Approved: March 21, 2007
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Co-Chairman James Barnett and Co-Chairman Dwayne Umbarger at 12:00 P.M. on March 15, 2007 in Room 123-S of the Capitol.

All members were present from the Senate Public Health and Welfare Committee except:
David Haley
Nick Jordan
Peggy Palmer
Pete Brungardt
Susan Wagle

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Nobuko Folmsbee, Office of Revisor of Statutes
Morgan Dreyer, Committee Secretary

Conferees appearing before the committee:
Dr. Andy Allison, Deputy Director, Kansas Health Policy Authority
Billie Hall, President and CEO, The Sunflower Foundation
Krista Postai, The Community Health Center of Southeast Kansas
Pat Cameron, Co-Director, The Benefit Bank

Others attending:
See attached list.

Upon calling the meeting to order, Co-Chairman Umbarger and Co-Chairman Barnett welcomed the conferees and thanked the Senators attending for participating in the joint discussion concerning HealthWave Enrollment.

Dicussion/Presentations on HealthWave Enrollment

Co-Chairman Umbarger called upon conferee, Dr. Andy Allison, Deputy Director, Kansas Health Policy Authority and Dr. Marcia Nielsen, Executive Director, Kansas Health Policy Authority who presented to the Committee a folder of information regarding HealthWave and Medicaid Programs. Highlights from the presentation included:

Testimony on:
- Enrollment in Kansas HealthWave and Medicaid Programs
- Health Insurance for Low-Income Kansans
  - Background
  - Federal Funding
  - State Programs
  - Background on Stairstep Income Thresholds Distinguish Medicaid and SCHIP Eligibility
- Long-run and short-run trends in enrollment
- HealthWave Outreach
  - Outreach challenges
- Graph - HealthWave Income Eligibility
- Graph - Federal Poverty Level for Household of Three

Slides/Charts on:
- Medicaid and SCHIP Eligibility Historical Trends
- All Kansas Medicaid Beneficiaries
- Kansas Medicaid Populations Groups
- Kansas Regular Medical Medicaid Expenditures by Population Groups Excluding LTC
- Regular Medical Medicaid Expenditures Per Person Per Month Per Population Group
- Enrollment in Medicaid and SCHIP: FY 2004-2007
- Health Insurance Status of Kansas Children

MINUTES OF THE Senate Public Health and Welfare Committee at 12:00 P.M. on March 15, 2007 in Room 123-S of the Capitol.

Fact Sheet on:
- Deficit Reduction Act requirements for citizenship and identity
- Impact on Beneficiaries
  - How beneficiaries have been affected
  - How has caseload been affected
  - How have other states been affected by these new requirements
- Caused by new documentation requirements and overworked enrollment process
  - What are the new documentation requirements
  - How have the new federal requirements impacted the enrollment process in Kansas
  - Who is being affected by these new rules
- Steps being taken to mitigate the problem
  - What are the budgetary costs of the new requirements for the state of Kansas
  - What measures are being taken to reduce the impact on beneficiaries

State Medicaid Fact Sheet: Charts, Sources and Notes

A copy of the presentation from the Kansas Health Policy Authority is (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senators Teichman, Kelly, Barone and V. Schmidt regarding losing children on enrollment, problems with DRA regulations and provisions, length and date what children started to drop off, backlog, Federal Government's part in the issue, Emergency Room use and safety net clinics.

Co-Chairman Umbarger called upon conferee, Billie Hall, Director, The Sunflower Foundation who presented the Committee with information regarding enrolling eligible Kansas children in both HealthWave and Medicaid programs. Highlights from the presentation included:

Testimony on:
- Health Coverage for Children
- Partnered Health Foundations
- Roundtable Discussions
- Kansas Barriers to Enrollment
- School-Based approach to Enrolling Children

A copy of the presentation from the Sunflower Foundation is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

No questions came from the Committee.

Co-Chairman Umbarger called upon conferee, Krista Postai, CEO, Community Health center of Southeast Kansas who presented the Committee with information regarding HealthWave enrollment. Highlights from the presentation included:
- Financial Support
- Uninsured Children
- Space and Money limits
- Backlog
- Success in enrolling children

A copy of the presentation from The Community Health Center of Southeast Kansas is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senators Barnett, Teichman, and Schmidt regarding creating a list of barriers for enrolling children, system for enrollment and clinic expansion.

Finally, Co-Chairman Umbarger called upon conferee, Pat Cameron, Co-Director, The Benefit Bank who

presented the Committee with information regarding who and what the Kansas Benefit Bank works. Highlights from the presentation included:

- what is The Kansas Benefit Bank
- Why is The Kansas Benefit Bank needed
- Who will The Kansas Benefit Bank make a difference
- When will these benefit applications be available
- How can my organization become a benefit bank site

Information facts on The Kansas Benefit Bank Inter-Faith Ministries

A copy of the presentation from The Kansas Benefit Bank is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senators Kelly, Schmidt and Barnett regarding web-based enrollment, dealing with paper documentation, funding, collecting information electronically, locations in Kansas, advertising The Kansas Benefit Bank and barriers.

With no more time left, Co-Chairman Barnett and Co-Chairman Umbarger thanked the Committee members for attending the discussion and thanked the conferees for spending time to discuss and present this information.

Adjournment

As there were no more items on the agenda and no more time left, the meeting adjourned at 1:20 p.m.

Joint Meeting
Senate Public Health and Welfare Committee
Senate Ways and Means Committee
Guest List
Date: 3-15-07

Sister Therese Bangert	Ks. Cath. Conference
Beatrice Arroyo	Ks. Cath. Conference
Marin Bordelhamon	KMPA
Christiane Swartz	KHPA
Dennis Priest	SRS
Sarah Carkhuff Azzell	KHI
Sheldon Weisgrau	KHI
Corrie Edwards	KHCC
Suzanne Wikle	Kansas Action for Children
Cara Greve	KAMU
Marci Nielsen	

Joint Meeting
Senate Public Health and Welfare Committee
Senate Ways and Means Committee
Guest List

Date: 3-15-07

Scott Rothfuchs	Lawrence Journal-World
Julia Thomas	DOB
Bob Hall	Sunflower Foundation
Larry Tolein	Sunflower Foundation
Carol J. Toland	Intern
YVETTE DESROSIERS-ALPHONSE	SUNFLOWER FOUNDATION
Karl Wingen	Kearney & Associates
Shauna Reynolds	University of Kansas BSW Student
Chris Brown	University of Kansas
Teresa Priddy	University of Kansas BSW Student
Derek Hein	Hein Law Firm
Brad Smoot	Family Health Partners
Amy Foster	Flinthills DBSA - Manhattan / Grandparents as Parents
Kathy Damron	UniCare
TOM BRUNO	EDS
MARK BOZANYAK	
Bob Finuf	Children's Mercy Family Health Partners
Shiva Green	" "
Patricia Cameron	Inter-Faith Ministries, Wichita
KRISTA POSTAI	Community Health Center of SEK
Paul Johnson	Ks Catholic Conference

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Coordinating health & health care for a thriving Kansas

MARCIA J. NIELSEN, PhD, ... d
Executive Director

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Testimony on:
Enrollment in the Kansas HealthWave and Medicaid Programs

presented to:
Senate Committees on Ways and Means &
Public Health and Welfare

by:
Dr. Marcia Nielsen
Executive Director

Dr. Andrew Allison
Deputy Director and
Acting Medicaid Director

March 15, 2007

For additional information contact:
Luke Thompson
Kansas Health Policy Authority

Landon State Office Building
900 SW Jackson Street, Suite 900
Topeka, KS 66612
Phone: 785-296-3981
Fax: 785-296-4813

Senate Public Health and Welfare Committee
Attachment #1
March 15, 2007

Senate Committees on Ways and Means & Public Health and Welfare
March 15, 2007

Enrollment in Kansas HealthWave and Medicaid Programs

Good afternoon. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority (KHPA). With me today is Andy Allison, Deputy Director and Acting Medicaid Director. I appreciate the opportunity to talk to you today about changes we've seen in the number of Kansans enrolled in Medicaid, SCHIP, and HealthWave in recent years, and in the last few months. After sustained growth in enrollment since 1999, the state has seen a very rapid decline totaling over 20,000 Kansans – roughly the population of Derby or Hays. I'd like to provide some historical background on insurance coverage in this state before I address the long-run trends and more recent enrollment challenges in our programs, especially the impact of Federal requirements to verify citizenship and identity.

Health Insurance for Low-Income Kansans

Background. Health insurance plays an important role in the U.S. health care system, spreading costs to ensure access to care and prevent catastrophic financial loss. However, affordable private health insurance is not available to all Americans, especially the poor and those with predictable health costs, such as the elderly and disabled, for whom private insurance markets are both expensive and unstable. To address these chronic gaps in private insurance markets, states and the Federal government have invested in at least three major health insurance programs since the 1960s: Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Medicare provides traditional health insurance services for the nation's elderly and disabled. Medicaid supplements Medicare for low-income seniors and insures low-income women and children. SCHIP provides health insurance to an additional group of low-income children. Today Medicare covers about 13% of the Kansas population, while Medicaid and SCHIP cover about 10%. About 65% of Kansas' population is privately insured, and 11% remain uninsured. Most of the uninsured in Kansas live in households with at least one worker. As the cost of health insurance continues to rise, an increasing number of working Kansas families cannot afford health insurance. Those working in small businesses are less apt to be offered insurance, and those with low and modest incomes often have difficulty affording health insurance.

Federal Funding. Medicaid and the State Children's Health Insurance Program (SCHIP) are Federal programs that provide matching funds for state-run insurance programs. Both Medicaid and SCHIP are contained in the Social Security Act of 1965 (SSA): Medicaid was authorized as a part of the original SSA legislation and can be found in Title XIX of the Act; SCHIP was added as Title XXI of the SSA in 1997. The Federal match rate for SCHIP is slightly higher than Medicaid (72% v. 60% in Kansas), but unlike Medicaid, SCHIP matching funds are subject to a state-specific cap, or allotment. In Kansas, SCHIP is available state-wide to children who are Kansas residents from birth to age 19 who are not eligible for Medicaid and who live in families with incomes up to 200 percent of FPL ($33,200 annually for a family of three). Medicaid covers children at lower levels of income.

State Programs. Medicaid and SCHIP are funding sources tied to specific Federally-determined populations. The state uses those funding sources to purchase health care through both managed care and fee-for-service programs. The managed care program is called "HealthWave," KHPA's best-known and most widely advertised product line. Both Medicaid- and SCHIP-eligible children and families have been enrolled in HealthWave since FY 2002. By state law, all 34,791 SCHIP children must be enrolled in managed care, which means all are enrolled in HealthWave. As of January 2007, about 145,000 Medicaid beneficiaries – mothers and children – are also eligible to be enrolled in HealthWave. To distinguish the Medicaid and SCHIP populations within HealthWave, KHPA often refers to the HealthWave-XIX and HealthWave-XXI populations,

a direct indication of the SSA funding rules and eligibility criteria that apply to the HealthWave program.

Background on Stairstep Income Thresholds Distinguish Medicaid and SCHIP Eligibility. Eligibility for public health insurance in Kansas can be based on family income, disability, or other specific health care needs, e.g., long-term care or community-based support. Most Medicaid - and all SCHIP - enrollees are eligible solely because of their family's low income. These populations also comprise the vast majority of our HealthWave program. Income-based eligibility in Medicaid and SCHIP is tied to Federal Poverty Levels (FPL). Medicaid covers the poorest Kansas children, while SCHIP covers children with incomes that exceed Medicaid limits but are less than 200% of the FPL. Because Medicaid income thresholds decline with age, the dividing line between Medicaid and SCHIP poverty-related eligibility is commonly referred to as a "stairstep."

- The highest Medicaid income threshold is 150% of the FPL and applies to infants less than one and their pre- and post-partum mothers.
- The next highest Medicaid income threshold is 133% of the FPL and applies to children ages 1 through five.
- The lowest eligibility ceiling for children is 100% of FPL and applies to children ages 6 through 18.
- SCHIP funding is used to provide health coverage for children in each age group above the Medicaid eligibility levels up to 200% of FPL.

Long-run and short-run trends in enrollment

- There has been steady growth in the cash assistance-related (TAF), poverty-related, and disabled populations in Medicaid and SCHIP since July 2003. Most of the increase is comprised of children in Medicaid and SCHIP.

- The drop in enrollment in Medicaid after July 2006 is due primarily to the new federal citizenship and identification requirements. Applicants who are most likely U.S. citizens are finding it difficult to obtain the necessary documentation to meet these requirements. New applications are not being processed as quickly as before, nor are reviews of existing beneficiaries being completed as quickly. A KHPA Fact Sheet is attached that describes the impact of the citizenship verification requirements on beneficiaries and KHPA operations in more detail.

- SCHIP has generally had smaller and steadier growth than Medicaid. Since the citizenship and identification requirements do not have to be applied to this program, there has been a smaller decline in enrollment since July 2006. Some decline did occur because of the volume of documents and phone calls the Clearinghouse began receiving in July.

Healthwave Outreach

There are an estimated 40,000 Kansas children who are uninsured and potentially eligible for HealthWave, although this estimate precedes the reduction in caseload of approximately 15,000 children due to the federal citizenship and identification requirements. Despite a more streamlined, less cumbersome enrollment process in general and several years of marketing efforts (until mid-2006), there remain a contingent of uninsured Kansas children who have not enrolled in HealthWave representing about 20% of the eligible, uninsured children in the state. KHPA believes that health insurance would benefit these children and their families and intends to explore additional outreach methods aimed at enrolling these children.

One of the efforts KHPA is already exploring is a presumptive eligibility process. This process has been successful in bringing children into the program at the time of service in the three pilot locations. However,

presumptive eligibility is not a long-term determination, and we have had disappointing success to date in getting children to enroll in HealthWave on an ongoing basis. Our budget proposals this year included resources to develop an on-line application form to facilitate the presumptive process and other outreach efforts. Together these efforts could help to improve the rate of enrollment following a presumptive determination. KHPA's vision of health for Kansans emphasizes prevention and wellness, and our approach to outreach and enrollment should be designed to support families in accessing preventive care for their children. This includes an emphasis on full-fledged enrollment in the program following, or in place of presumptive eligibility.

KHPA looks forward to the opportunity to partner with other organizations that can provide more personal assistance with the enrollment process. It should be noted that SRS does still perform about 15% of determinations into the HealthWave program and a local SRS office is still very important to the current and future enrollment model for the HealthWave program. However, KHPA believes it could be beneficial to partner with other organizations that will answer questions and help families gather the necessary verification. When the HealthWave Clearinghouse can receive applications that are accompanied by the necessary verification, the enrollment process moves much more quickly. KHPA looks forward to the opportunity to coordinate efforts with volunteer and grant-funded community-based organizations that can assist with this.

KHPA also believes that partnering with other state programs such as the school lunch program may be an avenue that will help us reach this eligible, uninsured population. Previous attempts to create these partnerships have been unsuccessful because federal laws around protecting the privacy of children on the free and reduced school lunch program are very restrictive. There is new information, however, that some programs have developed successful models for reaching this population, and KHPA may be able to develop a similar model. KHPA will investigate these possibilities further and will develop the necessary partnerships to open up this avenue if possible.

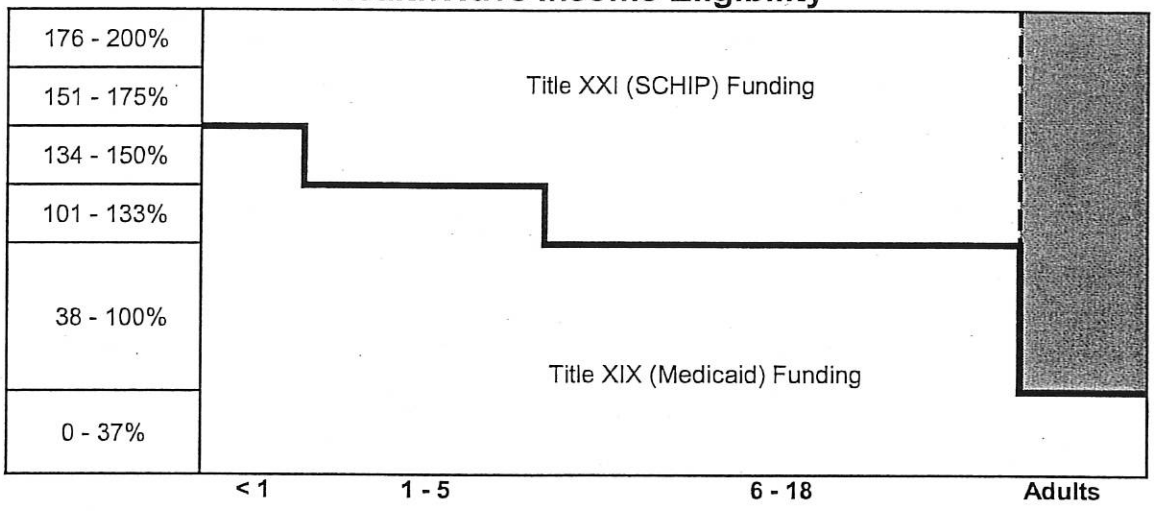
Outreach challenges. KHPA has requested $336,000 SGF and $822,000 All Funds for outreach for FY 2008. This request was originally made prior to understanding the full impact that the citizenship and identity verification requirements would have on the HealthWave Clearinghouse. Currently, there are approximately 15,000 applications pending at the HealthWave Clearinghouse. KHPA's concern is that an un-coordinated increase in outreach efforts could exacerbate this problem.

KHPA has also requested additional funding for FY 2007 and FY 2008 that would allow us to increase contract and state staff at the Clearinghouse in order to meet the demands of the citizenship verification requirements. Approval of these additional funds is crucial to any additional outreach that KHPA can do to enroll eligible, uninsured children. In addition, after the staff are put in place, it will take time to reduce the backlog of applications. It would do no good to increase outreach efforts and, if successful, add more applications to the backlog at the HealthWave Clearinghouse.

It is KHPA's position that we do need to increase outreach so that we can insure all children in the state of Kansas, but these efforts need to be mindful of the type of outreach performed, the timing of the outreach, and what type of strain this may put on an already over-burdened system. KHPA must coordinate these outreach efforts to ensure that accurate information is being disseminated and proper procedures are being followed by staff and by partners. This will require increased effort on the part of KHPA.

ATTACHMENT 1

HealthWave Income Eligibility



Federal Poverty Level (FPL) for a Household of Three (3)

Percent of Federal Poverty Level (FPL)	Income Thresholds
200%	$33,200
175%	$29,050
150%	$24,900
133%	$22,078
100%	$16,600

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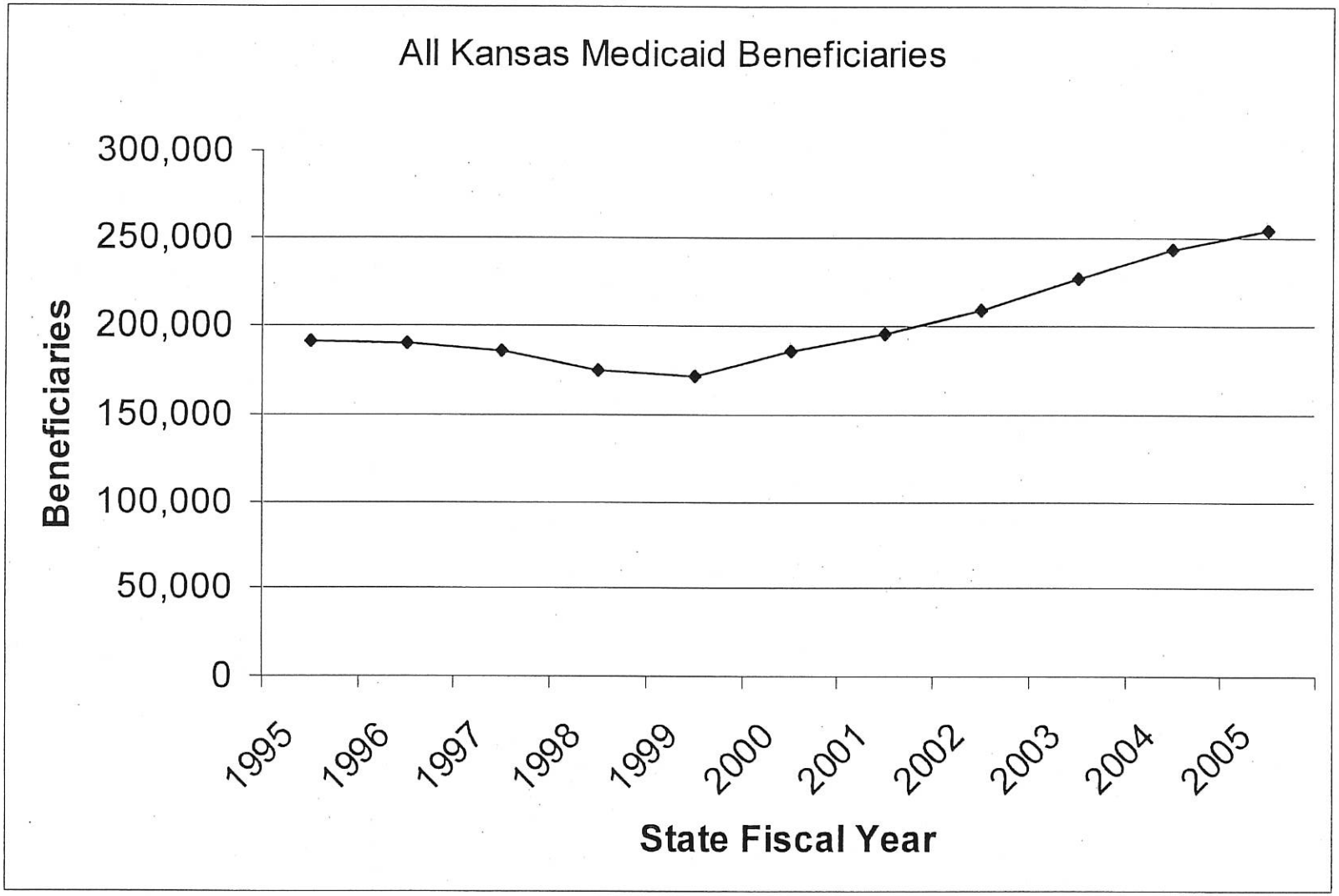
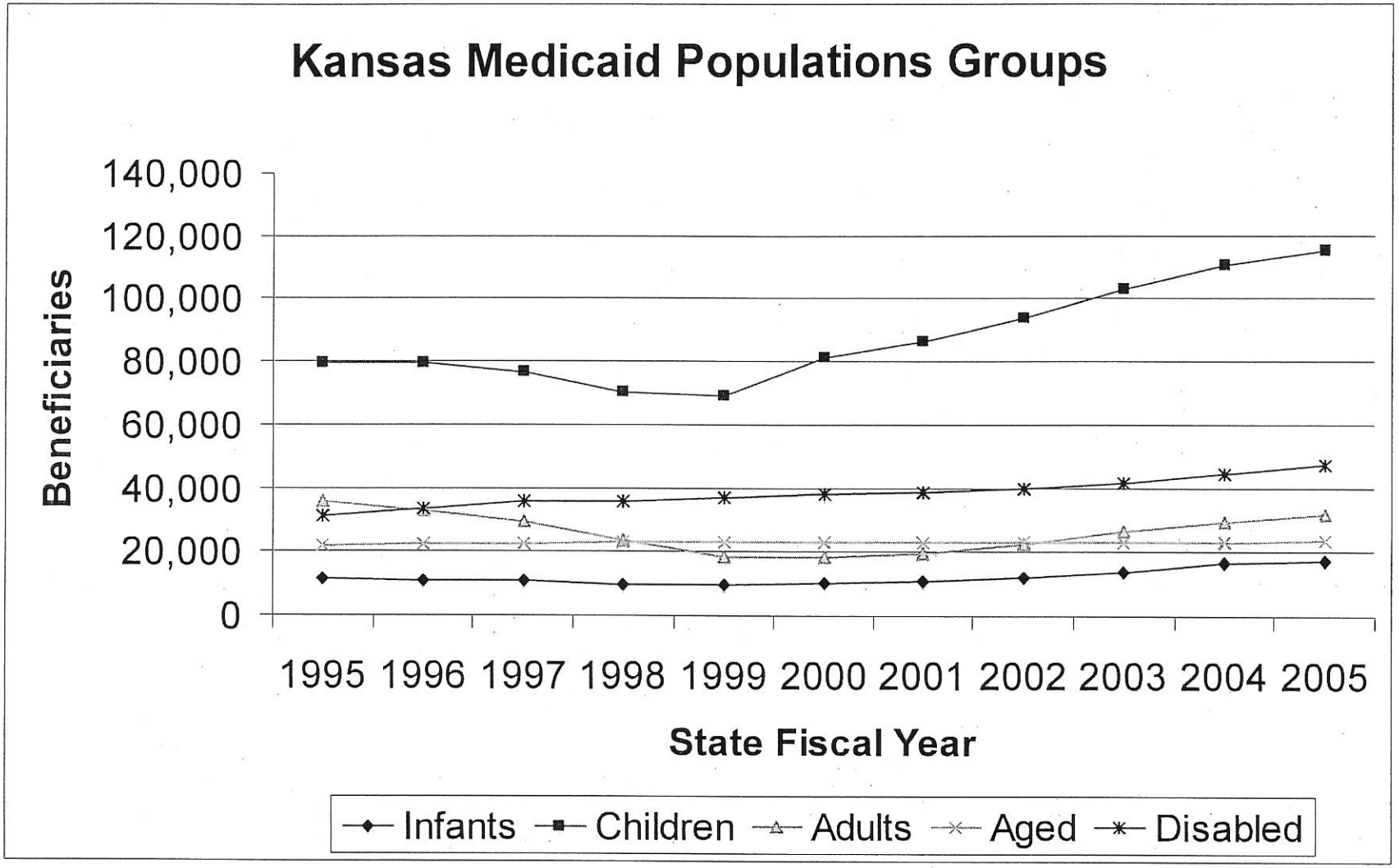
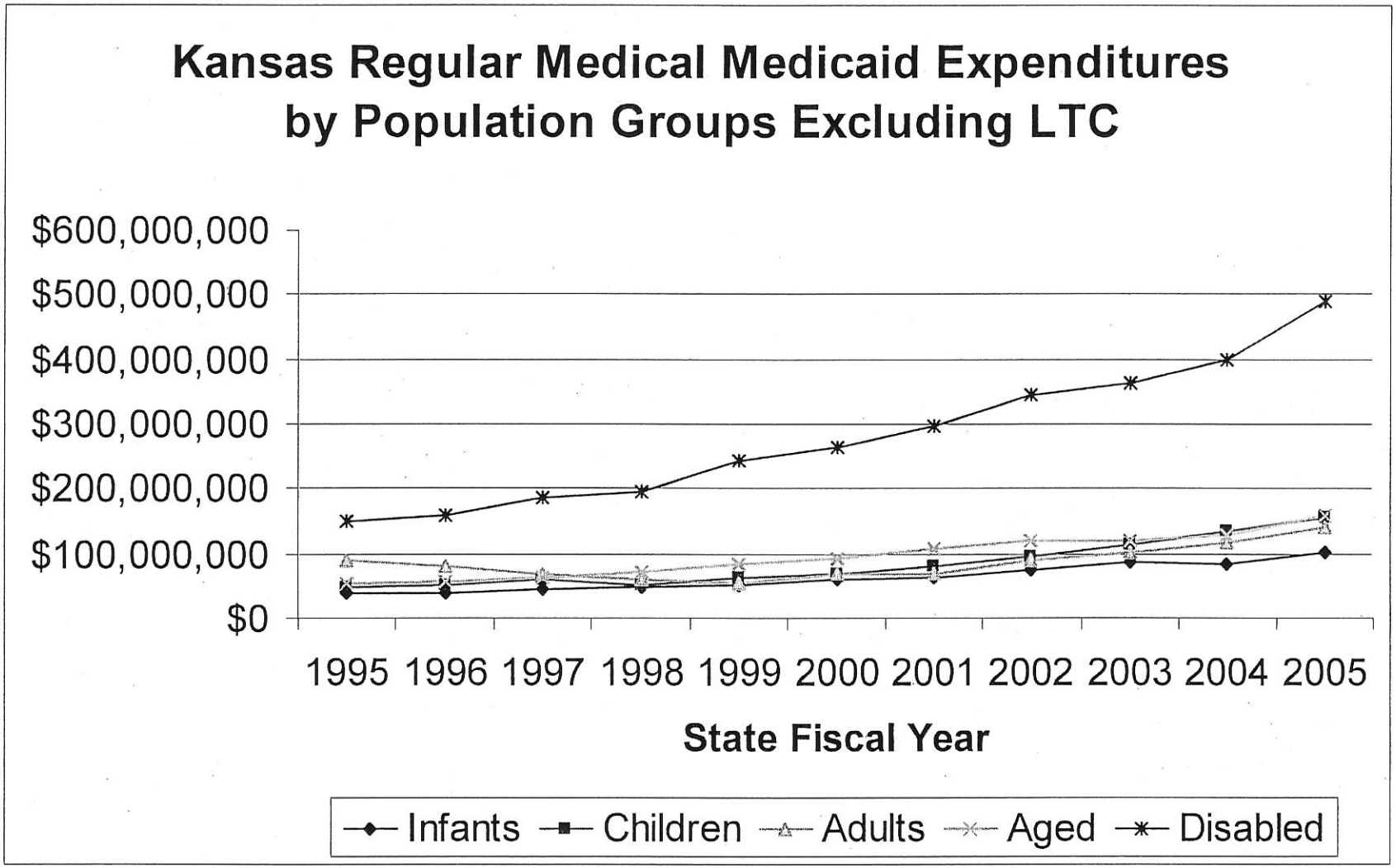
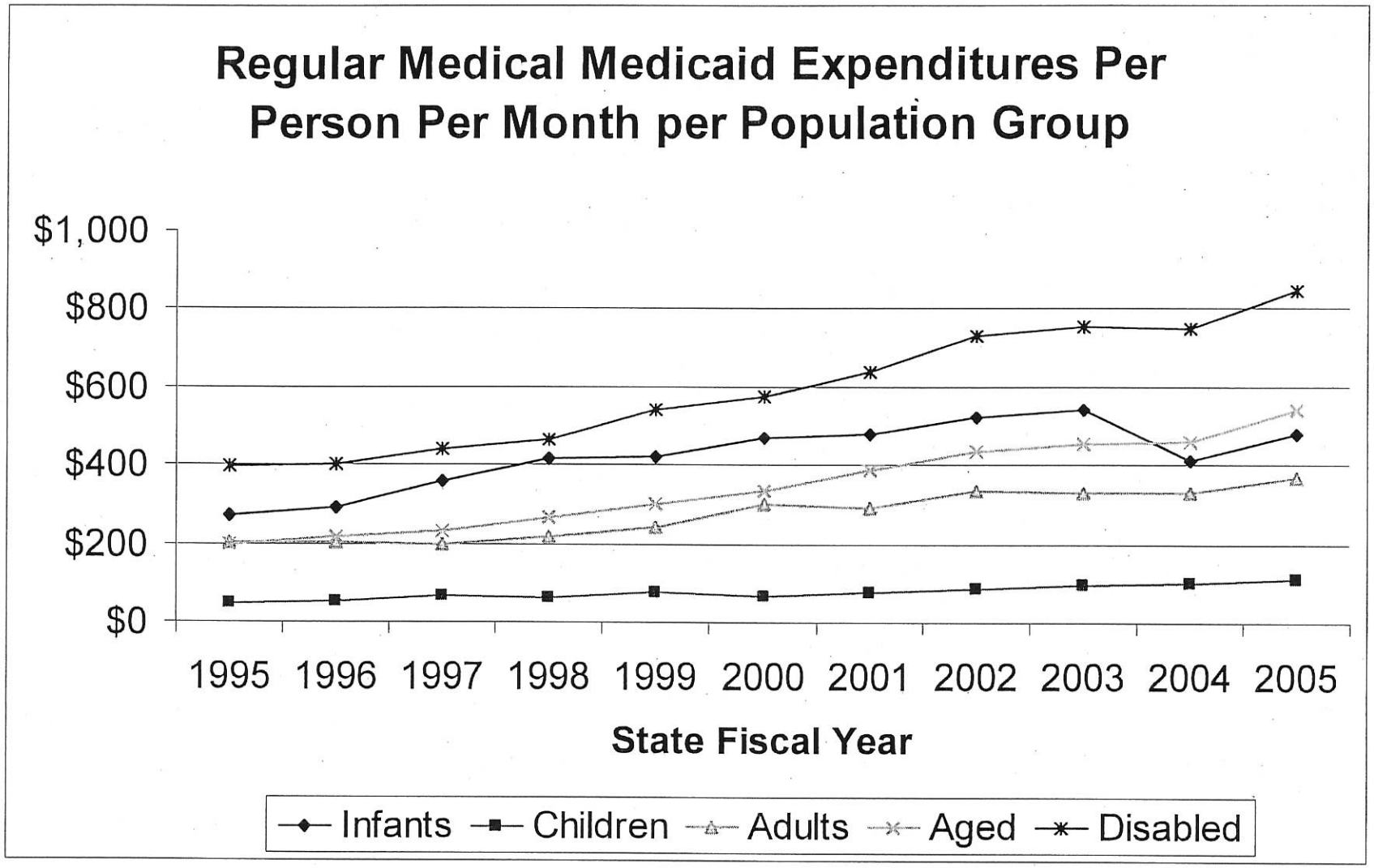
Medicaid and SCHIP Eligibility Historical Trends

Marcia J. Nielsen, PhD, MPH
Andrew Allison, PhD

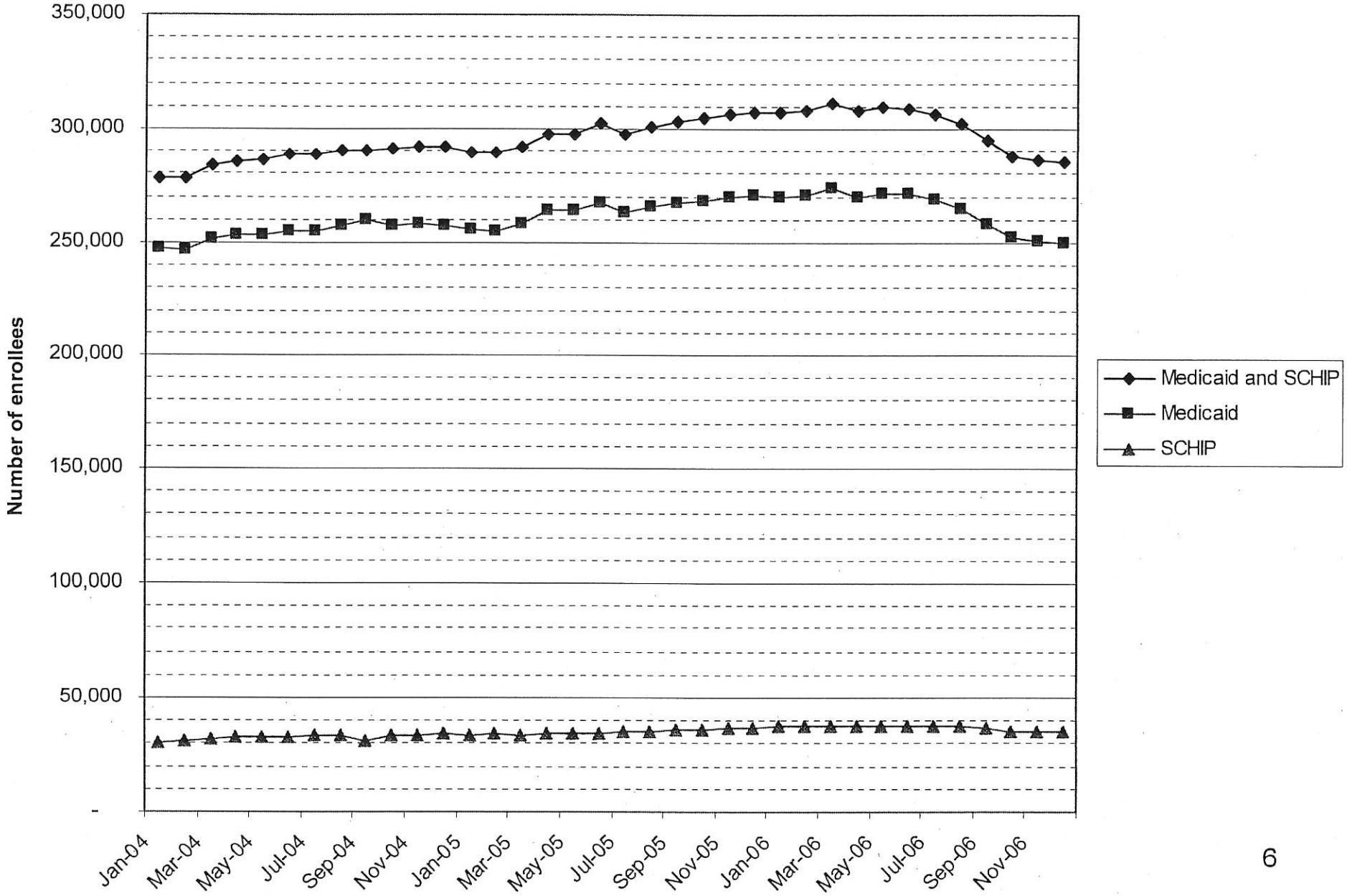

All Kansas Medicaid Beneficiaries
300,000
250,000
200,000
150,000
100,000
50,000
0
Beneficiaries
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
State Fiscal Year


Kansas Medicaid Populations Groups
Beneficiaries
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005
State Fiscal Year
Infants
Children
Adults
Aged
Disabled

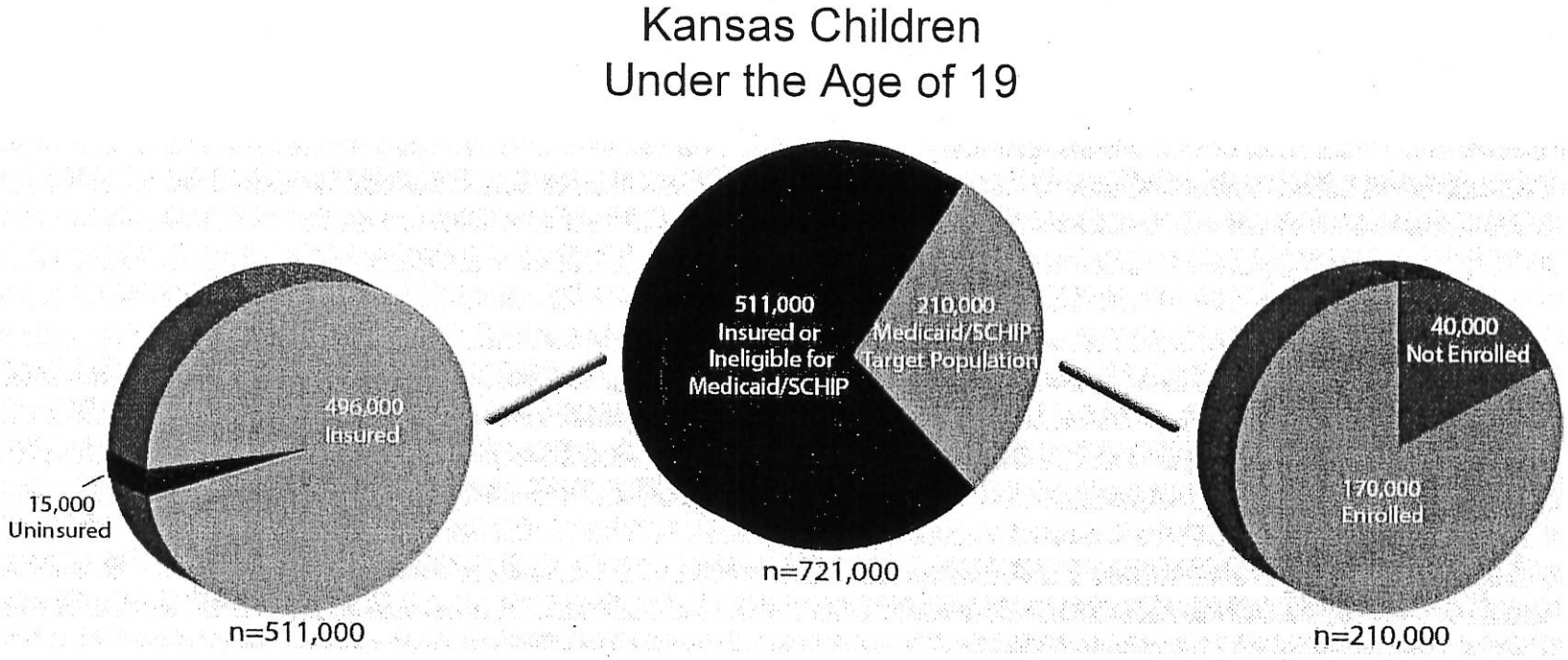

Kansas Regular Medical Medicaid Expenditures
by Population Groups Excluding LTC
$600,000,000
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$0
1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005
State Fiscal Year
Infants
Children
Adults
Aged
Disabled


Regular Medical Medicaid Expenditures Per Person Per Month per Population Group
$1,000
$800
$600
$400
$200
$0
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
State Fiscal Year
Infants
Children
Adults
Aged
Disabled

Enrollment in Medicaid and SCHIP: FY 2004-2007



Health Insurance Status of Kansas Children



Insured or Ineligible for Medicaid/SCHIP

Medicaid/SCHIP Target Population

- Kansas Medicaid/SCHIP programs insure 81 percent of target population

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Executive Director

ANDREW ALLISON, PhD
Deputy Director

SCOTT BRUNNER
Chief Financial Officer

Fact sheet on Deficit Reduction Act requirements for citizenship and identity

Kansans of all ages need health coverage. Unfortunately, in the past six months, between 18,000 and 20,000 Kansans have lost their Medicaid benefits due to the state's compliance with a new federal law, which became effective July 1, 2006, that requires many Medicaid applicants to provide documentation verifying their citizenship and identity. These new requirements, additional work now required for both applicants and state eligibility workers, and the abbreviated implementation timeframe dictated by the Federal government have created a barrier to coverage for both Medicaid and State Children's Health Insurance Program (SCHIP) eligible individuals. KHPA staff have re-engineered enrollment and utilized electronic verification where appropriate, but will not be able to address the new workload without additional resources. Even after resources are made available, the new requirements may have a negative impact on coverage for eligible Kansans. KHPA is recommending that Congress revisit the legislation to consider the impact on states and beneficiaries.

Impact on beneficiaries

How have beneficiaries been affected?

- Significantly increased time and other costs of applying for Medicaid benefits have affected beneficiaries. Although KHPA has made arrangements to electronically "match" with Kansas state birth certificate records, many applicants who were born out of state report the need to purchase and wait for their birth records to be sent by mail.
- Those denied coverage or who are waiting for their applications to be reviewed may experience increased out-of- pocket health costs and reduced access to service.
    - Research clearly indicates that the uninsured have a harder time accessing health care services than those with Medicaid coverage.
    - Those who are uninsured as a result of the new laws may be required to purchase medical services using grocery money or other scarce resources, or to incur medical debt that could otherwise have been avoided.
    - Applicants in Kansas have shared numerous personal stories with the Clearinghouse over the last six months that validate these concerns:
        - A woman who applied for benefits for her and her child two months ago, has still not heard back on whether they are insured. Now, her child is sick.
        - After applying for Medicaid several months ago, a pregnant mother has not yet received her Medicaid card. The baby is due soon and her doctor is now billing her.
        - One family moved from Iowa and is struggling to get their son medication for his extreme case of ADHD. An Iowa doctor sent the prescription twice and asked a pharmacy to pay, but he will no longer fill the prescription and the family cannot get the son into a doctor without HealthWave coverage. The school reports that the son is spending more time in the principal's office than in the classroom because he is not getting his medication.

How has caseload been affected?

- The number of individuals enrolled in Kansas Medicaid or SCHIP has fallen significantly since the requirements went into effect. Caseload in the two programs combined was 308,994 in June 2006 and 285,134 in January 2006. We estimate that 18,000-20,000 of this decline is a direct result of the new verification requirements.
- Of this drop, 2,381 individuals are those whose applications or renewal cases have been closed because they could not provide the newly required documents in a timely fashion.
- Another 16,000 or more are waiting to enroll in the program, or have fallen off the program while waiting to be re-enrolled, as a result of the large backlog of cases the new requirements have created.
- Many of those waiting to be enrolled are eligible citizens. Recent experience indicates that the majority of children and families with pending applications will qualify for coverage under the new requirements when we are able to complete processing.

How have other states been affected by these new requirements?

- Since Kansas first reported on the impact of the new requirements in November, other States across the country have reported similar difficulties.
- Virginia has seen about 12,000 children who have been dropped from the state's Medicaid caseload since July 1, 2006. Iowa, Louisiana, New Hampshire and Wisconsin have experienced similar decreases.
- Like Kansas, Iowa reports the impact of the requirements on eligible citizens who need Medicaid benefits and are not able to obtain coverage.

Caused by new documentation requirements and overworked enrollment process

What are the new documentation requirements?

- The new Federal laws, effective July 1st, do not change eligibility rules but instead require applicants to provide certain documents verifying that they comply with rules governing citizenship and identity. States were notified of this new requirement on June 9, 2006 and the interim final rule was published in the federal register on July 12, 2006.
    - Citizenship: Medicaid eligibility has long been restricted to American citizens and certain legal immigrants such as refugee.
    - Identity: identity isn't an eligibility requirement, per se, but individuals and parents are required to apply on behalf of themselves and their children. In addition, applicants already must provide social security numbers and documentation of family income.
- The new laws require applicants, including those renewing their eligibility, to document citizenship and identity through one of the following criteria:
    - A *primary* document that verifies both citizenship and identity, such as a passport or certificate of naturalization; or
    - Separate *secondary* documents, one verifying citizenship, such as a birth certificate, and another verifying identity, such as a driver's license or school picture ID.

How have the new federal requirements impacted the enrollment process in Kansas?

- The Kansas Family Medical Clearinghouse, which handles about 85% of applications from children and families, receives about 9,500 applications or renewals each month representing about 35,000 individuals, each required to provide at least one new document.
- The number of customer service calls to the Clearinghouse has more than doubled from 23,000 to 49,000 per month.
- The number of voicemails received has increased tenfold from 1,200 to 11,000 per month.
- The number of faxes received has doubled to 6,000.
- Collecting, matching, and verifying these documents have increased the average amount of time required to

complete an application.

Who is being affected by these new rules?

- The new rules apply to all Medicaid applicants and beneficiaries EXCEPT Medicare beneficiaries and those individuals receiving Supplemental Security Income (SSI). Recent federal law changes have also provided additional exemptions to those receiving Social Security Disability benefits and most youth in foster care or receiving adoption support.
- The primary impact of the new requirements is on children and families.
- To one extent or another, all Medicaid applicants may be affected.
    - Applicants who are unable to provide the required documentation in a timely manner are denied coverage.
    - Many applicants – especially children and families -- end up in the backlog that has developed since the new requirements were introduced. These applicants may or may not meet the documentation requirements, but in the meantime experience delays in the application process.
    - Disabled applicants who are not qualified for Medicare or SSI must comply with the new requirements, including children receiving home and community-based services, children needing institutional care, and adults applying for medical assistance through the Presumptive Medical Disability process, many of whom have a mental illness.
    - Because the vast majority of seniors age 65 and over receive Medicare, very few elderly are affected.

We anticipate hospital emergency rooms and other health care providers will bear some of the costs associated with uninsured applicants – especially for pregnant women who have been unable to enroll in Medicaid.

Steps being taken to mitigate the problem

What are the budgetary costs of the new requirements for the state of Kansas?

- In order to meet the new administrative burdens and mitigate the resulting impact on applicants, the KHPA is requesting an additional $1 million in funding for FY 2007 and FY 2008 for the operation of its enrollment clearinghouse.
- These funds will be used by the enrollment contractor to hire 17 new contract staff to work through the backlog of pending applications, reduce waiting times and return eligible applicants to the program.
- KHPA is also requesting to hire an additional 4 state staff in FY 2007 and FY 2008 to address additional volume-related issues at the Clearinghouse, not related to the new citizenship requirements.

What measures are being taken to reduce the impact on beneficiaries?

- Resources at the Clearinghouse have been reallocated and enrollment processing has been adjusted to accommodate the new documentation requirements.
- KHPA is utilizing approved and reliable electronic sources of documentation, including the state's birth and immunization registries.
- KHPA will also be calling on our Congressional delegation to provide an update on the impact of these new laws, to suggest policy alternatives, and to recommend a Congressional review of the legislation.

(Rev 1-19-07)

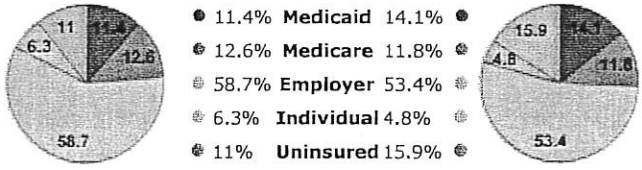
Kansas & United States

State Medicaid Fact Sheet
The Kaiser Commission on Medicaid and the Uninsured

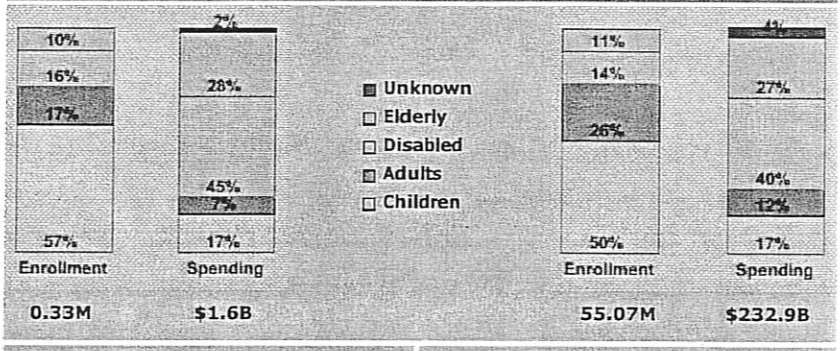
Total Residents, 2004-2005	
KS: 2,671,740	**US:** 292,947,440

Distribution By Insurance Status, 2004-2005

Kansas	United States
11.4% **Medicaid** 14.1%	
12.6% **Medicare** 11.8%	
58.7% **Employer** 53.4%	
6.3% **Individual** 4.8%	
11% **Uninsured** 15.9%	



Medicaid Enrollment and Spending by Group, FY2003



Kansas	United States

	Number		Percent		Notes
	KS	US	KS	US	
Demographic Profile, 2004-2005					
Total Residents	2,671,740	292,947,440	-	-	-
Income					
Poor: Below Federal Poverty Level (FPL)	403,530	50,658,400	15	17	% of total residents
Near-Poor: 100-199% of the FPL	497,530	55,241,860	19	19	% of total residents
Non-Poor: 200% of the FPL and above	1,770,690	187,047,180	66	64	% of total residents
Median Annual Income, 2003-2005	$43,802	$46,037	-	-	-
Age					
Children (0-18)	722,090	77,908,220	27	27	% of total residents
Poor Children	146,450	17,721,680	20	23	% of total children
Adults (19-64)	1,608,740	179,534,430	60	61	% of total residents
Poor Adults	224,760	28,177,220	14	16	% of total adults
Elderly (65+)	340,910	35,504,790	13	12	% of total residents
Poor Elderly	32,330	4,759,500	9	13	% of total elderly
Race/Ethnicity					
White	2,220,250	195,289,750	83	67	% of total residents
Black	145,600	35,539,910	5	12	% of total residents
Hispanic	162,600	43,077,110	6	15	% of total residents
Other	143,300	19,040,670	5	6	% of total residents
Non-Citizen	100,080	21,757,770	4	7	% of total residents
Population Living in Non-Metropolitan Areas	957,800	48,327,760	36	16	% of total residents
Health Insurance Coverage of the Nonelderly, 2004-2005					
Medicaid	247,970	34,802,750	11	14	% of Nonelderly
Children	162,900	20,354,580	66	58	% of Medicaid
Adults	85,070	14,448,170	34	42	% of Medicaid
Uninsured	289,330	46,118,230	12	18	% of Nonelderly
Children	50,050	9,035,420	17	20	% of uninsured
Adults	239,280	37,082,810	83	80	% of uninsured
Poor: Below Federal Poverty Level (FPL)	111,540	16,749,520	39	36	% of uninsured
Near-Poor: 100-199% of the FPL	91,860	13,345,370	32	29	% of uninsured
Employer Sponsored Insurance	1,572,020	156,430,100	67	61	% of Nonelderly
Individual Insurance	166,100	13,928,090	7	5	% of Nonelderly
Other Public	55,410	6,163,480	2	2	% of Nonelderly

	Number		Percent		Note
	KS	US	KS	US	
Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2004-2005					
Uninsured	-	-	-0.2	0.3	% point change
Medicaid	-	-	0.0	-0.1	% point change
Employer-Sponsored	-	-	0.7	-0.3	% point change
Individually Purchased	-	-	0.1	-0.1	% point change
Medicaid Enrollment					
Total Enrollment, FY2003	325,100	55,071,200	12	19	% of total residents
Children	184,400	27,263,000	56.7	49.6	% of Medicaid enrollees
Adults	55,200	14,257,300	17	25.6	% of Medicaid enrollees
Blind and Disabled	-	-	-	-	% of Medicaid enrollees
Elderly	32,700	5,871,700	10.1	10.5	% of Medicaid enrollees
% Enrolled in Managed Care, 2004	-	-	56	62.9	% in managed care
Medicaid Expenditures					
Total Medicaid Spending in Millions, FY2005	$1,981	$305,337	-	-	Including DSH
Disproportionate Share Hospital Payments (DSH)	$64	$17,089	3.2	5.6	% of total spending
Acute Care	$1,080	$182,604	54.5	59.8	% of total spending
Rx Drugs	$203	$30,658	18.8	16.8	% of acute care spending
Long Term Care (LTC)	$838	$105,644	42.3	34.6	% of total spending
Nursing Home	$340	$46,949	40.5	44.4	% of LTC spending
Home/Personal Care	$420	$41,277	50.2	39.1	% of LTC spending
Per Enrollee Medicaid Spending, FY2003					
Total	$4,856	$4,072	-	-	-
Children	$1,499	$1,467	17.1	17.2	% of total spending
Adults	$2,058	$1,872	7.0	11.5	% of total spending
Blind and Disabled	$4,856	$4,072	-	-	% of total spending
Elderly	$14,027	$10,799	28.4	27.2	% of total spending
Unknown	-	-	-	-	% of total spending
Other Medicaid Spending Measures					
Federal Contribution per State Dollar, FY2006	-	-	-	≥50	federal matching rate
General Fund Spending on Medicaid, SFY2004	-	-	12.7	16.9	% of general fund spending
Medicaid Eligibility Levels by Annual Income and FPL, 2006					
Working Parents	$5,916	$10,849	36	65	% of federal poverty level
Pregnant Women	$24,135	$21,400	150	133	% of federal poverty level
Infants	$24,900	$22,078	150	133	% of federal poverty level
Children 1-5	$22,078	$22,078	133	133	% of federal poverty level
Children 6-19	$16,600	$16,600	100	100	% of federal poverty level
Medicaid and Medicare Dual Eligibles					
Total Dual Eligible Enrollment, 2003	-	-	15	14	% Medicaid enrollees
Total Dual Eligible Spending in Millions, 2003	-	-	50	40	% of all Medicaid spending
Total Medicare Enrollment, 2005	396,527	42,394,926	14	14	% of total residents
Estimated Annual "Clawback" Payment, 2006	$44,048,082	$6,605,675,559	-	-	-
SCHIP					
Eligibility Income Level for Family of 3, 2006	$33,200	-	200	-	% of federal poverty level
Current SCHIP Enrollment, December 2004	-	-	-	-	% growth, 2003-2004
Total SCHIP Spending, FY2004	-	-	-	-	% of health spending

Sources and Notes

All data are drawn directly from ***statehealthfacts.org***, Kaiser's continuously updated database for state-level health data. More detailed notes and sources are available by following the online links from each topic on the fact sheet.

Demographic Profile

Total Residents, Income, Age, Race/Ethnicity, Citizenship, Population Living in Non-Metropolitan Areas

Source: KCMU and Urban Institute analysis of the Current Population Surveys, March 2005 and 2006.
Notes: These demographic data may differ from Census Bureau figures due to grouping by health insurance unit (HIU) rather than household. A Metropolitan Statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 population. A Non-Metropolitan Statistical Area lacks at least one urbanized area of 50,000 or more inhabitants.

Median Annual Income

Source: U.S. Census Bureau, Current Population Survey, 2004, 2005, and 2006 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2003-2005

Health Insurance Coverage

Medicaid, Uninsured, Medicaid, Employer-Sponsored Insurance, Individual Insurance, Other Public, Percentage Point Change in the Rate of Coverage of the Nonelderly Population (0-64 years old)

Source: KCMU and Urban Institute analysis of the Current Population Survey, March 2005 and 2006.
Notes: State figures are based on pooled 2004 and 2005 data; U.S. figures are based on 2005 data.

Medicaid

Total Enrollment

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2003.

% Enrolled in Managed Care

Source: Medicaid Managed Care Penetration Rates by State as of December 31, 2004, CMS, DHHS.

Total Medicaid Spending in Millions

Source: Urban Institute estimates for KCMU based on CMS Form 64 for FY2005.
Notes: All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments; do not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about $316.5 billion in FY2005.

Per Enrollee Medicaid Spending and Distribution by Group

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2003.

Multiplier and Federal Matching Rate

Source: KCMU calculations based on the FMAPs as published in the Federal Register.
Notes: The multiplier is based on the FMAP and represents the amount of federal funds a state receives for every dollar it spends on Medicaid. The rate varies year to year and is based on each state's relative per capita income. It ranges from a low of 50% to 76%, averaging roughly 60% nationally. For FY2006, the rate for Alabama was 1:2.30 (69.51%).

State Medicaid Spending as % of State General Fund

Source: 2004 State Expenditure Report, National Association of State Budget Officers
Notes: A state's general fund is the predominant fund for financing a state's operations.

Medicaid Eligibility Levels

Source: In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families, The Center on Budget and Policy Priorities for KCMU, October 2005; and Medicaid Eligibility, DHHS, CMS.
Notes: All dollar figures represent the annual income for a family of three. For Working Parents, the U.S. figures represent the median annual income in dollars and as a percent of the FPL. For other groups, the U.S. figures represent the federal minimum annual income in dollars and as a percent of the FPL.

Medicaid and Medicare Dual Eligibles

Sources: *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Urban Institute for KCMU, July 2005. CMS Statistics: Medicare State Enrollment, CMS. *An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit*, KCMU, March 2006.

SCHIP

Eligibility Income Level for a Family of Three

Source: In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families, The Center on Budget and Policy Priorities for KCMU, October 2005; and *Medicaid Eligibility*, DHHS, CMS.
Notes: The levels are for separate SCHIP programs only. The following states do not have a separate SCHIP program: AK, AR, DC, HI, LA, MN, MO, NE, NM, OH, OK, RI, SC, TN, WI.

Current SCHIP Enrollment

Source: Collected by Health Management Associates for KCMU. Data as of December 2004.
Notes: Figures represent the current monthly enrollment. AR and TN phased out their Medicaid expansion programs in September 2002.

Total SCHIP Spending

Source: FY2004 SCHIP Expenditures (state and federal), CMS, Special Data Request.

Abbreviations

CMS: Centers for Medicare and Medicaid Services
DHHS: U.S. Department of Health and Human Services
FMAP: Federal Medical Assistance Percentage
FPL: Federal Poverty Level (The FPL for 48 states was $16,090 for a family of 3 in 2005; Alaska $20,110 and Hawaii $18,510.)
KCMU: The Kaiser Commission on Medicaid and the Uninsured
MSIS: Medicaid Statistical Information System
SCHIP: State Children's Health Insurance Program

Presentation to the Joint Meeting
of the
Senate Public Health and Welfare Committee
and the
Senate Ways and Means Committee
March 15, 2007

Billie G. Hall, President & CEO, Sunflower Foundation

- Senator Barnett, Senator Umbarger, committee members and guests: I am Billie Hall, President & CEO of the Sunflower Foundation.

- I want to thank you for the opportunity to participate in today's discussion about enrolling eligible Kansas children in both HealthWave and Medicaid programs and how these efforts, coupled with the potential for expanding health coverage to all children between birth and five, will improve not only access to care but quality and cost of care.

- The Sunflower Foundation believes that all children should have health care coverage. Health coverage means access to health care and a medical home. Children who have health care coverage are more likely to stay healthy and grow to their potential. Healthy children do better in every aspect of life, including school. It is also a fact that children who receive consistent, preventive care are less likely to use emergency room services for routine illnesses or non-acute care. It is more cost-effective to keep children healthy than to treat illness, especially chronic illness and disease that can often be prevented through good, routine medical care.

- That is why we have recently partnered with other health foundations in Kansas, including the Health Care Foundation of Greater Kansas City, the REACH Healthcare Foundation and the United Methodist Health Ministry Fund, to host roundtable discussions on how to facilitate enrollment of Kansas children in public health insurance programs. These roundtable discussions have included

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representatives of the Kansas Health Policy Authority, provider organizations, consumer organizations, and children and health advocacy organizations.

- The purpose of these roundtable discussions is to learn more about the barriers to enrollment and to share best ideas and solutions for addressing those barriers and facilitating enrollment. Not surprisingly, there are many committed organizations at both the state and community level aware of this issue and doing what they can to connect children to insurance. In fact, we believe this incredible work around enrollment is one of the best examples of a public/private partnership we have seen. I think I can say that those involved want the public health insurance system to work for the people it was intended to serve and, at the same time, they want the system to be accountable and credible for the people that pay for it.

- The point of today's conversation is to focus on how much is going on in Kansas to address the barriers to enrollment. There are barriers – some of which may be addressed by education, awareness, outreach and process. Some of the barriers may be more complex and solutions may require going beyond the usual. That's why we are excited about a recent study, completed by Kansas Action for Children, that examines the efficacy of using the free and reduced school lunch program as a vehicle for identifying eligible children and working in partnership with schools and communities to enroll children. The early results are promising. Sunflower Foundation provided support for this project and will continue working with Kansas Action for Children on the feasibility of testing this enrollment strategy in Kansas schools.

- In addition to the school-based approach to enrolling children in public health insurance, there are many community-based initiatives that are going on across Kansas. We have asked representatives of two organizations to share their stories and strategies for connecting families and children to health coverage. These organizations work on the "front line" to help eligible children and families enroll in public health insurance programs. They know the challenges that families face

when they are living at the lowest income levels. There is no greater comfort for a parent than to know that their children are healthy and that they have a place to go if they get sick. I believe you will find it encouraging to see how much effort and commitment there is at the community level to help children and families – not only in times of need, but also in helping families live better and improve the quality of their lives.

- First, you will hear from Krista Postai, CEO of Community Health Center of Southeast Kansas, Pittsburg, who will share with you from a safety net clinic perspective. Secondly, Pat Cameron, with Inter-Faith Ministries, Wichita, will explain the Benefit Bank concept, which is an enrollment tool under development for regional and, ultimately, statewide use.

- Again, I thank you for the time you have committed today to exploring concerns about and opportunities to improve facilitated enrollment efforts in our state. We know there are many issues around health coverage for children that need careful attention, and enrollment is certainly one of them. And we are here to demonstrate our willingness to work together in a public/private partnership to help break down enrollment barriers. But our sincere hope is that the policy discussion on expanding coverage for all children birth to five remains a priority while work continues on improving enrollment.

Testimony of Krista Postai, CEO, Community Health Center of Southeast Kansas
March 15, 2007

Good afternoon, I am Krista Postai, CEO of the Community Health Center of Southeast Kansas – one of 10 federally qualified health centers in the state of Kansas. Located in Pittsburg, we provide medical, dental and mental health services to more than 9,300 patients with almost 30,000 patient visits over the last 12 months. We are currently in the midst of a major expansion project – going from a 1,500 sq. ft. doublewide – to a new facility 10 times that size to accommodate our 425% growth over the last three years.

At the same time, we are closely watching our finances to ensure that we'll be able to support our new building. With federal and state funding comprising only 16% of our budget, we are very dependent on patient revenues – especially Medicaid which represents about 50% of our patients.

We monitor the impact of any changes to our environment but even we were shocked at what occurred after July 1 when birth certificates became a requirement to qualify for Medicaid. In six months, our number of uninsured children increased 42% while our services increased 68% indicating that those we were seeing were sicker. Our providers expressed concern that parents were waiting too long – even though we provide care regardless of ability to pay. One little boy went from our pediatrician's arms into a helicopter to Children's Mercy in Kansas City. Total charges for the services we provided to these uninsured children between July and December was $30,000 of which we received patient payments of $1,300.

So when I was asked to speak today on what has been described by some as an "innovation," please know that what we started in Pittsburg last November was born out of both frustration and desperation.

Space and money prevented us from having a social worker on staff and so I contracted with other agencies thinking that folks with 20+ years experience would understand Medicaid. I quickly discovered that my billers knew Medicaid better than they did. We agreed to be an SRS Access Point thinking that would mean something. Not to be disrespectful, but all it got us was a brochure rack with forms….

And then last November a woman walked in our office that had worked for SRS for 30 years and was retiring and wanted to help…

One day a week we give her names of kids and pregnant women who are listed as uninsured and she sits in a corner of the doctor's office with a clipboard…and one day a week over her first two months she went through 131 patients and, so far, has gotten 46 of them coverage either through Medicaid or HealthWave. About 1 in 3. Face to face she sits down with them, goes to their homes, calls them at night…doing whatever it takes…and then shepherding through the system.

To get around the backlog at the Clearinghouse in Topeka – where most applications are processed -- she helps them fill out the long forms which can be processed at the local SRS office. While much harder, her experience is – at least in our county which is number five out of the 105 Kansas counties for number of people living in poverty – that they will probably also qualify for other services, such as food stamps.

She then goes to the SRS office on Friday afternoons – when things are a little quieter – and an employee there reviews the applications, checks the status of pending apps already

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at the Clearinghouse and "red letters" – an internal method of prioritizing -- those apps that are complete and had been hanging for months.

Along the way we discovered lots of things….many had applied but had not heard anything for months. Many had moved in the meantime. A lot of them didn't understand how to get a birth certificate…or have the money to do so.

We also discovered that people wanted coverage for their children – only two of the 131 we contacted rejected our help…they would show up to fill out forms, they would bring pay stubs…they did what we asked because we are their medical home, we take care of them and their children, we have people who speak their language or understood that they had never been taught to read because 1 in 3 in our county can't and are embarrassed to ask for help…

So pleased with our success, we did some math and estimated that at least 800 children in our county are eligible for Medicaid or HealthWave, but aren't signed up….so we contacted our school district and next month when they hold kindergarten enrollment – we're setting up a table….

This one won't be one of those neatly arranged ones with brochures on HealthWave with someone with arms folded looking bored behind it – and I can say this because we've done more than our share – this will use every trick I learned from timeshare salesmen in Branson…including the free show tickets if we have to…and we're going to be parked next to the lunch ladies who have been getting information on the kids who qualify for free and reduced lunches for years…

I guarantee you that by the end of the day, we'll know the status of almost every child who has been through there…and we'll have every child potentially eligible on our radar…the neat thing about enrollment, is that they have to bring a birth certificate and identification…a lot of what they need will be in their hands and we're going to try and see if what worked in our clinic will work in our schools. And, if that works, our next stop will be child care centers…

I've talked enough, but before I go let me tell you what happened to that little boy lifeflighted to Children's Mercy. He's home and he's healthy. He recovered from a potentially fatal disease if left untreated. Our interpreter went to his home last week and his mother met her at the door with a pile of bills and an envelope full of cards looking confused…when Colleen looked closer she realized that enclosed were medical cards going all the way back to November…you see, this was one of the first families we sat down and worked with on the paperwork…Colleen got on the phone and called our clinic where they had a $100 bill, then the ambulance with a $1,300 bill, then the hospital with its $2,000 bill and finally, Children's Mercy with a stack totaling several thousand. In 30 minutes this hardworking, but poor family, was out of debt. And they had cards in hand so they would never feel like they have to wait again until their child was so desperately ill…

One person, one child at a time…that's how it's done. At least that's how we're doing it.

Because I never want to wake up and read a child died in Pittsburg, Kansas because his family couldn't afford healthcare…and I know you don't want that either.

Thank you.

THE KANSAS BENEFIT BANK

WHAT IS THE KANSAS BENEFIT BANK?

The Kansas Benefit Bank is a one-stop shop for services and benefits that support low-wage working families. Congregations, social service providers, government agencies, businesses, libraries and schools can serve as sites for The Kansas Benefit Bank. Staff or volunteers using user-friendly, web-based software developed by Solutions for Progress will simplify the application process for benefits such as Food Stamps, health insurance, childcare subsidies, and tax credits and refunds.

WHY IS THE KANSAS BENEFIT BANK NEEDED?

Many low-income people who are eligible for benefits that could improve their economic situation don't apply for these benefits. For example, only 57% of eligible Kansans apply for and receive food stamps; 39,000 children eligible for HealthWave or Medicaid are not enrolled in these programs, and about 15% of those eligible for the Earned Income Tax Credit do not apply for it, even though the EITC could bring these families an average of over $1,200. Eligible people often don't apply for these benefits because they don't know about them, assume they're not eligible, get frustrated having to go to multiple agencies to access the benefits, or are intimidated by complicated application forms.

HOW WILL THE KANSAS BENEFIT BANK MAKE A DIFFERENCE?

Because of its multiple sites and multiple application capacities, we project that The Kansas Benefit Bank will significantly increase applications for Health care coverage under HealthWave and Medicaid, averaging $1800 per application; Food Stamps, averaging $2,500 per application; the Childcare Subsidy, averaging $4,000 per application; and refundable tax credits, averaging $1,000 per application. The numbers of people served and the benefits they receive will continue to increase as The Kansas Benefit Bank expands state-wide.

WHEN WILL THESE BENEFIT APPLICATIONS BE AVAILABLE?

The tax filing software is available now. Low-income people in Wichita, Dodge City, Garden City, and Great Bend are receiving assistance in filing for federal tax benefits. By June, software for medical benefits (Medicaid and HealthWave) will be available, and by September, software for Food Stamps, the Child Care Subsidy, Low Income Energy Assistance, and Voter Registration. By the 2008 tax season, we expect to have the capacity for filing state taxes and possibly the Homestead Exemption.

HOW CAN MY ORGANIZATION BECOME A BENEFIT BANK SITE?

We're looking for sites anywhere in Kansas willing to use The Benefit Bank software to help people access the benefits to which they are entitled. We can provide you with information about site responsibilities, training events, and costs.

For more information about The Kansas Benefit Bank, contact Karole Bradford or Pat Cameron at Inter-Faith Ministries, 829 N. Market, Wichita, KS 67214; (316) 264-9303; kbradford@ifmnet.org; pcameron@ifmnet.org

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The Kansas Benefit Bank
Inter-Faith Ministries

- The Benefit Bank will boost enrollment in health care and other benefit programs in Kansas.

- The Benefit Bank requires a computer, software, a printer, and trained counselors to help narrow the gap between those who are eligible for, and those who are actually receiving, the benefits of these programs.

- The Benefit Bank is a web-based, counselor-assisted software program that calculates benefit eligibility and helps the applicant apply for these benefits.

- The software guides the applicant through the application process. The software asks questions of the applicant, written at a 4th grade reading level and available in English and Spanish. The information provided by the applicant is imported into the form that appears at the end of the process.

- The software retains information entered in previous applications, so there is no need for the applicant to repeat this information for subsequent applications.

- The software is designed by Solutions for Progress and is endorsed by national faith-based organizations. The Benefit Bank is operational in Philadelphia, Florida, and Ohio.

- The Sunflower Foundation and the United Methodist Health Ministry Fund have provided Inter-Faith Ministries with the capacity to develop all of the software, starting with HealthWave, Medicaid, and Food Stamps by June 2007.

- The next three years will focus on a demonstration project in southwest Kansas, with the long-term goal to have sites for The Kansas Benefit Bank in every county.