Kansas Schedule S, Part A (Kansas Modifications to Federal Adjusted Gross Income).

- The state should allow a refundable tax credit of 25 percent of the long-term care insurance premium to be claimed on line 22 of K-40 Individual Income Tax.

- The state should protect an individual's estate by excluding from Medicaid spend-down, assets of value equal to the amount of the policy maximum benefit. Additionally, we should suggest a similar policy be adopted in the U.S. Congress.

Regulatory Changes Regarding Asset Requirements

- Social and Rehabilitation Services and the Department on Aging should jointly review financial and disability requirements to ensure a tight system, yet one that accounts for the particular needs of each person. Kansas Medicaid financial eligibility standards currently are more lenient than other states. They allow Kansans to shelter a large portion of their assets and become eligible sooner than they would in other states.

- Social and Rehabilitation Services should become more aggressive in identifying people who have transferred assets or created trusts by increasing the look-back period to 60 months from the current 36 months for non-trust property and apply any resulting penalty period to begin with the month of application for assistance rather than the month the property was transferred.

- The Task Force supports the Social and Rehabilitation Services-proposed regulatory change to adopt the current federal minimum limit on non-business property ($6,000 limit with 6 percent return requirement). Additionally, the agency should adopt the federal minimum limit on the

value of vehicles ($4,500) and replace the blanket exemption of all personal effects and furnishings with a limit of $15,000. In so doing, the Department may focus any recovery assets on extravagant purchases done for sheltering purposes.

Legislative Proposals Regarding Asset Requirements

- We support legislation similar to SB 497 presented in the 2002 Session which permitted the agency to establish a lien on the real property of a Medicaid recipient who has been in a long-term care facility for a year or more. The lien would be enforced at the time of sale or upon the death of the individual for repayment of Medicaid expenditures.

- We support legislation changing the definition of an estate, for estate recovery purposes, to include jointly owned property. Such property currently passes to a survivor upon the death of the other joint owner and is not available for estate recovery purposes. Each year, the Social and Rehabilitation Services Estate Recovery Unit closes out approximately 1,000 cases due to property which cannot be collected because of joint tenancy ownership. The property passes to other survivors and does not go to probate. If such property were subject to estate recovery, it is estimated that recoveries could increase by at least $1 million.

- The state should prohibit property owners applying for or receiving Medicaid from specifying a certain percentage of ownership of jointly owned property. Where such ownership already exists, the full value of the property would still be considered for Medicaid purposes and be subject to estate recovery. A recent Kansas Court of Appeals decision allowed a Medicaid recipient to add an additional owner to exempt property without penalty and avoid estate recovery. The new owner received only 1 percent ownership while the recipient retained 99 percent. This did not result in a penalizable transfer, but did remove the property from the recipient's estate and prohibit the agency from establishing a claim at the time of death.

- We support legislation that requires discretionary trusts funded by people other than the consumer (or spouse) to be considered a countable resource for public assistance purposes based on the total value of assets contained in such trusts. Refusal to pay for necessary medical care from the trust would be considered a breach of fiduciary duty and contrary to public policy. This would overrule a longstanding District Court case that allowed such trusts to be exempted for Medicaid purposes.

- We support legislation to limit the scope of contracts, written prior to Medicaid eligibility being established, between a Medicaid recipient and his or her family members to provide basic services in exchange for a large prepayment. These contracts established solely for socialization services such as visitation and transportation for appointments and

errands would be considered as a transfer of assets solely to obtain Medicaid coverage and result in a penalty. The agency has seen an increase in such contracts whereby, for example, the recipient gives his or her family $50,000 or more to perform such duties instead of using the money for medical needs.

Public Education

- As the above changes are adopted, Social and Rehabilitation Services and Aging should gather a multi-disciplined team of all interested parties, including consumers and consumer advocates to review the results.

- Social and Rehabilitation Services and Aging should educate the public on eligibility requirements and enforcement actions as it applies to recipients, parties that jointly own property with recipients, and potential heirs. The legal department of Social and Rehabilitation Services shall closely monitor Elder Law Seminars and report the latest impoverishment schemes to become eligible for Medicaid.

Program Request

- The Task Force heard testimony on waivers referred to as "Cash and Counsel" or referred to as "Project Independence" by the Centers for Medicare and Medicaid Services, that recognize the importance of an individual or family member planning and purchasing his or her community-based long-term care services. This type of waiver is designed to delay more restrictive institutional or other high cost care by supporting the elderly or disabled individual in his or her own home. In the three states that have experience with such waivers, each individual in the waiver receives a cash allowance based on a calculation of service needs developed by each state. Individuals may, at any time, drop out of the project and return to more traditional waiver services. In one program, while enrolled, the participants are assigned a counselor who offers advice and recommendations about issues involved with self-directing care and assistance with management functions, particularly payroll and bookkeeping. Funds can be used for virtually any facet of the waiver, services or items; they are not exclusively for salary. The potential for fraud and abuse critics of these waivers feared has not materialized and consumer satisfaction has been nearly universal. The Task Force believes the objective of this type of waiver is for the individual to get the right amount of care, and recommends a Project Independence waiver be requested by Social and Rehabilitation Services or Department on Aging. The Task Force believes this approach could be beneficial in other parts of the Medicaid system.

Legislative Follow-Up

The Task Force understands that nationwide, states will be very active adopting and implementing many of these initiatives. We recommend and encourage the Legislative Post Audit Committee periodically to direct Legislative Post Audit to review Kansas compliance with changes related to the sheltering of assets and other relevant aspects of long-term care. The findings from those audits should be presented to the appropriate legislative committees.

PRESCRIPTION DRUGS

Statement of the Issue

Prescription drugs are an essential component of any Medicaid solution. Last year there were 7,500 less people receiving pharmacy assistance, but the prescriptions of those that did receive assistance cost $25 million more. During the first six months of FY 2003, the cost of prescription drugs was approximately $114 million, while the combined cost of inpatient and outpatient hospital services and physicians' fees was approximately $118 million. The Task Force recognizes prescription drugs have had a significant and beneficial effect on the lives of many Kansans. Many disabled and elderly Kansans are able to have productive lives through the stabilizing effect of medications.

However, the Task Force views with alarm the extreme growth in prescription drug costs. Without proper cost competition at the manufacturing level, further hardship will fall to the Kansas pharmacists whose dispensing fees have been reduced from $7.05 in the 1960s to $3.40 currently. However, any system changes require a close partnership with pharmacists, but little trust exists for efforts to reform this system.

According to figures provided by IMS Health (2001), 22.4 percent of an average prescription cost stays with the retailer. 3.4 percent for the wholesaler, and 74.2 percent makes its way back to the manufacturer. Further breakdown of the manufacturer's 74.2 percent portion indicates that only 29.3 percent goes to material cost: the rest is distributed 28.7 percent for advertising, 20.8 percent for research and development, 6.1 percent for taxes, and 15.1 percent for net profit. While nationally 92.5 percent of all prescription dollars are for brand names, in the Kansas Medicaid program, Social and Rehabilitation Services has reduced the brand name proportion to 85 percent.

Jim Cleland, pharmacist from WaKeeney, provided revealing information as to how complicated the pricing structure is for prescription drugs. As he went through a number of containers he had with him, it was hard to avoid the sense that the pharmacist who was the best bargainer was going to be the pharmacist who got the best price. There did not seem to be a lot of logic to the pricing. The Task Force was struck by the fact that, when Mr. Cleland suggested the state should get rid of the Average Wholesale Price (AWP), one of the drug company lobbyists indicated agreement with such a change.

Interestingly, the Task Force reviewed information indicating that both the privately insured population and Medicaid beneficiaries have little incentive to manage their prescription costs. Prescription benefits, in both cases, are constructed with relatively low, fixed-dollar co-payments. In Medicaid, the maximum co-payment is $3.00 and is a voluntary payment.

Some medications can be obtained either in a higher dosage form with a doctor's prescription or a lower-dosage form across the counter. An example is Pepcid AC, a popular stomach acid controller, which can be obtained as a 20 mg. pill with a doctor's prescription or as a 10 mg. pill over the counter. A study of the average price from eight Kansas City area pharmacies found the 30 pill quantity 20 mg. Pepcid AC to be $67.94 and the price of a 60 pill quantity 10 mg. over the counter to be $21.33. Why the difference? The doctor prescribed form is covered by insurance and Medicaid; the over the counter dosage is not.

In the current system(s), the physician, the patient, or the pharmacist has no financial incentive to save money. Requiring beneficiaries to pay a percentage of the costs of brand name medicines at 20 percent, 30 percent, or even higher will create consumer discretion.

A positive side the Task Force saw was in the work of Steve Smith, pharmacist from Hiawatha. He knows his community and its facilities and has developed, in cooperation with medical staff in his community, a means to integrate the medical-pharmaceutical needs of persons receiving institutional care so the prescription drugs are geared to the needs of the patients, including a means for cross-checking to ensure there are not competing medications. Members of the Task Force have had the opportunity to talk about this system and are optimistic that a similar system would work in the Medicaid program.

We commend Social and Rehabilitation Services and the pharmacists of the state for all of the good work that has been done in a genuine effort to contain costs related to prescription drugs. A complete listing of these steps and possible savings has been incorporated into the Medicaid budget document, so we will not repeat that information. We do suggest a review of those steps to get a sense of the work that has been done.

Because of the potential for continued escalating costs in this area, it is imperative that new and innovative thinking go into new strategies in this area.

Strategies for Action

Purchasing and Negotiation

- Social and Rehabilitation Services legal and program staff, the Office of the Attorney General, the Office of the Governor, the President's Task Force and pharmacists should explore ways for the agency to make maximum use of its purchasing power to drive down the costs of drugs. The exploration should look at the possibility of Social and Rehabilitation Services securing a purchase price for the individual pharmacist which is as low as any place the drug can be purchased in the United States. This negotiation with wholesalers and drug manufacturers should be on behalf of all citizens and not just the Medicaid recipients. This would require a

change in federal law. The Task Force suggests the development of a multi-state purchasing cooperative. (Note: In FY 2002, the state spent $27.5 million for the top five drugs by expenditure and $41.6 million on the top ten. Any purchasing cooperative could focus on these drugs for bulk purchase.)

- On Friday, March 14, 2003, the Task Force was notified by the Governor's Office of a pending agreement to join the State of Michigan in a multi-state pharmaceutical program. Michigan took the lead in establishing an expansive preferred drug list and supplemental rebates with pharmaceutical manufacturers negotiated through First Health Services. While we appreciate the Governor's efforts and the direct rebate payments to the state, we believe it still allows manufacturers to raise their selling prices to all citizens to cover such rebates.

- An important factor in maximizing purchasing power is the ability to determine actual costs. Social and Rehabilitation Services should consider reviewing the systematic approach used to track the cost of liquor at the manufacturer, wholesaler, and retailer level to see if it is transferrable to the pharmacy system. Both systems have the same three tier industry structure and require permits or licenses at each tier. The pharmacy compensation fee will be implemented simultaneously with this strategy.

Cooperation With Pharmacists

- Participating pharmacists should receive adequate compensation for their services; we would recommend a pharmacy compensation fee of $10 for brand name prescriptions and $15 for generics. When tablets are prescribed, many times money can be saved if higher strength tablets are halved by the pharmacist. We recommend paying the pharmacist 50 cents for each dosage halved. Legislative Post Audit estimates $700,000 can be saved annually by halving tablets on one drug alone.

- Social and Rehabilitation Services and the Kansas Pharmacists Association. should work together to develop several pilot projects that duplicate the whole care integration of Mr. Smith in Hiawatha.

- The Task Force recommends the Kansas Board of Pharmacy beef up its inspectors. We would recommend hiring pharmacists that have many years of experience behind the counter and want a new challenge. We would like to raise the level of professionalism within the ranks and recommend inspections include spot checks comparing amounts of specific medicines ordered with medicines dispensed as well as Medicaid compliance checks.

- Clinical pharmacists should be utilized to provide academic detailing to providers. The Task Force received an example of how a pharmacist worked with the physician and patient, without compromising the patient's

welfare, to reduce the number of prescriptions from 12 to 9 and the cost from $1,315.11 per month to $96.96 per month. Many drugs are tried and true. Generics, over-the-counter, and herbal supplements are available. Thousands of drugs have been approved for dispensing, but the average physician prescribes less than 25 different drugs. Knowledgeable academic detailing offers potential savings without compromising patient care.

Scrutiny of Medicaid Claims

- The prescription drug program lends itself to management by exception. Recipients taking more than nine unique medications per day should have their medications reviewed by their doctor and pharmacist. Edits in the new Medicaid claims system (MMIS) can identify these recipients on the basis of high usage, expensive medications, or multiple prescriptions from different pharmacies.

- Social and Rehabilitation Services should identify and counsel doctors who might be over-prescribing certain medications as indicated in the MMIS edits.

- Medicaid currently allows and pays pharmacy claims without requiring the pharmacist submitting the claim to include information identifying the prescribing physician. Without that information on the claim, it is impossible to conduct a review of claims information to identify potential fraud or efficiently pursue alleged fraud. We recommend the new Medicaid Management Information System require this information before payment authorization.

- Social and Rehabilitation Services should consider audits of pharmacy providers that include comparing claims to actual prescription documents.

- An initial check of all Medicaid eligible patients should include a review of eligibility for Veterans Administration assistance.

Program Request

- As noted previously, Independence Plus and Cash and Counseling are waiver programs currently operating in other states. These waiver programs allow the consumer to buy his or her own personal home and community based services and the consumer satisfaction rates are near 100 percent. One reason this is so successful is consumers move from a defined benefit program to a system where the money they save in one area can be utilized in others. Examples given include saving money to purchase a new wheelchair for the consumer. We recommend Social and Rehabilitation Services ask for a demonstration waiver or develop a pilot program to establish a voucher system that encourages consumers to

utilize over-the-counter or generic drugs instead of brand name prescriptions and allow the money they save to be utilized like a medical savings account in other areas.

Legislative Follow-Up

The items suggested above could have a significant impact on the way in which the state does business in the name of Social and Rehabilitation Services. For that reason, we are suggesting regular reports be made to the Office of the Governor and the Legislature.

CARE MANAGEMENT AND THE VARIOUS POPULATIONS

Statement of the Issue

One of the most important topics covered by the Task Force is care management which arose from a recommendation of the consultant, Don Muse, who pointed out certain high cost Medicaid clients whose care, if managed by a team of health professionals, could result in better quality care at lower cost. The Task Force also discussed capitated managed care with conferees as well as traditional case management.

In the 1980s and 90s, managed care became a buzz word denoting a number of ideas. For persons with long involvement in the health services area, it was taken as an idea for genuinely managing the care of individuals. Medicaid is widely thought of as protection for poor women and children. Indeed, they are 75 percent of the recipients, and Kansas covers uninsured kids and pays for over half the births through Medicaid, largely through capitated managed care providers. The costs represent about 32 percent of the money in the program.

For the aged, mentally ill, and disabled consumers, though much smaller in terms of numbers of recipients, capitated managed care has been more challenging. It was thought that managed care was a way to assure adequate and appropriate care. It did not take long to discover that managed care had too often become another mechanism for controlling cost by turning medical practice over to clerks. It became a different way of rationing care and met very few expectations of persons who were getting the service or purchasing the service.

Over time, the medical system, the consumers, and the advocates insisted there be some mechanism for making good decisions on behalf of one's medical care. In this context, care management began to emerge as a more descriptive term. It was a term that could be filled with new meaning and was not burdened with the same, faulty ideas encompassed in managed care. It began to emerge as a descriptive word to explain that there was going to be a trained person giving an assist to those who were needing additional guidance as to their own medical care. Medical care management moves away from the concept of capitated managed care guided by clerks to an understanding that a trained person, where

necessary will interact with the medical professionals to arrange the proper and appropriate care.

The problem already being faced by Social and Rehabilitation Services is the question of who is to provide the care management. If the agency and the state are to be assured of the best possible use of budget dollars, then there has to be an evaluation as to whether the service is best provided by a professionally trained medical person or by an attendant. It would seem that if the care management system is to work in the best interest of the consumer, then the initial medical evaluation needs to be done by a medically trained professional. The implementing of the medically prescribed program, hopefully, could be done by an attendant. By the blending of these two functions, the hope is that there can be a medically sound program which is guided day-to-day by an attendant but under the watchful eye of the health professional.

As we begin to think about care management, it is important to note we have two large population groups that Social and Rehabilitation Services is working to serve. The first grouping would be that of persons qualified for some type of institutional care and care provided through the home and community based waiver programs. The second grouping would be those individuals who are a part of Temporary Assistance for Needy Families (TANF), Pregnant Women and Children, and other childrens' groupings. These two populations are similar in that they are dependent upon Medicaid for their medical services, but they are different in that the latter group would not necessarily be involved with a medical professional or making use of attendant care. For that reason, different strategies will need to come into play.

The issue of long-term care and home and community based services is probably the most important topic covered by the Task Force. Both the manner in which the programs are operated and the recommendations the Task Force can make will make a difference in the lives of many. The significant challenge faced by the Legislature and Governor is to structure and fund the programs in ways to ensure individuals continue to have a high degree of independence and living in the community.

Strategies for Action

- Social and Rehabilitation Services should continue its good work with the consumers and consumer advocates to build even stronger community-based programs. In view of the substantial cuts made in home health skilled services last year, the Task Force is calling upon the agency to re-examine the extent of those cuts. The Task Force agrees with the turn to care management, but it should not be viewed as a new way to cut back on the quality of care for these vulnerable populations.

- The Task Force feels that to provide an opportunity for long-term control of health care costs, Social and Rehabilitation Services should complete an analysis of the major causes of illness and disability found in Medicaid recipients. Following that analysis, recommendations should be considered for development of appropriate public policy dealing with prevention and health promotion.

- If it is not already available, the Task Force recommends that a health and well-being protocol be developed and agreed to by all parties to assure the citizens of Kansas that appropriate medical services and attendant care are being provided by our health care personnel. These vulnerable populations should not feel as if they are second-class citizens simply because they are making use of these state sponsored programs.

- We recommend that a program be devised that would assure the Medicaid consumer there is someone who cares about his or her health and well-being and that such professional is really working to keep the consumer healthy. This could be the beginning of an extensive program of preventative care and wellness maintenance, instead of over-utilization of emergency rooms and hospitalization. Wichita or Sedgwick County could be the site for a pilot program in light of past activities in the area.

- In reviewing these recommendations, the Task Force recognizes there are likely existing multi-discipline committees already functioning. If so, such committees could do some of this review. The Task Force asks only that the committees be multi-discipline and they include consumers and consumer advocates.

- Target care management, identify the amount of financial resources we can commit, strategically analyze and select a specific area for care management, make the investment, learn from mistakes and expand the program. We suggest that we start with patients with congestive heart failure just as they are discharged from a hospital and those that have any major chronic disease such as diabetes or asthma combined with mental illness, *i.e.*, a dual diagnosis.

- There have to be financial incentives for the individuals involved in care management, not flat fees, but rewards for doing great work. It cannot be on the "low-hanging fruit" legislative budget list. Care management is a long-term commitment, and the Legislature has to be a trustworthy partner.

- The State of Kansas should make a commitment to increasing the Medicaid physician fee schedule so it is equivalent to the Medicare fee schedule. This should be phased in over a three or four year period.

- The state should pursue all options available under federal rules to maximize how hospitals are compensated for their services. The state should re-examine the methodologies and rational it uses for establishing payment rates and work collaboratively with providers to ensure that state resources are being spent appropriately.

- In urban areas specifically, and other areas where practical, the Task Force recommends the expansion of the Program of All-Inclusive Care for the Elderly (PACE). This is a unique capitated frail elderly management care idea that utilizes a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service based on the participants' needs.

- Quietly whispered, though not substantiated, is the insinuation that psychotropic drugs are being used as a restraint in nursing homes and in schools. Drugs developed for schizophrenic disorders and other mental illnesses are being prescribed in disturbing amounts to people who do not have these clinical diagnoses. Therefore, the Task Force recommends a study involving six nursing homes that have received no citizen complaints or any citations by the Department of Health and Environment for violations of rules and regulations within the last two years to be compared with six nursing homes that have been cited with substantial complaints and violations. The study should analyze the prescribing practices between the two groups; render an opinion on the appropriateness of the prescribed drugs; compare the interaction of multiple drugs of each resident of the nursing home; and compare each nursing home's emphasis on resident participation in social activities and wellness activities. With these study results, the state will have the tools to assess the effective level of psychotropic drug use in Kansas, and provide the appropriate education to the nursing home provider.

- The Task Force is aware of a pilot program in Wichita that integrates primary care and mental health services through the utilization of advanced registered nurse practitioners. Research has shown that such nurse practitioner providers are particularly well suited to manage the primary care patient, including the medically complex patient with demanding chronic health issues. By integrating family practice and psychiatric health care specialities under the "same roof" and using advanced registered nurse practitioner providers, this model meets the three critical standards for today's health care delivery systems of effectiveness, efficacy, and efficiency, and patient satisfaction. The Task Force recommends this pilot project be expanded beyond Wichita and be used as a model of treatment for those with a combined diagnosis of mental illness and chronic health issues.

Legislative Follow-Up

As noted, the Task Force thinks the provision of long-term care and home and community-based care, as well as covering the balance of populations in the Medicaid program, is very essential and sets the tone for how we respond to vulnerable populations. As a result, the Task Force requests an assessment by Social and Rehabilitation and others as to the feasibility of the action items above and a report to the Task Force during the Veto Session.

INTERNAL MANAGEMENT

Statement of the Issue

The members of the Task Force are firmly convinced the management of the Medical Assistance Program within Social and Rehabilitation Services is a monumental task. We have been pleased with our interactions with the appropriate agency staff in their information and insights. We recognize the dispensing of money for services rendered has the potential to generate ill will. However, it appears that hard work by both Social and Rehabilitation Services and the various service providers has resulted in a reasonably good working relationship. Nevertheless, with that said, there are some areas that need critical attention.

Strategies for Action

- In administration of the Medicaid program, the level of reimbursement for service providers has not changed in many years. With that in mind, the Task Force suggests a determined effort to reduce the hassle factor for providers. In light of the flexibility offered by the federal Department of Health and Human Services, we suggest Social and Rehabilitation Services and the Kansas Medical Society develop a plan to incorporate best management practices (BMP) into a payment plan. As a result, any provider operating within these BMPs would be cleared for payment. To assure program integrity, a sample audit of claims would remain.

- It would appear the state and the Department of Social and Rehabilitation Services will continue to operate with scarce funds. At the same time, the agency has moved to do even more purchasing of services from individual providers or small operations. This means they have limited cash flow capability. For that reason, Social and Rehabilitation Services must further refine its reporting systems in order to make timely reimbursement adjustments so local providers may avoid cash flow problems.

- Over time the Medicaid Program has loosened up in such a way that it is possible for a variety of non-SRS programs to make use of favorable funding available through Medicaid. The Task Force requests a report on these arrangements; a location of such funding, how the non-federal match is handled, and other similar programs that might qualify under Medicaid.

- In certain circumstances, waiver services for individuals are costing more than if the individual were in a long-term care facility. As such, the Task Force recommends placing appropriate caps on waivers so others on the waiting list can utilize waivered services. We fully recognize the restraints imposed by the Olmstead case and recommend sensible parameters for determinations.

- Persons qualifying for the frail elderly or physically disabled waivers that currently are served in a long-term care facility should have the appropriate dollars follow them into independent living. A mechanism needs to be adopted where there is a transfer of budgeted dollars from Social and Rehabilitation Services to the Department on Aging. As an example, a person who falls and breaks a hip, following successful rehabilitation in a nursing home, may need to utilize some waivered services in order to return home. The transition plan approved by a care management team should provide that financial resources will follow the person until the waivered services become more expensive in the community than in a long-term care facility.

- The Task Force recommends that Social and Rehabilitation Services and the Department on Aging, along with their contractors, provide for the payment of durable medical equipment when an individual is transferred between programs instead of equipment being retained by the agency. We also recommend that the equipment be recouped at the time the equipment is no longer needed or at the death of the client. We suggest any equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles.

Legislative Follow-Up

Testimony from Social and Rehabilitation Services indicated there were a certain number of provider claims exceeding the expected number of claims in process. Hence, the Task Force would like to have a current report on the claims processing during the Veto Session.

Additionally, the Task Force requests a progress report on each of the above recommendations. After receiving these reports, the Task Force will determine when and where there might be additional reporting to the Legislature.

ISSUES BEYOND THE STATE

Statement of the Issue

The Task Force recognizes we are a small state, and for that reason we think attention should be given to see if there are ways to enhance the power of our state. Large numbers and expenditures are persuasive. The current federal administration has given every indication of wanting to reach out to the states. Any case that Kansas wanted to make would be enhanced if other states joined with it. Through the various associations in which Kansas has membership as well as Health and Human Services, every effort should be made to secure greater flexibility in funding and programs.

Strategies for Action

- The Task Force underlines again the exploration of the possibility of establishing a purchasing cooperative with other states to drive down the costs related to medical supplies, durable medical equipment, and assistive technology.

- The Task Force should work with the leadership of the Legislature and their counterparts in other states to make the case for the federal government to assume full responsibility for those individuals who are dually eligible for both Medicare and Medicaid. This could be a win-win situation all of the way around. It would financially benefit the state, and it would simplify the administration of both programs. If federal funding is unsuccessful, we would then advocate that any realized cost savings to Medicare as a result of successful care management be reimbursed to Kansas at the current Medicaid reimbursement rate.

- The Medicaid program should be subject to the same provisions of the Veterans Administration Federal Supply Schedule prices for purchasing prescriptions. According to the annual report of the U.S. Attorney General, Medicare paid more than double the Veterans Administration price for name brand prescriptions. We assume Medicaid and Medicare prescription costs are similar. Working with the National Conference of State Legislatures, the American Legislative Exchange Council, the Council of State Governments, and the National Governers Association, we advocate seeking immediate administrative and legislative remedies.

- State and federal policy makers know the current growth of the costs of providing Medicaid services is unsustainable. A primary Task Force goal is care management, not managed money. In order to work, Medicaid must be structured to place more decision making authority in consumers. "Independence Plus" and "Cash and Counsel" waivers are steps in the right direction, but voucher programs have to be authorized for consumers, and risk-based contracting that rewards providers must be adopted. This Task Force is committed to an investigation of the reform of Medicaid and the opportunity to work with President Bush and Governor Sebelius.

PUBLIC HEALTH ISSUES

Statement of the Issue

When the work of the Task Force began, we did not anticipate significant discussion of public health issues. However, a representative of Social and Rehabilitation Services articulated that before the state makes any significant improvement in the health conditions of many Medicaid recipients, it will have to give attention to the environment in which we all

live. While we imagine the scope and needs in the area of public health, the Task Force did not spend enough time on this topic to make an extended statement. Just the suggestion of the topic with some amplification suggested that we should not let it drop. It is on that basis we make some observations.

We would like to see special attention given to encouraging more healthy living options for Medicaid recipients and the general public. There is a considerable body of literature that outlines some broad social health risks: We don't eat in a healthy way. We don't take good care of our bodies. We don't exercise properly. The list is extensive. An extensive public education campaign on healthy living may be necessary to address these societal problems.

The Task Force recognizes everyone is functioning on an overload basis. Yet we wanted to recognize that work in the area of changing the health environment, living healthier lifestyles, and making greater use of existing research has the potential for changing the well-being of many. We suggest inter-agency discussion and joint development of a coordinated public education campaigns on this subject.

DIRECTION FOR THE FUTURE

Statement of the Issue

Does more health care mean better health? What is this assumption is wrong? According to the Center for Evaluative Clinical Sciences at Dartmouth Medical School, 20 to 30 percent of health care spending pays for procedures, office visits, drugs, hospitalization, and treatments that do absolutely nothing to improve the quality or increase the length of our lives. At the same time, the type of treatment that offers clear benefits is not reaching many Americans, even those who are insured.

It is a sobering thought, but perhaps legislators, insurers, and the health-care industry might be able to save money by concentrating on improving the quality of medicine rather than controlling costs. Statistical patterns of Medicare spending nationwide are enlightening. A 65-year old in Miami will typically spend $50,000 more in Medicare expenses over the rest of his life than a 65-year old in Minneapolis. During the last six months of life, a Miamian spends twice as many days in the hospital and is twice as likely to see the inside of an intensive care unit.

This regional variation would make perfect sense if the regions where citizens were the sickest were the ones that used the most medical services. If this were true, the region around Provo, Utah , one of the healthiest in the country, would get fourteen percent fewer Medicare dollars than the national average. Instead it receives seven percent more. In contrast, the elderly around Richmond, Virginia tend to be sicker than the average American and should be receiving eleven percent more–than 21 percent less–than the national average. And these regional differences are not as a result of the cost of health care.

Rather, much of the variation among regions–about 41 percent–is driven by hospital resources and the number of doctors. In other words, it is the supply of medical services, rather than the demand for them, that determines the amount of care delivered. The national average for expensive MRI technology is said to be 7.6 machines per one million patients. By this standard, Kansas should have 19. We have 47! Nearly the same as Michigan (48) which has four times the population. Medicare beneficiaries in Miami see, on average, 25 specialists in the last year of their life versus two in Mason City, Iowa, largely because Miami is home to a lot more specialists.

Recent studies show that excess spending in high cost regions does not buy the citizens better health. Patients in high-cost areas are no more likely to receive preventive care such as flu shots or careful monitoring of their diabetes, and they do not live longer. In fact their lives may be slightly shorter. The most likely explanation for the increased mortality in high-cost regions is they spend more time in the hospital. (Shannon Brownlee, "The Overtreated American," *Atlantic Monthly*, January-February 2003).

In the private sector, Blue Cross-Blue Shield of Kansas reported there were 201,000 more physician office visits in 2001 than in 2000. This is an increase of 14 percent, even though their membership grew only 5 percent. Hospital charges were 20.6 percent higher, diagnostic imaging 25.3 percent higher, clinical lab work was 29.2 percent higher, and speech, occupational, and physical therapy charges were 26.9 percent higher. If you are paying $1,000 or more a month for your family health insurance policy, you expect to get your money's worth. However, the incentive is in the wrong place and thus utilization rates continue to increase!

As noted previously, the runaway health costs of recent years have led many Medicaid programs and private insurance companies to impose Managed Care. And all too often, managed care consisted of an impersonal bureaucracy with a focus on managing dollars, instead of providing needed care. As an alternative, employers (and a few states with specific Medicaid waivers) across the country are empowering employees instead—by giving them the opportunity to manage some of their own health care dollars and experience the costs and benefits of prudent consumer behavior in the medical marketplace.

Additionally, a new ruling from the Internal Revenue Service allows the creation of a new kind of policy, called a Health Reimbursement Arrangement (HRA), which resembles a Medical Savings Account (MSA). HRAs, used with high deductible health insurance, can be funded by the employer and offer the employer an excellent vehicle to provide health insurance benefits. Individuals utilize the money in their HRA to pay out of pocket medical expenses. Money from the accounts can be rolled over year to year and the money travels with the employee in the event that the employee leaves the job. These accounts, instead of being drivers of medical inflation, now become inhibitors of inflation.

Strategies for Action

- Kansas Medicaid needs to follow the example of the private-sector HRAs. Accordingly, Social and Rehabilitation Services should explore the possibility of developing a Medicaid Benefit Account (MBA) to include patient cost-sharing and a health care savings account.

- Since these MBA's would be funded with taxpayer dollars, they should be restricted to the payment of medical bills and insurance premiums. This means that beneficiaries who consume health care wisely and see their account balances grow through time would not be able to withdraw these balances for non-health care spending. Instead, they would be able to use the funds for medical services not covered by their health plan. And in the future, they would be able to use unspent balances to pay insurance premiums and buy medical care directly after they have left the Medicaid rolls.

- We commend Social and Rehabilitation Services for the development of the Working Healthy program and encourage its continuation and expansion to allow individuals to retain health care coverage as they transition from welfare to the workforce.

- Challenges to the Medicaid system will persist until solutions are found for health insurance. Medicaid has to exist as a safety net. Market initiatives have to be adopted in both areas with individuals making and paying for the medical services that they choose to access.

AN ONGOING MEDICAID REVIEW STRUCTURE

Statement of the Issue

When President Kerr established his Task Force on Medicaid Reform, we had no idea of the level of interest which has been shown by interested parties. For Task Force members, it has been an eye-opening experience as we developed a deeper understanding of the work of Medicaid.

We have been pleased to learn of the many instances of positive activities taking place among consumers, consumer advocates, providers, Social and Rehabilitation Services and Aging. We commend all of them for their hard work. With a program as massive as the Medicaid program and involving so many people, it is not by accident that good things are happening. Good things are happening because of cross-discipline activity and the desire to serve the consumers. While there have been some instances where communication may have broken down, our general sense is that there has been good discussion. We have been pleased that the work of this Task Force has provided further opportunities for interaction between all parties. There are serious minded people working to make a system out of an unsystem.

In that context we recognize the merit of ongoing meetings of a multi-discipline group representing all aspects of the Medicaid program. While the Task Force is not interested in pointless busy work, an ongoing committee with the task of looking at the big picture would have merit. Such a committee of this type, including agencies, consumers, and providers, would have the task of visualizing the grand design of a Medicaid Program in Kansas. Instead of simply looking at the mechanics of the program, this committee should

focus on how to make the system professionally sound, fiscally sound, user friendly, and responsive to the Governor and the Legislature.

The Task Force believes the work started here allows us an opportunity to begin adopting and implementing many of the initiatives discussed during the last seventeen meetings. To that end the Task Force highly recommends that an ongoing review continue to take place and recommends that a proposal be put together to solicit a health grant from Kansas foundations. We would recommend the following possibilities:

- Kansas Health Foundation
- Sunflower Foundation
- United Methodist Health Ministry Fund
- Wyandotte Health Foundation (see also Appendix B)

Additionally, Social and Rehabilitation Services has just received a three-year grant of $1,385,000 funded from the Centers for Medicare and Medicaid Services. This grant, the Real Choice Systems Change Grant for Long-Term Care in Kansas, will be used to help make community based services as accessible as institutional services. As Task Force members we are interested in further pursuing this issue. To that end, if asked, we will pursue the outline of a plan before the end of the Veto Session. See also Appendix C.

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