Chapter 15: Eligibility Policy and Operations of Public Insurance Programs

Executive Summary

Description

The core purpose of this review is to evaluate eligibility policy and operations and to develop recommendations in both areas for the KHPA Board. This review describes and assesses Medicaid eligibility rules and eligibility policies, as well as the critical components of the eligibility determination process: Operations, Automated Systems and Program Integrity. Since the Medicaid program targets low-income populations, the report also includes information that describes poverty in Kansas, and state and federal minimum wage levels (Appendix C and D). Future reviews will focus on enrollment, with an evaluation of historic changes in enrollment and performance and outcomes for the Medicaid enrollment process.

To participate in the Kansas Health Policy Authority's (KHPA) public health insurance programs, a person must be determined to be eligible. Staff at the KHPA or Department of Social and Rehabilitation Services (SRS) review a consumer's application for medical coverage and decide if the person is eligible based on certain criteria. Public health insurance coverage is available through three primary programs; Medicaid, SCHIP (or HealthWave 21) and MediKan, as well as several smaller targeted programs. These programs provide a payment source for services to meet the health care needs of the poor elderly, persons with disabilities, pregnant women, children, very low-income families and other needy persons.

Key Points

- Determining who is eligible for our programs is becoming more technically complex based upon changes in state and federal law. Adoption of improved computer technology to increase accuracy and efficiency of eligibility determinations is essential for the future of KHPA programs. A new automated eligibility information system is needed to support program policy and ensure accurate and consistent implementation of that policy.
    - Increased computer automation of the eligibility determination will streamline the processes and result in more timely, accurate, and consistent determinations.
    - Implementation of a more flexible and sophisticated system will facilitate the transition of public medical programs from traditional outdated welfare models to more innovative approaches to provide public health insurance coverage.
    - KHPA and SRS have collaborated for the past year on the design of a web-based eligibil-

ity determination system.

- KHPA is in the process of acquiring and implementing an innovative online application system for consumers to use to apply for public insurance.

- KHPA and its fiscal agent, EDS, recently implemented a multi-functioning web-based tool which gives consumers information about their benefits and processes to be completed for maintenance of their medical assistance.

- A web based presumptive eligibility (PE) screening tool will be incorporated into the online application, improving accuracy of determinations and increasing the number and location of sites where PE determinations can be completed.

- Although eligibility policy encompasses numerous groups and special categories of individuals, policy gaps remain, leaving many vulnerable and very low-income Kansans without access to public health insurance coverage.

KHPA Staff Recommendations

- Promote community-based outreach by placing state eligibility workers on-site at high-volume community health clinics. Eligibility workers out-stationed at these clinics will be able to do full determinations at sites serving populations most likely to be eligible for public health insurance.

Cost to provide out-stationed eligibility workers

	FY 09	FY 10	FY 11	FY 12	FY 13	5 Year Total
State General Fund (SGF)	$0	$560,000	$565,000	$580,000	$595,000	$2,300,000
Total	$0	$1,102,000	$1,130,000	$1,160,000	$1,190,000	$4,582,000

- Expand access to care for needy parents by increasing the eligibility income limit to 100% Federal Poverty Level (FPL), ($1,467 per month for a family of three). Current coverage levels are no greater than 30% FPL ($440 per month for a family of three), and fall each year as inflation eats away at the fixed dollar threshold for eligibility.

Cost to expand Medicaid for parents (caretakers) up to the federal poverty level

100% FPL	FY 09	FY 10	FY 11	FY 12	FY 13	5 Year Total
SGF	$0	$10,500,000	$41,000,000	$65,350,000	$73,500,000	$190,350,000
Total	$0	$31,000,000	$102,000,000	$162,700,000	$183,000,000	$478,700,000

Additional Options Identified by KHPA Staff

- Change household composition rules for pregnant women so that they are consistent with those used for other medical populations, which would have the effect of increasing the number of eligible women.

- Expand coverage to childless adults from the current age of 19 years of age to the age of 21.

- Expand Medically Needy coverage to parents and other caretakers of children to provide catastrophic coverage.

- Medicaid's support for low-income Medicare enrollees through (a) providing access to full prescription drug coverage and (b) paying the Part B premium by eliminating asset tests and increasing the income limit for Medicare Savings Programs (MSPs) up to 185% Federal Poverty Level (FPL).

- Increase the Protected Income Limit for medically needy (primarily elderly and disabled people who do not yet qualify for Medicare) so that it is tied to the FPL. The last increase for this program was in 1994 and it is currently at $475 per month for both single people and couples (55% and 41% FPL respectively).

Overview

The core purpose of this review is to evaluate eligibility policy and operations and to develop recommendations in both areas for the KHPA Board. This review describes and assesses Medicaid eligibility rules and eligibility policies, as well as the critical components of the eligibility determination process: Operations, Automated Systems and Program Integrity. Since the Medicaid program targets low-income populations, the report also includes information that describes poverty in Kansas, and state and federal minimum wage levels (in the Appendix C and D). Future reviews will focus on enrollment, with an evaluation of historic changes in enrollment and performance and outcomes for the Medicaid enrollment process.

To participate in the Kansas Health Policy Authority's (KHPA) public health insurance programs, a person must be determined to be eligible. Staff at the KHPA or Kansas Department of Social and Rehabilitation Services (SRS) review a consumer's application for medical coverage and decide if the person is eligible based on certain criteria. Public health insurance coverage is available through three primary programs; Medicaid, SCHIP (or HealthWave 21) and MediKan, as well as several smaller targeted programs. These programs provide a payment source for services to meet the health care needs of the poor elderly, persons with disabilities, pregnant women, children, very low-income families and other needy persons.

The Application Process

Medicaid eligibility determinations are made by qualified staff from the Kansas Health Policy Authority (KHPA) and the Kansas Department of Social and Rehabilitation Services (SRS), who are assisted by sub-contractors employed at HealthWave Clearinghouse. These determinations are based on whether an individual fits into a specific Medicaid eligibility group and meets both non-financial and financial criteria. Once determined eligible, beneficiaries are required to report any changes that affect their eligibility and a complete redetermination of eligibility occurs annually. The operation of Kansas Medicaid's eligibility process is described in greater detail below.

Eligibility Policy

Public health insurance coverage is available through three primary programs; Medicaid, SCHIP (or HealthWave 21) and MediKan, as well as several smaller targeted programs. These programs provide a payment source for services to meet the health care needs of the poor elderly, persons with disabilities, pregnant women, children, very low-income families and other needy persons. Often referenced as the payer of last resort, all programs are means-tested (based on level of income or assets), but each program utilizes different eligibility criteria and standards.

Federal rules greatly influence state Medicaid and SCHIP programs, since federal funding for both operating expenses and coverage of medical services is dependent upon adherence to various federal requirements.

Of KHPA's three major public health insurance groups, Medicaid provides health insurance coverage to the largest number of people and is the most complex. Medicaid also provides the historical and policy foundation underlying the MediKan and SCHIP programs. The Kansas Medicaid program includes 35 separate categories of coverage.

Introduction to Eligibility Groups

In order to qualify for benefits, an individual must fit into a Medicaid eligibility group. This is a fundamental principle of Medicaid eligibility. A Medicaid eligibility group is comprised of persons who share defined common characteristics and meet specific eligibility requirements. Medicaid eligibility groups show great variation, having arisen through 40 years of policy innovation and expansion of Medicaid since its creation in 1966 as Title XIX of the Social Security Act. Eligibility groups range from very broad to narrow and targeted.

As a requirement of its Medicaid program, the state must provide coverage to individuals who meet the eligibility requirements for mandatory eligibility groups. The state has the option to provide Medicaid coverage to other groups of individuals, known as optional groups. Coverage of these optional groups provides states with a mechanism to expand coverage to a subset of an existing population. Regardless of the groups the state chooses to cover, there are federally mandated standards and limitations that the state must follow, even when the group is optional.

Examples of Basic Medicaid eligibility groups include:

- Pregnant Women
- Children Under Age 19
- Persons determined disabled by Social Security Standards
- Seniors age 65 and older

Medicaid eligibility groups can also be quite specific, providing coverage to particular subgroups of individuals. These well-defined groups are usually created by targeted federal expansions of eligibility. Some examples of specific groups include:

- Women diagnosed with breast or cervical cancer by the Early Detection Works program
- Medicare beneficiaries
- Disabled individuals with earned income
- Children receiving Adoption Support or Foster Care payments

Finally, medical eligibility groups can be tied to other programs. These narrow eligibility criteria can complicate eligibility policy implementation in a state. Some examples of very specific groups include:

- Individuals who would be eligible for cash assistance if they were not in a medical institution.
- Individuals receiving only an optional state supplement which is more restrictive than an optional state supplement the individual could receive under SSI.
- Disabled individuals whose earned income exceeds the limits for SSI, but who are still considered SSI recipients under Section 1619(b).

Eligibility Tests

Another basic principle of Medicaid eligibility is that an individual must meet both financial and non-financial criteria for the specific Medicaid eligibility group.

Non-Financial Criteria

Non-financial eligibility criteria are used for almost all individuals seeking eligibility for public health insurance. Non-financial factors include age, state residency, U.S. citizenship or satisfactory immigration status, verification of citizenship or immigration status and Social Security Number. In addition, individuals must complete an application, cooperate with the agency by supplying necessary information to make a determination, and provide to the agency any third party payments from other sources of medical support and medical insurance. Most non-financial criteria are established at the federal level.

Financial Criteria

Financial eligibility requirements consist of income and/or resource limits. Financial eligibility criteria vary significantly among the various eligibility groups. It is helpful to understand the basis for these varying standards.

Originally, eligibility for Medicaid was tied to the receipt of cash assistance – Aid to Families with Dependent Children (AFDC) for children, pregnant women, parents and caretakers or Supplemental Security Income (SSI) for aged, blind and disabled individuals. Over the years, coverage was extended to persons who were not getting cash assistance, for example, poverty level children. After federal welfare reform passed in 1996, Medicaid eligibility was de-linked from cash assistance.

Yet still today, these other means-tested programs are the starting point for the financial eligibility criteria used by Medicaid. Medicaid eligibility groups for families, children and pregnant women use the counting rules for income and resource standards applied in its AFDC program on July 16, 1996. This is the date established as a point of reference in federal welfare reform legislation. These groups are linked and often called family medical programs.

Medicaid eligibility groups for the elderly and disabled are linked to the income and resource standards and methodologies of the SSI program as the benchmark level. These groups are often labeled elderly and disabled medical programs.

Although benchmarks and counting rules for both family medical and elderly and disabled groups

have been established, there is flexibility to make changes to the income and resource levels. Generally, states are allowed to adopt less-restrictive income and resource criteria. States cannot adopt more restrictive criteria than those that exist in the benchmark cash assistance programs.

Individuals who fit into a Medicaid eligibility group and meet all financial and non-financial eligibility criteria for that group are deemed eligible to receive coverage. It is not uncommon for individuals to fit into more than one group, for example, a pregnant woman with a disability. A hierarchy of coverage has been established for these situations, as coverage must be considered for all categories.

Featured Eligibility Groups

This section provides in depth reviews of six different eligibility groups, including a brief history and some background information about each specific group. The reviews identify gaps in coverage and other issues related to current eligibility policy. To help illustrate the kinds of families and individuals covered, or not covered, in each of these groups, case examples are described in Appendix A. Some examples are fictional, but representative of actual situations. Others, which are labeled as such, are actual examples of Kansans who have given written permission for their stories to be shared in this way**.** Finally, suggestions for improvements to the program are included.

TAF-related Medical Group

Low income families which include a minor, dependent child are covered under the TAF-related medical groups. Families may be headed by parents, relatives such as grandparents, or other caretakers who have primary responsibility for the child. Both adults and children are potentially eligible for coverage under this program.

Description

Three distinct medical groups comprise the Temporary Assistance for Families (TAF) program: Caretaker Medical (MACM), Transitional Medical or TransMed and Extended Medical. These labels reflect the historic linkage to cash assistance programs. Kansas has, for the most part, baseline eligibility requirements and provides coverage only at minimum levels which do not adjust to inflation and do not rise with poverty thresholds.

Families qualify for MACM only if they have a very low income - less than 30% of the Federal Poverty Level (FPL). The eligibility determination is further complicated by the methodology used to determine the income standard. The MACM income standard is not tied to the poverty level or other common standard expected threshold. It is actually based on the TAF (or welfare) need standard where factors such as county of residence (Shelter Groups) and living arrangement (shared vs. non-shared living) are considered. For example, a parent of two children living in Topeka can only receive medical coverage if the family income is less than $403 gross per month. In Garden City, that same family has an income limit of $386. If these families are sharing an apartment with a friend, the income limits fall to $359 for the family in Topeka and $349 for the family in Garden City. Monthly rent for a 1-bedroom apartment in Topeka is about $300, necessitating the sharing of a home with friends, family, or a roommate. When families share homes

they are subject to the shared living reduction, which reduces the income limit allowed to qualify for medical coverage. Although a small earned income disregard is also considered for families with wages ($90/month), the vast majority of people who qualify initially are not employed.

Once families qualify for MACM, they may be eligible for additional programs when their income increases beyond the MACM income limits. The Transitional Medicaid program (TransMed) assists as a safety-net to families who have been receiving MACM coverage and then gain employment which puts their income over the required limit. Instead of losing medical coverage immediately, the family receives up to 12 additional months of coverage. Although the program provides a necessary transitional benefit to the consumer, it is a difficult program to administer due to various reporting criteria and mandated eligibility checks. For example, all adults in the family are initially approved for a six-month period. At the end of this timeframe, they are expected to complete a review and must submit proof of all income received in their first three months of TransMed coverage. If their income meets additional income guidelines, the adults can then qualify for an additional six months of coverage. The children, however, continue to remain eligible for the entire 12-month period regardless of the adult's compliance with the reporting requirements.

The Extended Medical program is the second transitional program for families who have received child or spousal support which results in countable income in excess of the limit. The adults in the Extended Medical group receive an additional four months of coverage, while the children receive an additional 12 months.

Any change to eligibility in the basic coverage group, MACM, will also have an effect on the TransMed and Extended Medical groups, as these groups are dependent upon receipt of MACM. When compared to coverage levels in other states, Kansas rates near the bottom. A report from the Kaiser Foundation places Kansas at or near the bottom 10 states when ranking income eligibility levels for parents and caretakers.

Options to Fill Policy Gaps

- *Extend Medicaid to poor working parents.* Eligibility requirements for low income parents are very strict, essentially resulting in a program for the unemployed. Offering health coverage to the working poor will not only help to ensure a healthier work force, but could also help set an example for the next generation by demonstrating the importance of maintaining adequate health insurance. This recommendation is comprised of three complementary policies that further de-link Medicaid from cash assistance programs and allow the program to operate more like modern insurance.

    - Equalize coverage across the state by simplifying eligibility determination for families. Eliminate the complexities in the current determination process, specifically the Shelter Group and shared/non-shared living factors and apply a standard income deduction to all household members equalizing access to the program for all low-income families in Kansas.

    - Expand coverage to families with incomes below the federal poverty level. Adopt a standard, reasonable income level for coverage, helping to eliminate the unemployment incentive. Indexing to the poverty levels, will provide some protection for future generations of very poor Kansans from the effects of inflation.

    - Adopt 12 month Continuous Eligibility for Parents. Because it is tied to cash assistance,

parental eligibility for Medicaid is re-determined each month. As with similar expansion for poverty-level children, these re-determinations would be conducted annually once Medicaid is fully de-linked from welfare. Current policies which require monthly income determinations may restrict a wage earner's desire to accept a new job or work more hours. Ensuring low income families have access to health care for at least 12 months can encourage advancement in the work force without the fear of losing health insurance. Continuous coverage mimics job-based enrollment cycles and reduces the administrative burden of monthly re-determinations.

- *Simplify TransMed Eligibility Policy and Procedures.* Simplified eligibility processes would encourage those families who achieve slightly higher wages to continue to receive health care coverage. Relaxing the rigid reporting criteria for continued TransMed eligibility will allow eligible individuals to retain insurance. Using interfaces and passive reporting options are possible solutions to reduce program complexity.

Pregnant Women Group

Pregnant women can receive Medicaid coverage through the term of the pregnancy and two post-partum months.

Description

Currently, coverage is provided for women with incomes up to 150% of the Federal Poverty Level (FPL), $1,950 gross monthly income for a single pregnant woman. However, the 2008 Kansas Legislature approved an increase to 200% FPL. KHPA plans to implement the expansion in May 2009.

Pregnant women initially applying for coverage receive an expedited eligibility determination. This means that pregnant women can receive access to medical coverage for a short period of time while they work on obtaining necessary income and pregnancy verification. This prevents any delay in accessing prenatal care while the administrative process continues.

Pregnant women have access to all Medicaid covered benefits, and most are enrolled in the HealthWave managed care program rather than the HealthConnect, or fee-for-service program. At the end of the coverage period, ongoing coverage may be provided to the mother if her income is very low and the family qualifies for the Caretaker Medical (MACM) program.

The household determination for pregnant women coverage is not aligned with the other medical groups. The household size used for the determination includes only the pregnant mother, the father of the child, if he is in the home, and the unborn child, or children. The needs of other children in the family are not considered, although the income of the parents is certainly used to support those children. For example, if the family includes a pregnant woman, her husband and their three children, the household size for the pregnant woman determination is three, as only the mother, the father and the unborn are included. This results in a maximum income threshold of $2,400 gross income per month. Because the income and needs of the entire household are used to determine eligibility for the children, this is often a point of confusion for the family. The effect of this state-optional distinction is that children in the family are more likely to qualify, even apart from the higher income thresholds that apply to children.

Option to Fill Policy Gaps

- *Equalize the eligibility threshold for Pregnant Women to reflect a true household determination.* Use the income threshold associated with the full household to determine eligibility for the pregnant woman. This would align eligibility calculations for pregnant women and children up to 200% of FPL, effectively raising eligibility thresholds for pregnant women who already have children.

Children's Medical Group

Children under age 19 are covered in Kansas families with incomes below 200% of FPL.

Description

There are three primary categories of medical coverage provided to children in Kansas. These groups are Medicaid, SCHIP and Presumptive Eligibility for children. All groups are designed for children up to the age of 19 years old and residing in Kansas.

Eligibility determination processes for the Medicaid and SCHIP groups have been combined into a single process, where children in families found to have lower incomes receive Medicaid and those found to have higher incomes receive SCHIP. Because the child's age is also considered, and the dividing line between eligibility for Medicaid and SCHIP rises with age, income eligibility is frequently referred to as "stairstep eligibility." For Medicaid, the following levels apply:

- Children under the age of one qualify for Medicaid if the household income does not exceed 150% of the Federal Poverty Level (FPL) ($2,400 per month for a household of three).

- Children ages 1 through 5 qualify if the household income does not exceed 133% of the FPL ($2,151 per month for a household of three.

- Children between 6 and 18 qualify at 100% of the FPL ($1667/month for a family of three).

- For HealthWave 21, children qualify if the household income exceeds the Medicaid threshold and does not exceed 200% of the FPL ($3,334 month for three). To be eligible for HealthWave 21 children must be uninsured and cannot have access to state employee health coverage. Families with incomes over 150% FPL must pay a monthly premium. The amount of the premium is based on the family's income. One premium covers all of the children in the family. Between 100 and 150% of poverty, children in the same family may qualify for either Medicaid or SCHIP, based on the child's age. Families with at least one child in each program are called "blended" and require staff to provide additional levels of education to assist members as they navigate through the differing groups and rules required of each of the groups. Previous analysis indicates that about 25% of SCHIP families also have a child in Medicaid.

Table 1.
HealthWave Income Eligibility Limits

Family Poverty Level	Newborns under age 1	Children ages 1-5	Children ages 6-18
176-200% FPL	$30 Monthly Premium Per Family		
151-175% FPL	$20 Monthly Premium Per Family		
≤150% FPL		No Premium	
≤133% FPL			No Premium

Key:

	Medicaid
	HealthWave 21 – No Premium
	HealthWave 21 – Premium

The 2008 Kansas Legislature approved an expansion of SCHIP to 250% of the FPL. However, due to the lack of federal funding currently available, the expansion will not be implemented at this time. The program will to be expanded when federal funding becomes available.

- Presumptive Eligibility for Children began in July 2006. Presumptive Eligibility (PE) allows designated Medicaid providers to enroll children at the time a medical service is provided while the application for coverage is being processed. Three entities are currently authorized to make presumptive determinations. Presumptive eligibility is time-limited and coverage terminates after two months if a follow-up application is not received. Participating Medicaid providers play a critical role by assisting the applicant in completing the eligibility process. The presumptive eligibility program is an essential part of outreach initiatives targeted towards enrolling the children in Kansas. At this time, three providers participate, with services offered at 10 locations. By the end of 2009, our goal is to expand to this program to an additional five providers who may operate at multiple locations.

Options to Fill Policy Gaps

- *Expand Presumptive Eligibility to additional health clinics and provide adequate support to all PE locations.* Allowing additional sites to make Presumptive Eligibility (PE) determinations will permit more children to receive critical health care immediately. KHPA plans to expand to five additional sites within the next year. However, personnel and other support are necessary at the clinics to make quick, accurate determinations. Having a trained staff person from the clinic assist the family with the application process increases the likelihood of a complete application, and therefore increases the likelihood of a positive determination.

- *Expand coverage to young adults under age 21.* Providing health coverage to low-income young adults will not only ensure they have access to care, but can also help the individual realize the importance and value of health insurance at an early age. Uninsurance rates are highest in this group of young adults who earn the least, are often investing time and money in their education, have few assets to protect against financial loss and are the healthiest group of adults. Medicaid coverage for individuals ages 19-21 is currently unavailable except

to young parents.

Medically Needy Group

Description

The medically needy or spend-down program covers pregnant women, children, the disabled, and elderly who are living independently in the community and have too much income to qualify for regular Medicaid. Persons in the medically needy program have a spend-down. A spend-down mimics the insurance deductible of private health coverage where the individual is responsible for a share of his or her overall medical expenses. Medicaid will pay for covered medical services once the deductible, or spend-down, is met. The amount of the deductible is based on the individual's or household's countable income. The amount of that income in excess of the protected income level in a six month base period is the spend-down. The current protected income level is $475/month for both an individual and a couple. There is also an asset limit for an elderly or disabled individual of $2,000 ($3,000 for a couple). Individuals with resources above these amounts are deemed ineligible for benefits. There is no asset limit for pregnant women and children.

It is important to understand how the Medically Needy income standard, or protected income level, relates to the eligibility determination. Unlike other medical groups, where there is a hard income limit, the protected income level (PIL) in the medically needy program allows consumers to keep some of their income. In theory, the PIL is used to meet the non-medical living expenses, such as food and shelter, of the individual or couple. Any income in excess of the protected income level is considered available to pay for medical expenses. The actual non-medical living expenses are not considered in this determination. For example, an individual at poverty level will have income of $847/month. The PIL is $475/month, which is protected, leaving $372/month ($847-$475) to be put toward health care expenses. For a six month base period the individual will have a $2,232 spend down, or deductible. Over the course of a year, the single individual living at poverty level must incur and remain responsible for almost $4,500 of medical bills. Considering the annual income limit is $10,400 – almost 43% of his or her income will be spent on medical expenses.

Although program rules are very similar, the way pregnant women and children use the medically needy program is different than the way the elderly and disabled use the program. Pregnant women and children fail to qualify for regular Medicaid at higher income limits than the elderly and disabled. Because of this, pregnant women and children with higher incomes can use the medically needy program to provide catastrophic coverage. When family income is too high to qualify for Medicaid, a pregnant woman or child may still qualify for medical assistance after a health care spenddown (or deductible) is met. With the income limits currently in place for Medicaid, medically needy coverage for pregnant women and children is actually only used by persons with relatively high incomes. Because people with higher incomes have larger spenddowns, they must also have very high medical bills to actually meet a spenddown. Consider a 10 year-old child in a family at 220% of poverty living with both parents – where income would be about $3227/month. The total spenddown for a six month base for the child will be $16,482, enough to bring the family's income for the six month period down to the Medicaid threshold of $480/month. It is important to note that the medically needy option may only be applied to the Medicaid eligibility threshold, not the higher SCHIP thresholds. If the family has medical bills to meet this deductible, they can receive Medicaid coverage to help with other expenses.

For the elderly and disabled, the medically needy Medicaid program is often used by those who

have very low incomes that are just above the eligibility threshold but who also have ongoing health care costs. Eligibility is typically long-term and provides primary or critical supplemental coverage to Medicare. As Medicare entitlement begins two years after the individual is eligible for Social Security benefits, the Medically Needy program is often the only coverage the individual may have available. Medicare doesn't always cover all health care needs, and additional coverage is often needed for services such as mental health and home health care. However, with such low eligibility thresholds for full Medicaid benefits, and with Medicare's coverage gaps, the neediest individuals are often under-insured. Because full Medicaid coverage is available to SSI recipients, a benefit usually provided to those with no work history, adults with work history who receive Social Security benefits are far more likely to have a spend down.

At current levels, the protected income level does not provide sufficient funds for many individuals and couples to afford to pay for their non-medical needs. When medical needs arise, the individual/couple may not have the means to pay these expenses. If the choice is made to forgo treatment, greater medical expenses in the future are a significant concern. If treatment is provided and the individual cannot pay, the provider may have to absorb the costs. Increasing the protected income limit would provide resources and a stable source of health care for needy, disabled and elderly individuals, and would offset uncompensated care for providers, both accomplished using a match of federal dollars.

Options to Fill Policy Gaps

- *Increase the Protected Income Level to Social Security Income (SSI) Limits.* The current protected income level for a couple was last increased almost 15 years ago in 1994 and for a single person in 1997. Previously, annual increases kept pace with the SSI monthly benefit rate. Returning to this standard is a natural transition because of the close association Medicaid has with the SSI program. Using the SSI benefit rate also provides a level playing field for persons with work history, as they are at a great disadvantage under the current structure. Also, by linking the income limit to an existing program with annual adjustments built in, such as SSI, protection against inflation is also provided. Annual cost of living adjustments are also needed in order to keep the protected income level at levels equal to those of the SSI program.

    - The current protected income limit is a little more than half of the poverty level, or about 55% of the Federal Poverty Level (FPL) for an individual and 41% for a couple. In contrast, the cost of living has increased approximately 31.8% since 1997 while the protected income level has remained fixed. The SSI limits are currently $637 for a single and $956 for a couple (about 74% of the FPL for a single and 82% for a couple).

    - Persons in these income ranges may go without health care coverage, or other basic needs, because they cannot afford them. Neglecting health care needs can have severe consequences, which may ultimately cost more than providing for primary preventive health care needs up front. Federal funding is available to help with some of these costs but is not currently being leveraged.

- *Provide Medically Needy Coverage to Caretakers*. The current medically needy program falls short of covering caretaker adults. There is no assistance for able-bodied adults in medical need under this program. Expanding coverage to caretakers will provide catastrophic protection to parents with higher incomes who may not be able to afford health insurance, including

people who have transitioned off of Medicaid. Kansas previously covered this group prior to 1992, when it was eliminated due to budget issues. Reinstating this coverage now would provide a substantially lower, but valuable level of protection for parents given the large effective drop in the caretaker income levels due to15 years of inflation.

Long-Term Care Groups

The long-term care eligibility groups serve children and adults who are receiving institutional or assistive living services. There are a wide range of both institutional and community-based options, including coverage for nursing home residents, in-home medical assistance under Home and Community Based Services (HCBS) and Work Opportunities Reward Kansans (WORK), as well as managed care in the Program for All-Inclusive Care for the Elderly (PACE). Each qualifying individual must pass a clinical screening to justify a medical need for institutional placement or community services.

Offering a variety of care options, especially community based alternatives, is a high priority of all state agencies responsible for administering long-term care. Continued movement toward home and community based services is absolutely critical for both social and budgetary resources. But, these expansions do not come without complications as each of these groups uses unique eligibility rules. This information needs to be made easily available and accessible to eligible families. For example, family groups that would normally be budgeted together due to their legal responsibilities are budgeted separately for purposes of eligibility for long-term care services - an adult applicant/recipient is budgeted separately from his spouse and a child applicant/recipient is budgeted separately from his or her parent(s).

Cost-sharing. Each qualifying individual must meet all financial eligibility criteria, including specific income and resource limits. Once qualified for coverage, and for those (the vast majority) who are able to pay, there is also a cost-sharing component for the recipient in all of the long-term care groups in the form of a monthly obligation or premium. Those in a nursing home or receiving coverage under the HCBS or PACE groups may pay an obligation to the provider. WORK program recipients may be obligated to pay a premium to participate in the Working Healthy program upon which the WORK program is based.

Protected income level. The amount of the monthly obligation is determined by the individual's own income. A certain amount of income to meet non-medical needs is protected in this determination. That amount is known as the protected income level (PIL). The amount of income in excess of the PIL is the monthly obligation. The current nursing home PIL is $60/month. This is the amount sheltered for personal needs (all other needs are being provided by the facility). This will increase to $62 effective January 1, 2009. The HCBS PIL is $727/month – this protects a higher amount of income since the individual remains responsible for regular non-medical household expenses like rent, utilities and food. The PACE program uses either the nursing home or HCBS PIL depending on the individual's particular living situation. The Working Healthy program premium amount for an individual ranges from $0 to $152 indexed to monthly income of $0 to $2,600.

Asset limits. Medicaid coverage for recipients of long-term care is designed to serve as a safety net for those individuals who cannot afford needed health care, which can cost tens of thousands of dollars per year and hundreds of thousands of dollars over a lifetime. In keeping with the principle that Medicaid is the payer of last resort, and that families should meet their own needs to the extent possible, there is an asset limit for each of the long-term care groups. As a result,

there is an asset limit for all of the long-term care groups. The resource limit for the nursing home, HCBS and PACE groups is $2,000. The resource limit for the WORK program which encourages and supports the individual's employment towards self-sufficiency is $15,000.

Types of assets. Application of the resource limit in the Medicaid eligibility determination can, in many instances, be complicated and involved. Assets such as life insurance policies, funeral plans, stocks, bonds, contracts, business partnerships, real estate, life estates, trusts and annuities all require thorough analysis to determine the availability and value to the individual. Other complicating variables such as multiple owners, encumbrances on the property and issues of inheritance must also be considered. Eligibility staff frequently must explain these subtle nuances to lawyers, bankers, financial planners, realtors, insurance agents and other professionals. All gifts, sales, purchases and other transactions involving an applicant's financial assets occurring within 60 months of application for assistance must be formally disclosed as part of the application process for the long-term care groups. Further complications arise when individuals or their family choose to be less than forthcoming in reporting and/or fully cooperating in documenting this resource information. Relevant information may at times be intentionally or inadvertently omitted. This could include the failure to report the actual existence or transfer of resources. Eligibility staff rely heavily on the prudent person concept which requires investigation and reconciliation information that a prudent person would consider incomplete, unclear or contradictory information.

Spouse protections. Special rules for married individuals add an additional layer of complexity. These special rules, known as Spousal Impoverishment or Division of Assets, allow additional resources to be protected for the non-long-term care spouse. This resource evaluation process involves an additional thorough, detailed analysis of the couple's resources at two specific points in time – at the time the long-term care arrangement began and at the time of application for assistance. The first point in time will determine the amount of resources the non-long-term care spouse can shelter for him or herself. The second point in time determines whether the long-term care spouse is resource eligible for assistance. Since this is such a complex process, eligibility staff frequently invest a significant amount of time explaining these rules and the consequences to the long-term care individual's spouse and family.

Integrity of Medicaid programs. While the long-term care groups provide a very important benefit to those individuals who are most in need, efforts to exploit these benefits through Medicaid estate planning activities – also known as planned poverty or artificial impoverishment – have caused Medicaid groups in every state to redirect a remarkable amount of resources and energies towards protecting the integrity of the Medicaid program from these abuses. The intent of Medicaid estate planning is to create a process where an individual presents the legal appearance of being impoverished within the existing resource limits with the express purpose of achieving Medicaid eligibility, even though he could have paid for some or all needed care. Various techniques have been employed over the years to help consumers quality for Medicaid – Medicaid qualifying trusts, transfer/gifting of assets, "loans" to family members, contracts for care, and most recently, the purchase of annuities. A more or less continuous stream of state and federal laws has been enacted over the years to thwart these practices. The most recent and wide sweeping was the federal Deficit Reduction Act of 2005.

Penalty Periods. One such policy to curtail these abuses involves the application of penalty periods - a delay in Medicaid eligibility, for individuals who transfer property without receiving a fair value in return. Penalty periods may be applied when an individual gifts money or property, sells property for less than fair market value, or refuse an inheritance or other property he is legally

entitled to receive.

Estate Recovery. A second key policy initiative was the creation of the Estate Recovery program. Upon the death of a long-term care recipient or the recipient's spouse, the state is allowed to recover any remaining assets in the individual's estate up to the amount in Medicaid claims paid for the individual. Assets may range from small bank accounts to houses to businesses. KHPA's estate recovery efforts recovered over $7 million in FY 2008.

Options to Fill Policy Gaps

- *Increase the HCBS protected income level to a specific percent of poverty.* The current HCBS protected income level is $727, or about 84% of poverty ($867). Increasing the protected income level will meet a legitimate need, but should be considered together with options for improving coverage of other long-term care groups so as not to create or make worse, some inappropriate incentives for applicants.

  Because the HCBS PIL ($727) is much higher than the Medically Needy PIL ($475 for a single or couple), individuals are drawn to the HCBS waiver in order to eliminate a cost sharing spend-down. This inherent discrepancy in the PIL's between the groups creates the potential for abuse in qualifying individuals for the HCBS program. Although all recipients for HCBS have been screened eligible for services under the program, those services may not be their primary need.

Medicare Savings Plans Group

The Medicare savings plans are designed to help low-income Medicare recipients with out-of-pocket Medicare expenses through the Medicaid program. Three separate groups are actually included as Medicare Savings Plans: The Qualified Medicare Beneficiary (QMB) program, which is much like a Medicare supplement program in that Medicaid pays for the Medicare premium and any co-pays and deductibles; the Low Income Medicare Beneficiary (Regular LMB), in which Medicaid pays only the Medicare Part B premium; and the Expanded LMB program, in which Medicaid pays only the Medicare Part B premium, but is 100% federally funded.

These Medicaid eligibility groups all have resource and income limits. The resource limit is $4,000 for an individual and $6,000 for a couple. The QMB income limit is 100% of the FPL ($867/month for an individual, $1,167/month for a couple). The Regular LMB limit is 120% of the FPL ($1,040/month for an individual, $1,400/month for a couple). The Expanded LMB income limit is 135% of the FPL ($1,170/month for an individual, $1,575/month for a couple).

All individuals who receive coverage under a Medicare savings plan also receive a Medicare Part D subsidy. Medicare Part D subsidy pays the prescription drug premium, provides reduced co-payments and eliminates the gap in coverage.

Together with low-income subsidies for Part D, the Medicare savings plans help low-income seniors and persons with disabilities to access comprehensive health coverage medical care. Offering assistance with Medicare related expenses ensures access to affordable health care through established networks. Beneficiaries can also benefit by using the funds available through premium relief to help with nutrition and housing expenses.

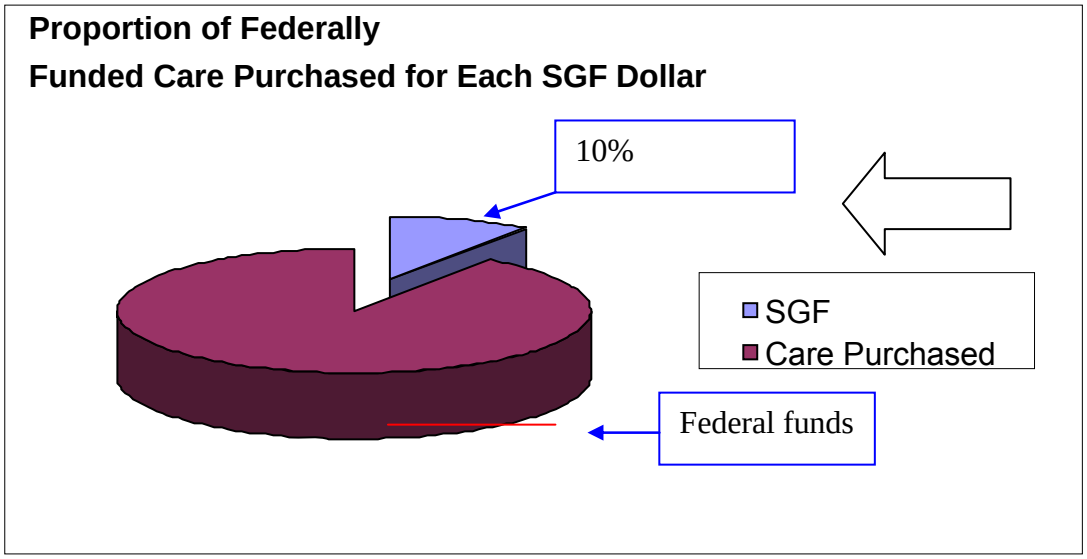
Estate recovery is not applicable to the Medicare Savings Plans and a simplified application and brochure are available.

Options to Fill Policy Gaps

- *Expand coverage of the Medicare Savings Plans by raising the income limits to 150% for QMB, 170% for Regular LMB and 185% for Expanded LMB and by eliminating the resource test for these groups.* The Medicare Savings Programs allow individuals to receive significant benefits for a relatively small amount of state funds. For a small investment (about 40% of the cost of the Medicare Part B premium, currently $96.40/month) an individual can also obtain subsidized drug coverage and, with QMB, the equivalent of a Medicare supplement insurance plan. Table 2 illustrates what this expansion would cost per person in State General funds (SGF).

Table 2:
Estimated Benefit Value For Medicare Savings Plans

Medicare Savings Plan	Cost Per Beneficiary Per Month	Approximate Benefit	Income Limit Increase	State General Fund/Month
QMB	$117	$5250	100% → 150%	$47
LMB	$96	$4750	120% → 170%	$38
ELMB	$96	$4750	135% → 185%	$0



Eligibility Operations

Before medical benefits and services can be delivered to a medical beneficiary, his or her eligibility must be established. However, establishing eligibility isn't enough. Determinations must also be made regarding the type of coverage for which the individual is eligible, premium amount, cost sharing, and a myriad of other variables. Staff in eligibility operations use program rules and policies to make individual eligibility determinations.

Initial Eligibility

Multiple program applications. Eligibility for medical assistance begins with an application for coverage. Kansas Medicaid uses a variety of applications in order to offer several methods to access program benefits. Two multiple-program applications are offered for people applying for medical assistance and other benefits (such as food stamps or child care). These applications are generally lengthy, but may be more efficient for an applicant who desires multiple services. These applications are also suitable for individuals who potentially qualify under several categories.

Targeted applications. KHPA has also developed a variety of targeted applications for persons who only want medical coverage, or only want a specific type of medical coverage. These applications are much shorter and more convenient, as the questions on the application are limited in order to gather only the information pertinent to the particular program. The most popular targeted application is the HealthWave application. This application allows a family who only wants medical coverage to avoid questions about assets or shelter expenses, as they aren't eligibility factors for the HealthWave program. Other targeted applications allow eligibility only for a special category of coverage. For example, a special application for women seeking coverage under the Breast and Cervical Cancer program asks limited questions, but can only be used to establish Medicaid under that program Other targeted applications include those for the Medicare Savings Plans and Tuberculosis coverage.

Time limits. Regardless of the application form used, an eligibility determination must be completed on an application within 45 days of the day it is received by the agency. This time limit increases to 90 days when a disability determination must be completed in order to make a decision. The date which medical assistance coverage is made effective is the first day of the month the individual is eligible. In other words, if an individual is eligible for one day of the month, that individual is eligible for the full month. Medicaid also provides up to three months of prior medical coverage. Thus, an individual who makes application in July may be eligible as far back as April 1.

Ongoing Eligibility

Once eligibility is established, members are required to report changes that impact their eligibility. These reporting requirements differ by eligibility group, as a change may or may not impact the individual's eligibility. A complete redetermination of eligibility occurs annually. These redeterminations, or reviews, require an individual to complete an application and provide current verification of certain eligibility requirements.

Persons who comply with these reporting requirements and continue to meet the specific requirements of the Medicaid eligibility group may receive coverage indefinitely, although turnover is frequent for many eligibility groups. Coverage may end for the following reasons:

- The individual hasn't complied with a program requirement, such as failure to return a review or provide additional information.
- Financial criteria are no longer met for example, income exceeds the limit or they own excess resources.
- Non-financial criteria are no longer met, such as when an individual moves out of state.

- Categorical or basic group requirements are no longer met, such as when children reach the age of 19.

When coverage terminates due to the death of a member, the estate recovery process begins for persons who were over age 54 or received coverage in a medical institution, such as a nursing home. With estate recovery, the assets owned by the individual at the time of death are subject to recovery by the state as a way to reimburse taxpayers for medical costs that were paid by Medicaid. Most of these requirements are federally-mandated, and reflect Medicaid's status as payer of last resort. KHPA currently contracts with Health Management Systems (HMS) to provide most estate recovery services.

Eligibility Business Model

In an effort to accommodate a variety of individual needs, persons are offered various avenues for accessing medical assistance. Applications are accepted by mail, fax, electronically with a manual signature, or in-person delivery. Face-to-face interviews are not required, but may be completed at the individual's choice. Various application forms are also used to allow the person to apply for multiple groups or special groups. For all applicants, any additional information needed to process is requested in writing. The customer is given 10 days to provide the additional information. A letter is sent to all applicants explaining the outcome of the eligibility determination regardless of the program or the location of the request.

KHPA relies on internal staff, as well as SRS and contract staff to make eligibility determinations. The following describes the medical assistance service delivery model:

HealthWave Clearinghouse. The Clearinghouse is a centralized processing center designed to handle the majority of Family Medical eligibility determinations. Families may apply for assistance at the Clearinghouse or at an SRS office, but all ongoing family medical cases are managed by the Clearinghouse. The Clearinghouse is operated by a contractor, currently Maximus, with KHPA staff also stationed at the Clearinghouse to provide oversight and make final Medicaid determinations, as required by CMS. The HealthWave Clearinghouse processes applications through a mail-in process; face-to-face contact with an eligibility counselor at the Clearinghouse is rare.

When an application is submitted, it is registered and then forwarded to an eligibility counselor (EC) for screening. Screening is the process by which the EC reviews the application and any supporting documentation to determine if additional information is needed. If additional information is needed, the EC can attempt to contact the consumer by phone but must also send a letter requesting the information. The goal at the Clearinghouse is to process the applications quickly and accurately.

Department of Social and Rehabilitation Services (SRS). SRS is responsible for processing and maintaining all elderly and disabled medical assistance applicants and recipients. SRS staff also process some initial family medical determinations, but send the cases to the Clearinghouse for ongoing maintenance.

SRS uses a caseworker model for nearly all cases. This means a single caseworker is responsible for ensuring eligibility actions are completed for the case. Persons can apply for medical assistance at any of the SRS offices throughout the state. Applicants may want other benefits in addition to medical, such as food stamps or cash assistance. The SRS model is set up to streamline these processes and consolidate requests and communication with the applicant. Persons may

also limit their requests to just medical assistance. Although interviews are not required for medical assistance, one is often conducted because the individual is applying for other benefits or if the individual makes a specific request for an interview. This is especially true with persons applying for the elderly and disabled groups, where face-to-face contact may be beneficial when explaining complex program rules and steps.

Eligibility Staff Training

Trained eligibility staff are essential to a successful eligibility operation. KHPA is responsible for developing and overseeing the training groups for KHPA and SRS medical eligibility staff. Providing staff with the knowledge, tools and confidence needed to make complicated eligibility decisions is best achieved through a strong training program.

The training program is developed to address three major competencies:

- *Social skills.* Eligibility staff must have the ability to work with a wide a variety of people. Examples include attorneys, financial planners or life insurance agents asking about long-term care eligibility; families and individuals in crisis desperately trying to take care of their loved ones; medical providers uncertain if coverage levels warrant providing a specific medical procedure; or social workers trying to plan the reintegration of a child back into a home from which he or she was removed. Eligibility workers need unique people skills that allow all people seeking help to feel comfortable.

- *Technical skills.* Eligibility staff are responsible for making determinations for more than 35 different sets of eligibility requirements. Staff must know the eligibility rules for each eligibility group, and be able to successfully navigate the system's multiple tools in order to record the results of eligibility decisions. In addition, many workers must also process other benefit groups too, such as food stamps, cash assistance and child care. Accordingly, eligibility workers must demonstrate both efficiency and good organizational skills.

- *Flexibility.* Eligibility staff must be able to adapt fluctuations in workload and changing rules. Because Medicaid is an entitlement program, the size of the caseload and the volume of work is difficult to predict, a factor that is important when managing a caseload and day-to-day work. Additionally, medical assistance polices are continuously being updated and changes in eligibility policies are common. These changes often require the eligibility worker to re-learn both the policy and the processes related to the change. Eligibility workers must be very flexible and able to retain and process frequent changes.

KHPA has developed two separate training path groups: one for Family Medical and one for Elderly and Disabled Medical. Both training path groups consist of detailed eligibility rules and processes, information on benefits, service delivery models and payment methods of various eligibility groups. Internal staff at both the SRS offices and the Clearinghouse are responsible for delivery of most training modules. KHPA has recently updated trainings with software to aid with online course development. KHPA partners with SRS to document training in a common learning management system. KHPA training staff determine training priorities in collaboration with training staff at the Clearinghouse and SRS.

Basic Training courses

- Basic Eligibility Training. The Personal Trainer is a web-based training course (anywhere, any-

time instruction delivered over a secure web site) that is used to present the basics of the Medical eligibility groups and policy. The course introduces new eligibility staff to basic principles and concepts used in the eligibility process. This course usually takes three to six months to complete. At the same time, the worker may be shadowing other workers, observing others in consumer interviews, spending time with a trainer or supervisor talking about policy or procedures, and generally getting acquainted with the agency and the duties of their job. Many are also processing a small caseload or doing basic work on their own.

- Training Academy – Classroom style training is available for staff that have completed Basic Training. These courses are designed to provide detailed level instruction and to secure concepts. Although the Elderly and Disabled modules are currently operational, Family Medical Training Academy courses are currently under development.

- New Policy Training – KHPA provides face-to-face training on major policy changes when necessary. However, most new policy training is delivered by the program manager via teleconference. Fact sheets and desk aids are frequently used to supplement these sessions.

- Refresher Training – KHPA plans to develop a series of refresher courses for experienced eligibility staff in the next two years. These courses will not only ensure long-term staff have kept up with policy changes, but will also allow eligibility staff an opportunity to share information with their peers.

Eligibility Outreach

The ultimate goal of the eligibility outreach program is to increase enrollment and retention of eligible beneficiaries. Increasing overall access to care reduces the number of uninsured. Partnerships with community organizations and advocacy groups are critical to achieving this goal.

The following principles guide KHPA's outreach efforts:

- A fully-staffed, well-trained eligibility staff is essential to successful outreach.

- Simplified eligibility policy and processes are used to the extent possible given fiscal and program limitations.

- Multifaceted campaigns which include both mass marketing and direct marketing approaches are preferred.

- Strategies are consumer-driven.

- Maximize the use of technology in outreach efforts, such as community-based enrollment options and the development of the online application.

KHPA hopes to further develop outreach strategies with the formation of the statewide Outreach Advisory Council, which began meeting in August 2008. The council consists of representatives from state agencies, community and advocacy organizations and medical foundations. The council will advise KHPA regarding the best approaches to take when attempting to reach potentially eligible uninsured, and underinsured, Kansans. KHPA is especially interested in strategies that can help hard-to-reach populations such as Native Americans. KHPA is also actively engaging in con-

sumer education for Medicaid eligibility through staffing exhibits and providing presentations at various statewide events.

The goal of outreach is to increase enrollment in and retention of eligibility beneficiaries in public insurance programs. This both improves access to health care and reduces the number of uninsured. Providing direct information and support to the uninsured by partnering with established, trusted health care providers such as safety net clinics has proven successful. The 2008 Kansas Legislature showed tangible support for these outreach initiatives by including a line item specifically calling for outreach and enrollment services in the health reform legislation, Senate Bill 81. However, the program failed to receive necessary funding.

Four specific initiatives for increased outreach were included as part of health reform in SB 81:

- Place an out-stationed eligibility worker at 10 health clinics throughout the state.
- Provide administrative funding necessary to support the Presumptive Eligibility program, which allows select medical providers to make a basic, temporary eligibility determination at the time of service. The Presumptive Eligibility Option will be expanded to five additional health clinics over the next year.
- Provide funding for direct marketing of KHPA's public health insurance programs, primarily HealthWave.
- Support additional administrative costs of the online application KHPA currently in the procurement process.

Automated Systems

Prior to 1988, eligibility determinations for all public assistance groups, including medical assistance, were recorded on paper. Forms were developed, appropriate data and figures were entered on the forms, and calculators were used to make final eligibility determinations. Once the determinations were made by eligibility staff, the forms were sent to a central data processing center that would issue the benefits that were approved. One problem with this manual process was that it relied entirely on each caseworker's knowledge and ability to apply policy correctly and consistently, even as the Medicaid program became increasingly more complex.

The Kansas Automated Eligibility and Child Support Enforcement System (KAECSES) was developed and implemented in 1988 in order to streamline eligibility determinations. Caseworkers were still required to know which eligibility groups an applicant might be eligible for, which questions to ask in an interview, and all of the policy that drove a determination of eligibility, but the system did most of the computing. To the extent that workers could collect and enter the appropriate data, the system could consistently apply calculations and policy to arrive at reasonably consistent results. Eligibility workers, however, still required substantial knowledge of eligibility policy to obtain appropriate information and communicate properly with consumers.

With passage of "welfare reform" in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), and the Balanced Budget Act of 1997 (BBA), the complexity of the eligibility process significantly increased. PRWORA required de-linking of medical assistance (Medicaid) from cash assistance (welfare) and allowed states to develop unique cash assistance groups. In Kansas, some new welfare reform options available to states were implemented. For

example, the resource test for family medical groups was eliminated and penalties related to work program participation were no longer applicable to Medicaid. The BBA established the State Children's Health Insurance Program (SCHIP). Implementation of the Kansas SCHIP program (HealthWave) further distanced medical assistance from cash by establishing continuous eligible for children. In addition, numerous other programs added complexity to Medicaid, such as the growth of Home and Community Based Services (HCBS) waivers for the elderly and disabled. Additional provisions passed as part of the Deficit Reduction Act of 2005 added yet more complexity with new rules for resource divestiture and estate planning, as well as the creation of the Medicare Part D pharmaceutical benefit.

Because of these additional requirements, the KAECSES system struggled to support public assistance eligibility determination, especially for medical groups. Although changes to eligibility policy were implemented by eligibility staff, re-programming KAECSES to fully reflect changes in eligibility policy nearly always pointed to a two to three year effort. Consequently, the modification requests for KAECSES were limited to elementary requests only, or just the minimum necessary to get the eligibility data to the appropriate other systems. In time, even the minimal eligibility change requests were too much. Instead, workers had to revert to making paper determinations, much as the workers did prior to 1988.

For over 10 years, eligibility staff have used a system that does not fully support their work. The problems that KAECSES initially alleviated, such as inconsistently applied policy, computation errors, and excessive human intervention, have resurfaced. KAECSES is the starting point for all data and eligibility information that feeds into other systems (see Figure 3). Yet KAECSES does not and cannot collect all of the data and provide sufficient decision support necessary to efficiently administer eligibility for the medical assistance groups.

KHPA continues to seek ways to compensate for KAECSES. For example, the Maxe^2 system, a proprietary system owned by KHPA's enrollment subcontractor, MAXIMUS, is used to provide management reports and other administrative staff tools for the HealthWave Clearinghouse operation. Electronic worksheets have been developed to compute countable income, penalty periods and other eligibility factors which aren't fully supported by KAECSES. Appendix B provides a more detailed description of some of the information systems upon which eligibility staff rely.

Future Systems

Modern Automated Eligibility System

KHPA, along with Social and Rehabilitation Services (SRS), has worked for the past year on the design of a web-based eligibility determination system. KAECSES has reached its maximum capabilities and is unable to effectively implement new groups. The system requires staff to conduct off-system, paper-based determinations and manual work-arounds, which are cumbersome and error-prone. Because both KHPA and SRS routinely add new groups and change existing groups, a modern, flexible integrated system that is easily modified is essential in order to keep pace with these changing groups. New systems also offer expanded opportunities to standardize procedures and improve accuracy. A new integrated system will allow multiple ways for customers to utilize and receive benefits, including e-mail notices and a portal to report all changes online. An efficient, reliable new system will also allow staff to focus more on prevention and customer/case management.

An automated eligibility system which is more flexible and requires less technical expertise to implement a greater variety of changes is necessary. A system built on the concept of a rules-drive decision tree would improve flexibility to implement new groups and allow current program determinations to be made by the system. Having this type of system will decrease the number of manual work-arounds, and ultimately decrease human errors made in eligibility work.

Currently, several types of eligibility are determined from the system, and the current system was not built with current data needs in mind, so data needs are not always met. All program eligibility determination needs to be done in the system and a robust, flexible and user friendly reporting system is needed.

Because eligibility determinations continue to become more technically complex, a new system is needed to incorporate more of the eligibility determination based on the rules maintained within the system. This will improve accuracy. Improved accuracy could prevent overpayments and potentially be a cost savings.

KHPA and SRS continue to work together to determine the best strategy for addressing this core business need.

Online Application

KHPA is in the process of acquiring and implementing an innovative online application system to apply for public insurance as well as a tool for designated entities to utilize for the presumptive medical eligibility process. This will be a web-based application that offers customizable features for varying types of users. It will feature an electronic signature making it possible for persons to apply anywhere, anytime. KHPA views this application as a critical building block for development of the outreach plan. It is a tool community partners can utilize to save time and money as well as facilitate ease of customer use, It is important to note that although an online application is available through SRS, it is not program specific and does not include an electronic signature. Implementation of the KHPA online application is planned in 2009

Beneficiary Self Service Options

KHPA has recently implemented a multi-functioning web-based tool for members to obtain information about their benefits and to perform functions related to maintenance of their medical assistance. This tool, commonly referred to as the beneficiary web portal, also serves as an information center by providing tips on health care management, general and specific information regarding medical assistance benefits and links to related websites. In addition to web-based services, a Beneficiary Automated Voice Response System (AVRS) is available. ROSIE, as the AVRS is called, allows a check of eligibility through a simple phone call. Both systems were implemented on November 3, 2008.

Imaging

KHPA is initiating a centralized uniform document management and imaging system. Currently, fragmented imaging services exist at KHPA. Departments essentially function as individual entities utilizing individual contracts and vendors. Upon the completion of this project the Clearinghouse, workers compensation, presumptive disability, the finance and operations department, and the state employee health plan will all utilize imaging services from a single vendor. Implemen-

tation dates vary depending on the program area. For the Cearinghouse, imaging is scheduled for implementation on January 1, 2010.

Premium Billing

KHPA is also in the process of procuring services that will centralize premium billing and collection services and related customer service across multiple departments. The goal is to utilize a single vendor for the entire agency. Implementation will occur in phases based on need and as departmental contracts with current vendors expire. Two medical assistance groups currently include a premium requirement, Working Healthy and SCHIP. Providing an automated and modern premium billing approach will allow eligibility staff to update premium obligations much easier and will also enable them to receive up-to-the-minute information without making phone calls or monitoring reports.

Program Integrity

As the single state agency ultimately responsible for medical assistance administration in the state, KHPA has an obligation to monitor the quality and accuracy of eligibility determination. The purpose is two-fold. First and foremost, it is critical that fair and accurate determinations are made for every applicant and recipient. We must ensure that customers receive correct benefits. The second reason is fiscal – to ensure that monies are expended appropriately. This involves avoiding incorrect payments and federal sanctions that may result from poor quality determinations.

Performance Measurement and Outcomes

As required by federal rules, KHPA formed a Medicaid Eligibility – Quality Control (ME QC) section with responsibility for both the ME QC function and the eligibility portion of the upcoming Performance Error Rate Measurement (PERM) project. The Centers for Medicare & Medicaid Services (CMS) implemented the PERM program to measure improper payments in both Medicaid and SCHIP. PERM is designed to comply with the Improper Payments Information Act of 2002. For PERM, CMS is using a national strategy to measure payment accuracy. Eligibility is one component in the process. States are involved in the PERM review once every three years. Although Kansas participated in a PERM pilot project a few years ago and was a first-round PERM state in October 2006, this is the first year a PERM eligibility review will be conducted in Kansas. Kansas operates exploratory pilot projects in the ME QC program - an option given to the state several years ago because of a history of low error rates – PERM will require a review of the quality and accuracy of eligibility decisions.

Given this heightened attention by the federal government regarding program error rates, Medicaid and SCHIP are coming under increased scrutiny. Separate from these federal efforts, KHPA is committed to maintaining the integrity of these groups and to establishing standards for key eligibility functions, including timeliness of application processing, accuracy of determinations, and customer experience. KHPA is in the process of developing program measures that will accurately reflect the condition of the program across a number of metrics. Measurements are needed across all aspects of eligibility-related work, including determinations made at the Clearinghouse and SRS and program support work provided by the MMIS contractor and any new contractors that will join in serving the Medicaid program under the new contracts.

Incorrect Payments

Medicaid beneficiary overpayments occur when eligibility is incorrectly determined and claims are paid in error. Claims may be traditional fee-for-service expenses, managed care capitation payments or service payments – such as HIPPS or Medicare buy-in. In theory, the eligibility worker will establish the Medicaid overpayment and initiate recovery. However, difficulty with the entire process, from establishing the actual overpayment amount to collecting the funds has resulted in low recoveries.

To complicate matters, when willful client error or beneficiary fraud is suspected, KHPA does not have access to investigators to look into the circumstances and gather evidence to support the case. These investigations could involve researching deeds, gathering bank records, and contacting collateral entities such as landlords, employers, brokerage houses and attorneys.

Long-term care cases present unique challenges for the program integrity project. Because long-term care is so expensive, beneficiaries often employ professional estate planners or estate planning techniques to qualify for Medicaid benefits. Efforts to curtail these activities are time-consuming and require a substantial amount of human resources.

If it is later discovered that benefits were not properly provided, an overpayment can be established. Efforts must then be made to recover the overpayment. The applicant may not be banned from assistance unless there is a federal conviction on a fraud charge, something that hasn't occurred in Kansas in recent history. By contrast, the Medicaid provider process has an extensive and substantial process for dealing with overpayments and fraud, including banning providers.

Summary

This program review has described Medicaid eligibility policy and operations in detail, identifying areas of potential areas of investment that would both improve Medicaid coverage and better facilitate access to existing coverage. The report identifies a number of populations with significant health needs, or who cannot afford care, who would benefit from expansions in Medicaid coverage. In particular, we note that the KHPA Board has endorsed in its broad health reform agenda the expansion of Medicaid to parents living in poverty. This recommendation is listed below, along with several other options identified by KHPA staff as representing the areas of greatest need that could be addressed through the Medicaid program.

This review has also identified improvements in Medicaid operations and outreach that would help eligible Kansans take advantage of the existing program to gain access to needed services and coverage. These improvements are outlined in the recommendations and options listed below. Future program reviews will closely review the dynamics of Medicaid enrollment in recent years, and will focus to a greater extent on the performance of the state eligibility and enrollment system.

KHPA Staff Recommendations

- Promote community-based outreach by placing state eligibility workers on-site at high-volume community health clinics. Eligibility workers out-stationed at these clinics will be able to make full determinations at sites serving populations most likely to be eligible for public health insurance.

Cost to provide out-stationed eligibility workers

	FY 09	FY 10	FY 11	FY 12	FY 13	5 Year Total
State General Fund (SGF)	$0	$560,000	$565,000	$580,000	$595,000	$2,300,000
Total	$0	$1,102,000	$1,130,000	$1,160,000	$1,190,000	$4,582,000

- Expand access to care for needy parents by increasing the eligibility income limit to 100% Federal Poverty Level (FPL), ($1,467 per month for a family of three). Current coverage levels are no greater than 30% FPL ($440 per month for a family of three), and fall each year as inflation eats away at the fixed dollar threshold for eligibility.

Cost to expand Medicaid for parents (caretakers) up to the federal poverty level

100% FPL	FY 09	FY 10	FY 11	FY 12	FY 13	5 Year Total
SGF	$0	$10,500,000	$41,000,000	$65,350,000	$73,500,000	$190,350,000
Total	$0	$31,000,000	$102,000,000	$162,700,000	$183,000,000	$478,700,000

Additional Options Identified by KHPA Staff

- Increase the number of people on Medicare who have access to full prescription drug coverage and who do not have to pay the Part B premium by eliminating asset tests and increasing the income limit for Medicare Savings Programs (MSPs) up to 185% Federal Poverty Level (FPL).

- Increase the Protected Income Limit for medically needy (primarily elderly and disabled people who do not yet qualify for Medicare) so that it is tied to the FPL. The last increase for this program was in 1994 and it is currently at $475 per month for both single people and couples (55% and 41% FPL respectively).

- Change household composition rules for pregnant women so that they are consistent with other populations and reflect equitable standards.

- Expand coverage to childless adults under the age of 21.

- Expand Medically Needy coverage to parents and other caretakers of children to provide catastrophic coverage.

- Develop a Medicaid Eligibility Program Integrity Project . This option is to review the state's process for determining and addressing beneficiary fraud in the medical assistance programs as a whole. The initial focus would be to identify and investigate positive eligibility decisions that were based on potentially incorrect information provided by the member; investigation could determine intent. The program would also need to focus on ways to detect and investigate possible fraud. It would also pursue prosecution and recover inappropriate expenditures where appropriate. Special focus will also need to be given to long-term care cases, where specialized staff would analyze the techniques employed and examine the current eligibility policies to determine how those policies might be adjusted in the future to combat estate planning techniques.

- Utilize claims information to identify women who are no longer pregnant. Medical coverage is not available to women in the third month following pregnancy termination. Women who mis-

carry are often not identified until the due date has passed, resulting in incorrect Medicaid payments. By establishing agreements with the Medicaid MCO's to report women appear to no longer be pregnant, coverage could be terminated timely and result in savings to the Medicaid program.

Attachment A

Kansas Case Studies

These case examples illustrate the current eligibility thresholds of each program. For most groups featured in this section, the income eligibility limits are at or below the federal poverty level (FPL). Many policymakers assume that publicly funded, basic health care coverage is available for all persons at or below the poverty level, yet in Kansas the eligibility threshold for most low-income parents is below 30% of the poverty level and Kansas Medicaid does not cover working age childless adults at any income unless they are disabled or pregnant. For people with disabilities, the level of coverage in the MediKan program is about 20% FPL. Nationally, over 13.9 million parents and childless adults with incomes less than 200% of the FPL are not eligible for Medicaid and are uninsured. A recent Kansas Health Institute study indicates about 340,000 Kansans are uninsured.

TAF-related **M**edical **G**roup

Case Study: Joe

Joe is a divorced father of three. Joe injured his back a few years ago and was unable to work. He was not eligible for workers compensation or unemployment benefits at the time, so Joe applied for cash benefits through his local SRS office. He and his children were also approved for MACM coverage at the same time, which allowed Joe to get treatment for his injury.

Joe returned to work, part-time at first to ensure that a re-injury didn't occur. Soon after his return to work, Joe's cash case closed as he was over the income guidelines for TAF benefits. He was also over the income guidelines for MACM, but instead of ending his benefits, Joe and his children were approved for the Transitional Medical or TransMed program. This gave Joe an additional six months of medical coverage, with a potential to increase this to a full year of coverage. Since Joe followed the requirements of the TransMed program, he was able to receive the full year of benefits. At the time his coverage ended, Joe had signed up for his company's health insurance. His children transitioned to the SCHIP program at review.

Case Study: Josie

Josie is a single mother of two children. Josie works full-time as a cook at a local café where she makes minimum wage ($6.55/hour, see Appendix D for more information regarding the minimum wage) and has a second part-time job cleaning office buildings every other weekend, where she earns $10/hour. Josie's children, ages 8 and 4, also receive a small amount of child support from her ex-husband. She is grateful to her mother who cares for her children when she is at work at a very low cost. Josie would like to buy a home, but can't save enough for the down payment. Josie's budget is very tight:

Income:	Café	$1125	
	Cleaning	$ 275	
	Child Support	$ 100	
Total Income:		$1500	Note: This amount is just slightly over poverty level.
Take Home Pay:		$1400	
Expenses:	Rent	$ 400	
	Utilities	$ 250	
	Car Payment	$ 250	
	Gas	$ 75	
	Car Insurance	$ 50	
	Food	$ 250	
	School Band Fee	$ 20	
	Credit Card Payment	$ 50	
	Child Care	$ 100	
Total Expenses		$1445	
Money For Savings		$ 000	

Josie's health is fairly good, though she does have severe migraine attacks which require her to miss work at times. Her children are fairly healthy too, though they don't seek medical care very often as no one in the household has health insurance. The family lives at least 30 miles from the nearest free health clinic.

Lately, Josie's migraines have been more frequent, putting her employment at risk. Josie applies for the MACM program, but was denied because her monthly income, $1500, exceeds the guideline of $403 that applies to her household size, living arrangement and county of residence. However, both of Josie's children are approved for Medicaid (HealthWave 19) coverage, but that doesn't solve her own health problems.

Because of her ongoing problems with migraines, Josie must give up her cleaning job and her hours are cut at the café to about 22 per week. Her monthly income is reduced:

Income:	Café	$ 620	
	Cleaning	$ 000	
	Child Support	$ 100	
Total Income:		$ 720	Note: This amount is about 49% of poverty.
Take Home Pay:		$ 680	

Because of the income change, Josie applies for, and receives, food stamps and child care assistance. She applies for MACM again, but is denied because her income continues to exceed the guidelines. She continues to work, pay her bills, and parent her children, in between her migraine attacks.

Pregnant Women Group

Case Study: Carrie

Carrie is a married mother of one child, and is also 7 months pregnant. Until recently, Carrie and her family had been living in Utah, where she was receiving medical coverage. Carrie's husband, a recent college graduate, obtained employment in Kansas, necessitating the family's move. When the family relocated, Carrie's medical coverage through her previous state of residence ended. Carrie now lived in a new and unfamiliar place, had no income (for the past two months), and had no medical coverage during the final stages of her pregnancy.

Prior to her move, Carrie had contacted KHPA to inquire about the application process. She was given information on the application process for pregnant women, how to fill out the application, and what to submit with it. She followed all of the suggestions and was approved for ongoing pregnant woman coverage within 7 days of the receipt of her application. Carrie was able to receive adequate, timely pre-natal care in her new state of residence.

Case Study: Mary and Richard

Mary and Richard are the proud parents of two children, ages 8 and 6. Richard is employed full-time at Wal-Mart while Mary is employed as a paraprofessional through the school district. They have just enough money to meet expenses each month.

Because of their tight budget, Richard and Mary are unable to afford health insurance for themselves or their family. Both of their children have health coverage through the HealthWave medical groups. Richard and Mary are in fairly good health and appear to be making it without health insurance.

Mary finds out she is pregnant. Mary immediately applies for Pregnant Woman coverage through HealthWave as this program provided access to health care during her previous pregnancies. Mary is sure she'll be covered since her children receive coverage and the household's income is modest.

Mary, however, receives a denial notice in the mail telling her that she's over income for the Pregnant Women (PW) program. When she calls for clarification, she is told that her other children are not considered part of the household for pregnant woman coverage - only she, her husband and her unborn child are considered. Since all of the family's income counts, the family is less likely to fall under the poverty-based eligibility threshold, since poverty thresholds are lower for smaller families. She and Richard are left to consider how, or if, they will pay for her pre-natal care.

Children's Medical Group

Case Study: Oscar and Tina

Oscar and Tina are married with two children. Both Oscar and Tina have lived and worked in the United States for a number of years and recently learned they were both approved for Lawful Per-

manent Residence status. They plan to become United States citizens as soon as possible. This is important to them as their children were born here and are already citizens.

Oscar works a well-paying job as a contractor for a construction company. He has no insurance as he can't afford to pay the premiums. Tina stays at home to provide care for their children, but earns some money teaching piano to a few young children.

Tina begins to worry about the health of her youngest child, who appears increasingly lethargic and pale. She takes both children to a clinic offering Presumptive Eligibility. The staff at the clinic determine that the child is anemic and prescribe the necessary medications to treat the condition.

Tina is referred to an office worker at the clinic who explains the Presumptive Eligibility and HealthWave groups; this worker then proceeds to help Tina complete the applications for both groups. Based on the applications, the children are presumptively approved for SCHIP coverage. Because Tina now has coverage, she goes to the pharmacy to pick up the prescription for the children. Staff at the clinic also helped Tina complete the full HealthWave application, which they submit.

Case Study: Brandon

Brandon recently graduated from high school and plans to enter college in the fall. When he was 6, Brandon was diagnosed with juvenile diabetes. Although it's under control, he has to carefully watch his diet and monitor his blood sugar levels. Brandon has been covered under HealthWave since the program began in 1999. It's the only health insurance coverage he has ever had. This month, Brandon turns 19 and he received a notice that his HealthWave coverage is ending. Both he and his mother are worried how he can manage his condition while at college without comprehensive health insurance coverage.

Medically **N**eedy **G**roup

Case Study: Harold and Maude

Harold is 71 years old and his wife Maude is 63. He worked up until last year when he had a stroke. He was in the hospital for months which took all of their savings. He is scheduled to go back in the hospital for more surgery in the fall.

Harold worked all his life selling insurance and Maude worked some of the time after the kids went to school, and until Harold's stroke, when she quit to take care of him. Both get Social Security and have Medicare. They didn't think they could afford Medicare Part D, so they do not have prescription drug coverage. They could use it now, but it's not open enrollment.

Harold's sister-in-law went to the senior center for lunch one day and brought him a flier telling about a program from the government. It will pay premiums, the co-pays and can even get him enrolled in a prescription drug plan. They filled out the form and received word they were approved for coverage. Soon, their Social Security checks went up almost $100 each because the Medicare premium wasn't being taken out. They were also enrolled in a prescription drug plan with no premiums and only small co-payments – never more than $7 for a prescription. With the

extra money in their pocket, Maude could afford to buy fresh vegetables at the grocery store. Harold and Maude were also able to go play Bingo for the first time since the stroke.

Case Study: June

June was born in 1922 and just celebrated her 86th birthday. When June was a young adult she worked as a secretary for a coal mine. When WWII began she worked in the local ammunition plant. She met Kenneth and they were married in 1946. During WWII, Kenneth enlisted in the Navy and flew blimps with the Wing 3 Squadron ZP-33. During their first years of marriage, Kenneth worked for a wholesale grocery distributor until they built and began operating their own grocery store in 1949. Kenneth and June lived above the store with their two children. In 1971, Kenneth and June sold the store due to competition from bigger chain stores. He made the most money ever that year: $12,000 and worked from 4:30 a.m. to 10 p.m. every day. After selling the store, Kenneth worked various jobs and June worked as a part-time secretary for the ambulance services. Once they became eligible for Social Security retirement benefits, Kenneth received $760 and June received $655.

Kenneth and June worked hard, drove used cars, canned food for the winter and saved money in a savings account where it was protected by FDIC. Everything was reused, including plastic sandwich bags. Kenneth would clean them out and dry them by the sink.

June and Kenneth could have used helped with their Medicare premiums, co-pays and deductibles but they would not have asked. That was not their way.

In 2006, Kenneth died and June, who has macular degeneration and is legally blind, was left alone. Although her income of $760/month fell below the limit for Medicare Savings Plan, the cash value of the life insurance policy that Kenneth purchased for her kept her from qualifying by placing her resources over the limit. She continues to pay her Medicare Part B premium of $96.40, along with a $300 per month Medicare supplement to help with co-pays and her Medicare deductible. This is to cover her in case of a catastrophic event, such as a hospitalization or surgery. She can live within her means most of the time. There are months when she has medical bills or extra expenses and she has to access her savings account.

Case Study: Harriet

Harriet is 58 years old and stopped working just seven months ago after 22 years as a printing press operator at the local newspaper. Harriet was forced to stop working due to the progression of her Multiple Sclerosis, which aggravated the asthma attacks she has had since she was a child. Harriet now receives Social Security Disability of $894 a month as her only income. Harriet does not have any health insurance and is still waiting to reach the age of eligibility for Medicare.

Harriet has an apartment in the city's subsidized housing complex so her lodging expenses are monthly rent of $250 and monthly fixed electric bill of $75. Harriet still has the one new car she bought in her life – her 1989 Chevrolet Impala. Harriet drives approximately 30 miles each week which includes a 24 mile round trip to visit her mother at a nursing home in a neighboring town. Because her condition is becoming so debilitating, Harriet is afraid to drive much.

Harriet is supposed to be on a strict diet for her condition. The only time Harriet eats out is one breakfast a week with her bridge friends at the City Square Café and she always has the $3 special. Even though Harriet shops frugally she still estimates that she needs to spend approximately

$55 a week for groceries, household supplies and her breakfast special.

Harriet's biggest expenses are for medical care. Harriet is supposed to have a standing appointment with the doctor each month, takes five medications, and her doctor wants her to take vitamins and to drink nutrition drinks (like Ensure). When Harriet's doctor prescribes another medication, she knows that she is in trouble. Harriet's medical expenses should be about $600 per month, but she can't always afford to buy her medications. Sometimes she cuts them in half. With the new prescription, her medical expenses will be close to $800/month.

Harriet's monthly budget looks like this:

Income		
Social Security Disability	$894	
Expenses		
Rent:	$250	
Utilities (electric):	$ 75	
Vehicle insurance & taxes:	$ 26	($312 a year ÷12 months)
Vehicle gasoline:	$ 20	($4 each week x 4 weeks)
Food & household supplies:	$220	($55 x 4 weeks)
Medical expenses:	$800	
Total Expenses	$ 1,391	

Harriet has found that she cannot meet her expenses on her income so she is not appropriately following her medical regimen. Harriet applied for Medicaid assistance. She was told she has a spenddown of $2,394 and that she would have to spend that amount on medical expenses before Medicaid would help with her bills. The eligibility worker explained to Harriet that this amount was reached by the following calculation:

Harriet's monthly income of:	$894
Minus the protected income level of:	$495
Available Income for Medical	$ 399
Multiplied by 6 Months	X 6
Total Spenddown	$2,394

Harriet eventually meets her spenddown when she has her prescriptions filled. But, she is now behind on her rent by two months. Even though Harriet is proud that she was able to work all her life, despite having two severe medical conditions, she is discouraged by the fact that others who haven't worked may be better off. Even living frugally, her non-medical expenses exceed the monthly income limit.

Long Term Care Groups

Case Study: Rick

Rick is a 45-year-old who has been determined disabled by Social Security. Rick worked as a construction worker but his job did not offer health insurance coverage. For the last couple of years, Rick has felt tired, lost weight, and his vision is not what it used to be. Rick figured he was get-

ting older and keeping up with the physical demands of the job could explain his symptoms. It wasn't until he ended up in the hospital and had his leg amputated that he became diagnosed with Type 2 Diabetes.

Since Rick worked and paid into Social Security, he had to wait five months to receive his Social Security Disability income of $900 and will not have Medicare coverage until he has been disabled for 24 months. If Rick had not worked and contributed to the Social Security system, he could have potentially been eligible for SSI and received automatic Medicaid coverage.

Rick applies with the local SRS office and is found eligible for the Medically Needy (spend-down) program. His spenddown or deductible will be $2,430. This will be the amount he has to pay out-of-pocket for medical expenses before Medicaid coverage will begin.

Rick doesn't feel he can spend almost half of his income on medical expenses. The worker refers him to the local clinic that helps those without medical coverage. The local clinic informs Rick that he has to receive a denial from SRS in order for the clinic to help. However, Rick's case cannot be denied as he is eligible for a spenddown. Rick asks if he can withdraw his application. The clinic states that he has to be denied for assistance and a voluntary withdrawal will not be considered. Rick asks his doctor for samples but they cannot give out samples of insulin. Rick contacts the pharmaceutical companies for help but has been denied as his income is too high.

Rick doesn't know what to do. He ends up going without his medication. Rick's blood sugar levels skyrocket. He is found unconscious in his apartment and rushed to the hospital. Doctors are able to stabilize him, but there may be irreversible damage to his kidney and brain functions. Due to the high cost of hospitalization, Rick meets his spenddown and receives Medicaid coverage.

Three months later, Rick resides in a nursing home. He is doing speech and physical therapy to try and regain some of his abilities. His condition is such that he will have to remain in a long-term care facility such as a nursing home or assisted living center.

Case Study: Doris

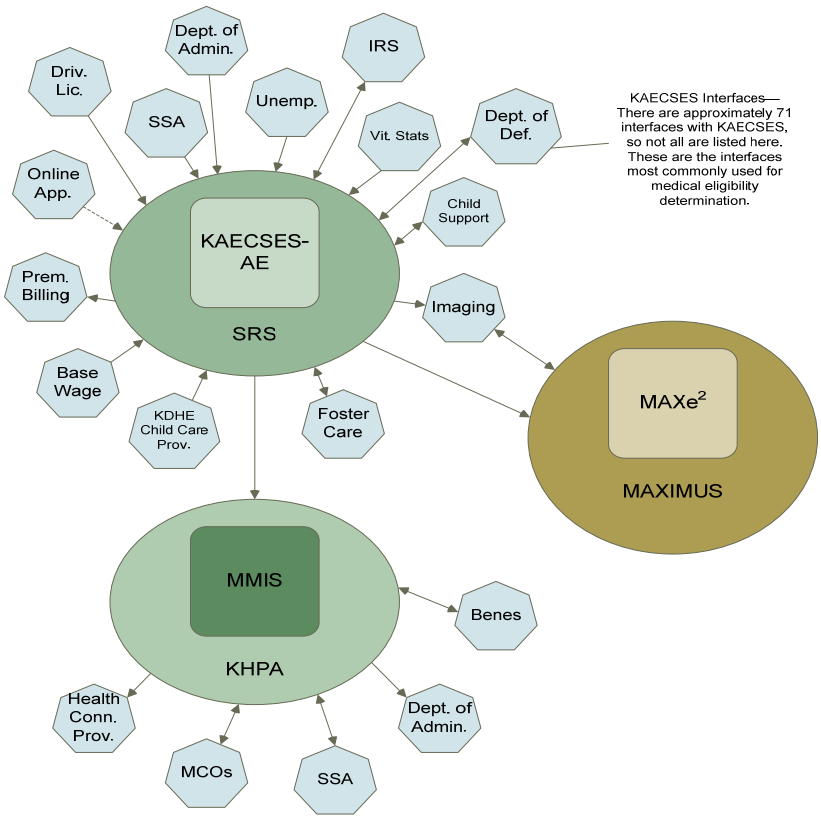
Doris is 89 years old and was active in her church, the Junior League and volunteering with the American Cancer Society until she suffered a stroke at age 83. She has been living in a nursing home since the stroke. Doris had substantial assets and was able to pay for her own care for many years. Her son, an attorney, takes care of her affairs. He read about a Medicaid planning seminar in the local paper and heard about a technique called the "'half-a-loaf," where people transfer half of their remaining assets to a family member and use the remaining assets to pay for their care. The presenter at the seminar told him that even though Medicaid will determine a penalty, the penalty period will expire before her remaining assets are spent. It seemed like the perfect plan to preserve some of mother's resources and he immediately transferred $50,000 to himself.

Nine months later he applied for Medicaid and found out that the rules had changed - the eligibility worker told him he would have to wait 12 months before Doris would be eligible. He panicked since she was out of money. However, after checking with three lawyers and going through a formal appeal process he felt he had no other recourse. He took out a loan to pay Doris' nursing home bill for the rest of the year.

Attachment B

KAECSES and Other Systems Used By Eligibility Staff

KAECSES and Other Systems Used By Eligibility Staff



Current Systems

The three primary computer systems that are used in the eligibility process are KAECSES (Kansas Automated Eligibility and Child Support Enforcement System), Maxe^2 (MAXIMUS Eligibility and Enrollment) and the MMIS (Medicaid Management Information System).

KAECSES

The KAECSES system is used to determine eligibility for all Medical groups. It is managed by SRS and used by staff in SRS, KHPA and KDHE. This system became operational in 1988. It has had numerous modifications made to it during the last 20 years to accommodate changes to the various groups it supports. Medical eligibility information is sent from KAECSES to the MMIS every night in order to provide beneficiary records to the claims payment system.

There are numerous interfaces and auxiliary systems that work with KAECSES to help eligibility workers. Staff have access to information from other agencies or groups through these systems. Formal interfaces have been established with some entities, such as Social Security and Child Support, to electronically exchange information. Access to information is obtained from many other systems that allow staff to obtain information about an individual's involvement with the other program or agency, such as driver's license records with the Department of Revenue. Automated access to auxiliary systems improve efficiencies and can reduce the workload of staff.

Maxe^2

This system is owned and operated by Maximus, the contractor that operates the HealthWave Clearinghouse, and is used by the Clearinghouse staff to track and monitor the applications that are received and processed. This system helps the Clearinghouse staff organize their work and produces key management reports to KHPA that are not available through KAECSES. KAECSES sends a nightly file to the Maxe^2 system to support eligibility operations in the Clearinghouse. The Clearinghouse contract is being re-bid in FY 2009.

MMIS

The MMIS is used to pay the claims for the beneficiaries who are found to be eligible for medical coverage. The current fiscal agent operating the MMIS is Electronic Data Systems (EDS). The MMIS maintains nearly all of the information necessary to manage the medical assistance groups. Information on beneficiary eligibility, medical providers, managed care enrollment and claims payments is maintained and housed in the MMIS. The MMIS sends numerous electronic files to subcontractors, federal agencies and others as necessary in order to manage the program operation. The MMIS is the primary source of information on both medical service expenditures and health care experiences as well as enrollment and eligibility. Performance, management and analytic reports are generally unavailable from KAECSES.

Attachment C

Poverty in Kansas

Poverty in Kansas

Introduction

Health insurance for those in poverty is often at the core of discussions about health care reform at both the national and state levels. The Centers for Disease Control reports that people with lower incomes experience more disease, have more chronic illnesses and live shorter lives (National Health Center for Health Statistics, 2007). A study prepared for the Task Force on Poverty at the Center for American Progress estimated that childhood poverty raises U.S. health care expenditures by almost $22 billion per year (Holzer, Schanzenbach, Duncan and Ludwig, 2007). Other researchers have also pointed out the strong correlation between poverty and poor health (Feinstein, 1993), (Kawachi, Kennedy, Lochner and Prothrow-Stith, 1997), (Mackenbach, et al., 2008).

While Medicaid covers most children and pregnant women in poverty, many states – including Kansas – cover very few non-elderly and non-disabled adults and often cover the aged and disabled at less than the poverty level. The national median eligibility threshold for working parents is 63% of the federal poverty level (FPL) and 41% for non-working parents (The Kaiser Commission on Medicaid and the Uninsured, 2008). In Kansas, these thresholds are about 33% and 27%, respectively.

It is estimated that 13.9 million parents and childless adults with incomes less than 200% of FPL, and who are not eligible for Medicaid, are uninsured (NIHCM Foundation, 2008). The Kaiser Commission on Medicaid and the Uninsured reports that 37% of the uninsured in Kansas have family incomes below the FPL, while 30% have incomes from 100%-199% of the FPL (The Kaiser Commission on Medicaid and the Uninsured, 2008).

Discussions about the poor, the FPL and health insurance raise the fundamental question of what is meant by the term poverty, and who is living in poverty.

What is Poverty?

The U.S. Bureau of the Census uses poverty thresholds to determine who is in poverty. These thresholds, originally developed in the 1960's, are updated annually and are used primarily for statistical estimates of the extent of poverty in the U.S. These thresholds do not vary geographically and are roughly based on what a family of three would need to spend to buy groceries for what the Department of Agriculture terms the economy food plan (developed for temporary or emergency use) (Fisher, 1997). The definition of poverty used to develop these thresholds uses gross income, but does not include noncash benefits (e.g. food stamps) or capital gains. The Bureau of the Census states that the thresholds are not a "complete description of what people and families need to live (DeNavas-Walt, Proctor and Smith, 2007)."

Attempts have been, and still are, being made to develop a clearer way of measuring poverty. Most recently, researchers at the Center for the Study of Poverty and Inequality at Stanford University have proposed a measure that would include government benefits (Frier, 2008). The National Research Council has also sponsored research into different ways to measure poverty (U.S. Department of Health and Human Services, 2007).

The current poverty thresholds are listed in Table 1.

Table 1

Poverty Thresholds in 2006 by Size of Family and Number of Related Children Under 18 Years

(Dollars)

Size of family unit	Related children under 18 years								
	None	One	Two	Three	Four	Five	Six	Seven	Eight or more
One person (unrelated individual):									
Under 65 years	10,488								
65 years and older	9,669								
Two people:									
Householder under 65 years	13,500	13,896							
Householder 65 years and older	12,186	13,843							
Three people	15,769	16,227	16,242						
Four people	20,794	21,134	20,444	20,516					
Five people	25,076	25,441	24,662	24,059	23,691				
Six people	28,842	28,957	28,360	27,788	26,938	26,434			
Seven people	33,187	33,394	32,680	32,182	31,254	30,172	28,985		
Eight people	37,117	37,444	36,770	36,180	35,342	34,278	33,171	32,890	
Nine people or more	44,649	44,865	44,269	43,768	42,945	41,813	40,790	40,536	38,975

Source: U.S. Census Bureau.

Based on the Bureau of Labor Statistics *Consumer Expenditures* report for 2005 (U.S. Bureau of Labor Statistics, 2007), the average percent of income spent on various necessities is as follows:

- Housing 32.7%
- Food 12.8%
- Transportation 18.0%
- Clothing 4.1%

For a hypothetical family of four which has less than $20,444 as their income, 33.6% of their income ($6,787) would be available for child care, health care, insurance, and other expenses. The average annual child care cost for a 4-year old in full-time daycare (in a family home – less expensive than a center) in Kansas is $4,940, leaving very little for other expenses and far less than would be required to purchase health insurance on their own.

The Census Bureau reports that the total poverty rate in the U.S. for 2006 is 12.3%, down from 12.6% in 2005 (U.S. Department of Health and Human Services, 2007). In Kansas, the total poverty rate for 2005 – the most current year of estimation – is 11.7% (U.S. Bureau of Census, 2008). When the number of people in poverty is broken down by other factors, such as race or gender, the rate of poverty can be higher or lower than the overall rate.

Poverty guidelines are issued annually by the U.S. Department of Health and Human Services (HHS). They are a simplified version of the poverty thresholds and are used to determine eligibility for various federally funded programs. Table 2 shows the current poverty guidelines.

Table 2
2007 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,210	$12,770	$11,750
2	13,690	17,120	15,750
3	17,170	21,470	19,750
4	20,650	25,820	23,750
5	24,130	30,170	27,750
6	27,610	34,520	31,750
7	31,090	38,870	35,750
8	34,570	43,220	39,750
For each additional person, add	3,480	4,350	4,000

SOURCE: *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

Although HHS cautions against using the term "Federal Poverty Level" to refer to poverty guidelines, it is widely used in just that way. The overall percentage of Kansans who are poor or near-poor - using the HHS poverty guidelines (rather than the Census Bureau poverty thresholds) as a measure - is similar to that of the U.S., as Table 3 illustrates.

Table 3
Population by Federal Poverty Level

INCOME	KS	US
< 100% FPL	16%	17%
100-199% FPL	18%	19%

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements)

Who is in Poverty?

Any number of factors correlate with the presence of poverty, many of which occur disproportionately in women, children and minorities, including:

- Job loss
- Bankruptcy
- Divorce
- Lack of education or job skills
- Disability or chronic ill health
- Poor English skills

Being born and raised into poverty can also result in people remaining in poverty, if circumstances combine to help keep them there. There are no clear reasons why a person falls into, or remains, in poverty.

U.S. Census Bureau Small Area Income and Poverty Estimates (SAIPE) for 2005 – the most recent estimates available – report the overall poverty rate in Kansas as 11.7%, compared to 13.3% for the U.S. Both nationally and in Kansas, among adults in poverty, more are female than male and more have children than are childless. A greater percentage of blacks, Hispanics and other minorities are in poverty than whites, although the poverty rate decreased nationally for Hispanics in 2006 (DeNavas-Walt, Proctor and Smith, 2007). More children are in poverty than adults – a reflection of the number of single parent households with more than one child (DeNavas-Walt, Proctor and Smith, 2007). For example, the poverty rate for female heads of households, with no husband present, in 2006 was 30.5%, compared to 4.9% for married-couple families (DeNavas-Walt, Proctor and Smith, 2007).

In addition to the overall poverty rate, on other demographics related to poverty, Kansas also mirrors national rates, with the exception of race. Table 4 shows these comparisons.

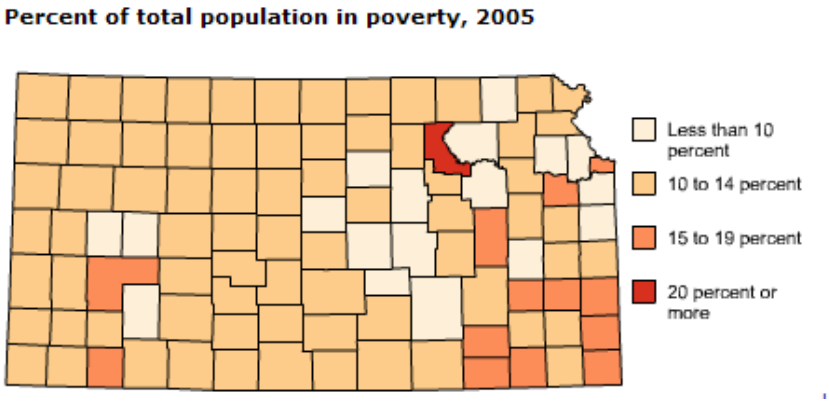
Table 4
Poverty Rate by Various Demographic Characteristics

DEMOGRAPHIC	KS	US
Adult Gender		
Female	15%	17%
Male	12%	13%
Race/Ethnicity		
White	12%	12%
Black	37%	33%
Hispanic	29%	29%
Other	22%	20%
Age		
18 and under	21%	22%
19-64	14%	15%
65+	10%	13%
Family Structure		
Adults with children	17%	19%
Adults without children	14%	15%

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements)

With the exception of the poverty rate for blacks, Kansas poverty rates are consistently close to the national rates, although the State has slightly fewer elders in poverty. The geographic distribution of poverty across Kansas is uneven, however, ranging from 5.2 in Johnson County to 20.2 in Riley County. Figure 1 shows the distribution of poverty rates across the State. Table 5 lists the top and bottom five counties in terms of percent living in poverty.

Figure 1
County-Level Poverty Rates for Kansas



SOURCE: U.S. Department of Agriculture, Economic Research Service

Table 5
Kansas Counties with the Lowest and Highest Poverty Rates

COUNTY	PERCENT IN POVERTY
Lowest	
Johnson	5.2
Miami	7.1
Scott	7.3
Leavenworth	7.9
Jefferson	8.0
Highest	
Riley	20.2
Wyandotte	19.5
Crawford	19.4
Elk	17.2
Cherokee	17.1

SOURCE: U.S. Bureau of the Census. (January 2008). Small Area Income & Population Estimates. Estimates for Kansas Counties, 2005.

The low rates in Johnson, Miami and Leavenworth counties reflect the prosperity that Johnson County has always experienced and that is now spreading to the other two counties as the Kansas suburbs of the Kansas City metropolitan area sprawl north and south. Scott County's low poverty rate is likely due to large corporate hog farming operations. The reason for Jefferson County's relatively low poverty rate is unclear.

On the other end of the spectrum, Riley County is home to many military families and college students, while Wyandotte County is home to a high concentration of both blacks and Hispanics – both groups that are more likely to be poor than whites. The remaining three counties are in southeast Kansas, an area of the state that has never recovered from the end of the strip mining and railroad eras.

How Does Kansas Compare?

Based on 2005 (SAIPE) estimates, Kansas ranks 20th nationally in lowest poverty rate (the same ranking it had in 2004) in the percent of all ages living in poverty. Since 2003, Kansas has dropped from a 17th ranking and had an overall poverty rate increase of 1.3%.

New Hampshire has the lowest poverty rate, while Mississippi has the highest (U.S. Bureau of Census, 2008). Table 6 lists the highest and lowest poverty rates among all states and the District of Columbia.

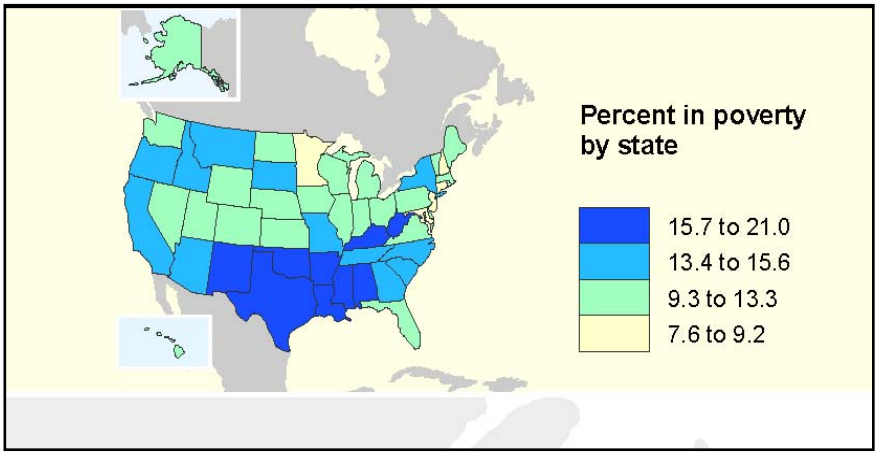
Table 6
States with the Lowest and Highest Poverty Rates

State	Percent in Poverty
Lowest	
New Hampshire	7.6
Connecticut	8.3
Maryland	8.3
New Jersey	8.7
Minnesota	9.2
Highest	
Mississippi	21
Louisiana	20.2
New Mexico	18.4
District of Columbia	18.3
West Virginia	18

SOURCE: U.S. Bureau of the Census. (January 2008). Small Area Income & Population Estimates. 2005 Poverty and Median Income Estimates.

Fewer Kansans are likely to experience poverty than citizens of most southern states, Arizona, California, New York, and some northwestern states, as illustrated by Figure 2.

Figure 2
Percent of Total Population in Poverty : 2005



SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates Program, January 2008

Kansas has a similar rate of poverty when compared to the states immediately surrounding it, and to Iowa, with the exceptions of Missouri and Oklahoma – both of which have significantly higher rates (U.S. Bureau of Census, 2008). Table 7 shows this comparison.

Table 7
Kansas and Region Poverty Rates

State	Percent in Poverty
Iowa	10.8
Colorado	10.9
Nebraska	11
Kansas	11.7
Missouri	13.6
Oklahoma	16.4

SOURCE: U.S. Bureau of the Census. (January 2008). Small Area Income & Population Estimates. 2005 Poverty and Median Income Estimates.

Conclusion

Kansas fares better than many states in terms of its overall poverty rate, but has areas within the State with higher than average rates. This paper did not attempt to examine rates beyond the county level, but it is expected that there are regions in the state with both higher and lower than average poverty rates.

Whatever the poverty rate, ample evidence exists that poverty contributes to poor health in both direct and indirect ways (Feinstein, 1993), (Mackenbach, et al., 2008). Poverty can lead to:

- Lack of access to health care – both through no insurance and the lack of available health care providers in or near poor neighborhoods
- Racial and ethnic disparities, since many minority groups are disproportionately poor
- Lower life expectancies, through greater infant mortality and death from chronic, treatable diseases
- Poor nutrition and substandard housing, both of which contribute to poor health (National Center for Health Statistics, 2007)

Poverty is a multidimensional problem, but it has clear effects on health. Providing health care coverage to the poor does not address all the health issues that are connected to poverty, nor health, but could ameliorate access issues and reduce disparities. Additionally, providing such coverage would allow the poor to have more income for other necessities by reducing personal spending on health care.

References

DeNavas-Walt, Carmen, Procter, Bernadette D., and Smith, Jessica. (2007). Income, Poverty, and Health Insurance Coverage in the United States: 2006. *U.S. Census Bureau, Current Population Reports*, P60-233, Washington, DC U.S. Government Printing Office, p.43.

Feinstein, J.S. (1993). The relationship between socioeconomic status and health: A reviewof the literature. *Milbank Quarterly, 71*: 279-322.

Fisher, G.M. (1997, Winter). The development and history of the U.S. poverty thresholds – A brief overview. *Newsletter on the Government Statistics Section and the Social Statistics Section of the American Statistical Association: 6-7. Retrieved July 9, 2008, from* http://aspe.hhs.gov/poverty/papers/hptgssiv.htm

Frier, Sarah. Stanford scholars try to measure poverty. *San Mateo County Times.* Retrieved June 3, 2008, from http://www.insidebayarea.com/sanmateocountytimes/ci_9443392.

Holzer, H.J., Schanzenbach, D.W., Duncan, G.J., and Ludwig, J., (2007, April). The Economic Costs of Poverty in the United States: Subsequent Effects of Children Growing Up Poor*. Institute for Research on Poverty Discussion papers no. 1327-07.* Retrieved June 3, 2008, from http://www.irp.wisc.edu/publications/dps/pdfs/dp123707.pdf

Kawachi, I., Kennedy, B.P., Lochner, K & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health, 87*:1492-1498.

Mackenbach, J.P., Stirbu, I., Roskam, A-J. R., Schaap, M.M., Menvielle, G., Leinsalu, M. & Kunst, A.E. (2008). Socioeconomic inequalities in health in 22 European countries. *New England Journal of Medicine, 358;23:* 2468-2481.

(2007). Op cit. *National Center for Health Statistics*.

(2007, February). Consumer Expenditures in 2005. *U.S. Bureau of Labor Statistics.* Retrieved July 9, 2008 from http://www.bls.gov/cex/csxann05.pdf

(2007, August 9). Op cit. *U.S. Department of Health and Human Services*.

(2007, August 9). Research on alternative approaches to poverty measurement. *U.S. Department of Health and Human Services: Further Resources on Poverty Measurement, Poverty Lines, and Their History.* Retrieved April 24, 2008, from http://aspe.hhs.gov/poverty/contacts/.shtml

(2008, January). Small Area Income & Population Estimates. Estimates for Kansas Counties, 2005. *U.S. Bureau of the Census*. Retrieved April 24, 2008, from http://www.census.gov/cgi-bin/saipe/saipe.cgi

(2008, January). Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2008. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved May 15, 2008, from http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4&print=1

(2008, April). Understanding the Uninsured: Tailoring Policy Solutions for Different Subpopulations. *NIHCM Foundation*.

(2008, April 8). State Medicaid Fact Sheet: Kansas and United States. *The Kaiser Commission on Medicaid and the Uninsured*. Retrieved May 5, 2008, from http://www.kff.org/MFS/jsp?rgn=18&rgn=1

(2008, January). 2005 Poverty and Median Income Estimates – States. *U.S. Bureau of the Census*. Retrieved June 2, 2008, from http://www.census.gov/hhes/www/saipe/downloads/estmod05/est05US.xls

Attachment D

The Minimum Wage in Kansas

The Minimum Wage in Kansas

Background

The Kansas minimum wage is the lowest state minimum wage in the nation at $2.65/hour. Although this wage has no effect on workers covered by the federal minimum wage, a number of Kansas workers may be only covered by the Kansas minimum or exempted from all minimum wage requirements.

Kansas Minimum Wage

A total of 20,000 Kansas workers received less than the federal minimum wage in 2006 (United States Bureau of Labor Statistics, 2008). However, this does not necessarily indicate that they were all paid the Kansas minimum wage since there is no data on the number of workers receiving the Kansas minimum. The 20,000 could include self-employed workers and those not covered by either Kansas or the federal law.

Employees covered by the Kansas minimum wage but not the federal standard include:

- Employees of private firms grossing less than $500,000 per year and not engaged in or producing for interstate commerce, education, residential care or running a hospital
- Employees of certain seasonal amusement or recreational establishments
- Employees of certain small newspapers and switchboard operators of small telephone companies
- Childcare workers
- Companions to the elderly or infirm

An unknown number of workers who are not classified as employees or who are members of what a report by the Ad Astra Institute refers to as the "underground economy" received less than the Kansas minimum wage. This group includes workers who are not reported as employees by their employer for reasons such as undocumented immigration, a desire to avoid paying taxes or child support, a desire to keep their name or location unknown, performance of illegal child labor, or work in support of an illegal enterprise. This report estimates that 2.2 percent of Kansas workers paid by the hour received less than the federal minimum wage in 2006 (Burress, 2007).

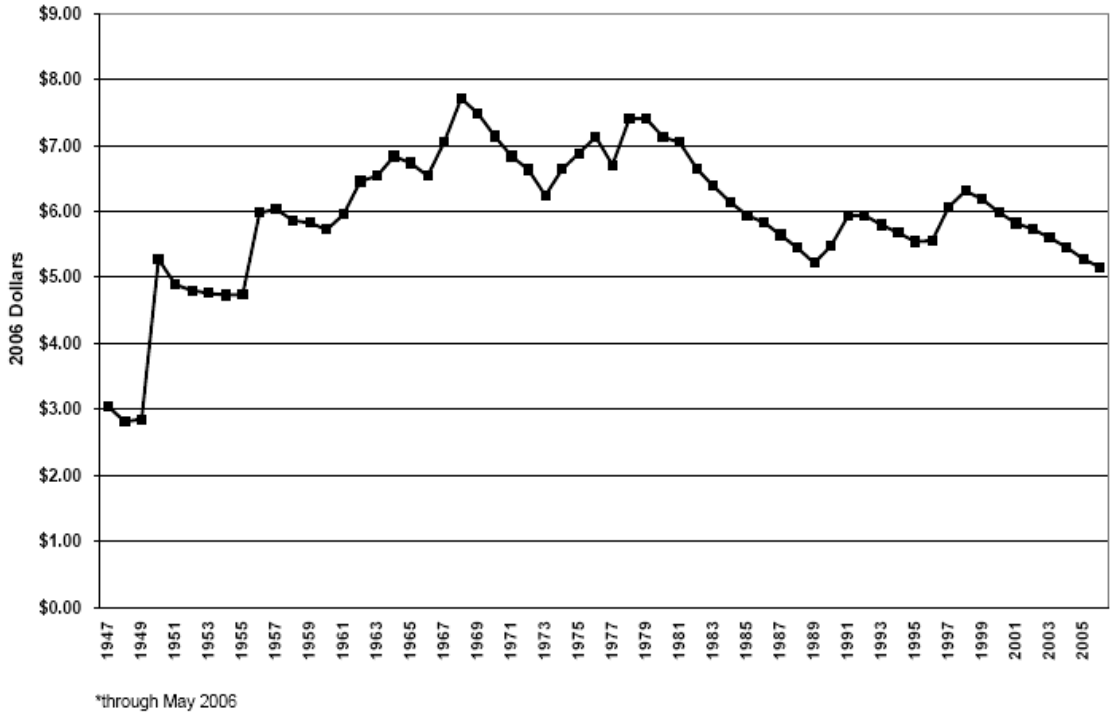
Federal Minimum Wage

Two-thirds of working-age poor in Kansas work at least part of the time. Of the 300,000 people living in poverty in Kansas in 2004, 170,000 were of working age and 110,000 worked full or part time. Many of these individuals earned minimum wage.

Twenty-six percent of federal minimum wage earners in Kansas are parents who would benefit from the scheduled increases. It is important to note, however, that these increases will probably not be enough to lift their families out of poverty. For example, the poverty level for a family of three in 2007 was $17,170. An individual working 40 hours 52 weeks out of the year for $7.25/hour would only earn slightly over $15,000. It would take a larger increase to lift this family out of poverty (Burress, 2007).

It is also important to note how the real value of the federal minimum wage has decreased. Since its inception in 1947, the real value of minimum wage peaked in 1969, but has decreased significantly since that time. A chart produced by the Economic Policy Institute shows the value of minimum wage in 2006 dollars from 1947 to 2006 (Economic Policy Institute, 2007).

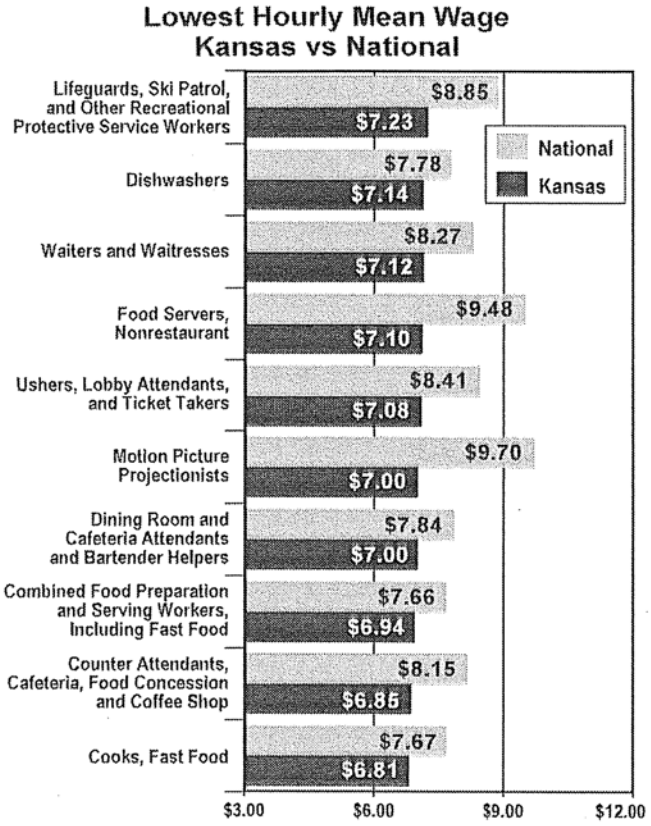
Figure 1: Real value of the minimum wage, 1950-2006*



*through May 2006

Low-paying Jobs in Kansas

The Kansas Department of Labor released the 2007 Kansas Wage Survey in September of 2007. Below is a chart from the survey showing the ten lowest-paying jobs in Kansas for 2007 compared to the national average pay rate for the same occupation. None of the ten lowest-paying occupations in Kansas paid more than the national average (Kansas Department of Labor, 2008).



Inequality of Income in Kansas

According to a report by the Center on Budget and Policy Priorities and the Economic Policy Institute, the gap between the richest and poorest Kansas families is the 28th largest in the nation. The average incomes of the richest 20 percent of families are 6.8 times as large the poorest 20 percent. This ratio has grown over the past two decades, as the ratio was only 5.0 in the late 1980s. This growth in inequality is the eighth largest in the nation.

When comparing the richest 20 percent of families with the middle 20 percent, the average incomes are 2.5 times as large. This has grown from 2.0 times in the late 1980s and is the 12th largest growth inequality for these groups in the nation (Center on Budget Priorities and Economic Policy Institute, 2008).

Historical Poverty Rates

Over the past two decades, the poverty rate in Kansas has remained relatively steady, hovering at around 11 percent most years. The chart below is compiled from information from the U.S. Census Bureau (http://www.census.gov/hhes/www/saipe/county.html), and shows the poverty rate in Kansas for all years that data is available since 1989.

Year	Rate	Rank
2005	11.7	20
2004	11.1	20
2003	10.4	17
2002	10.0	16
2001	9.5	18
2000	8.9	15
1999	10.2	21
1998	10.5	19
1997	10.9	18
1996	10.8	16
1995	11.0	18
1993	12.2	20
1989	10.8	19

The chart also shows where Kansas ranked nationally compared to other states. As shown, Kansas ranked between 15 and 21 on a national scale, but normally fluctuated around the 19-20th place.

Conclusion

Even with the federal step increases in minimum wage that were enacted in 2007, many Kansas workers will earn less than workers in other states for the same occupation. For some, the increase in the federal minimum wage will not be enough to lift them out of poverty. Those workers earning the Kansas minimum wage or less than the federal minimum wage are among the lowest-paid workers in the nation.

References

Burress, D. (2007, December). Impacts of Minimum Wage Increases in Kansas: A Background Report. *Lawrence, KS: Ad Astra Institute of Kansas, Inc*. Retrieved April 21, 2008, from http://www.raisethewagekansas.org/wichita/wp-content/uploads/2007/12/report-12-3-07-kan.pdf.

(2008, April 9). *Pulling Apart: A State By State Analysis of Income Trends*. Center on Budget Priorities and Economic Policy Institute. Retrieved May 27, 2008, from http://www.cbpp.org/states/4-9-08sfp-fact-ks.pdf.

(2007). Minimum Wage Issue Guide. *Economic Policy Institute.* Retrieved May 21, 2008, from http://www.epi.org/issueguides/minwage/figure1.pdf.

(2008). Kansas Wage Survey 2007 Edition. *Kansas Department of Labor*. Retrieved May 21, 2008, from http://www.dol.ks.gov/lmis/wagesurvey/ws2007/krip442(09-07).pdf

(2008, April 9). Pulling Apart: A State By State Analysis of Income Trends. *Center on Budget Priorities and Economic Policy Institute.* Retrieved May 27, 2008, from http://www.cbpp.org/states/4-9-08sfp-fact-ks.pdf.

(2008, May 7). Characteristics of Minimum Wage Workers, 2007. *United State Bureau of Labor Statistics*. Retrieved May 28, 2008, from http://www.bls.gov/cps/minwage2007tbls.htm#2. http://www.census.gov/hhes/www/saipe/county.html