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Verbal Neutral Testimony on SB 363
Senate Committee on Government Efficiency
February 10-11, 2026
Christine Osterlund, Deputy Secretary of Agency Integration and Medicaid Director
Kansas Department of Health and Environment

Chairwoman Erickson and Members of the Senate Committee on Government Efficiency,

Thank you for the opportunity to provide neutral verbal testimony on Senate Bill 363 regarding data matching agreements with state agencies, data submission to the Centers for Medicare and Medicaid Services (CMS), the prohibition of self-attestation, and the requirement to redetermine eligibility on a quarterly basis. SB 363 potentially creates increased costs to the state and risk of noncompliance with federal law, which could potentially result in lost federal funds, repayment of federal funds, and higher error rates. It is likely at least an additional 192 full-time employees would be needed to process Medicaid eligibility within the parameters SB 363 sets.

Fiscal Impact of SB 363

Overall Fiscal Impact:

Funding Source	**Cost**
State General Funds	**$3,595,310**
Federal Financial Participation	**$6,367,231**
All Funds	**$9,962,541**

Eligibility Fiscal Impact:

Funding Source	**Cost**
State General Funds	$2,112,410
Federal Financial Participation	$6,337,231
All Funds	**$8,449,641**

It was estimated that 192 additional full-time employees would be needed to comply with changes SB 363 would make to eligibility processing and includes staff time for data matches that would not result in immediate termination of eligibility. In addition, if self-attestation is

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prohibited, it will very likely result in longer application and renewal processing times, as well as additional incoming documents that would need to be processed by our mailroom and scanning/imaging vendor.

Data Fiscal Impact:

Funding Source	**Cost**
State General Funds	$10,000
Federal Financial Participation	$30,000
All Funds	**$40,000**

It was estimated that it would be around 800 hours of time for the year and cost projections of implementing SB 363 requirements. The 800 hours include:

- Meetings for reporting
- Time to build reports
- Continuous monitoring
- Maintenance

Systems Fiscal Impact:

Estimate Cost: KDHE: $1,472,900 +/- 30%

Estimate Hours: KDHE: 12,280 hours +/- 30%

NOTE: These costs are available for 75% federal funding. However, the higher match is subject to CMS approval and there is a strong possibility that CMS would refuse to fund the cost of running the income verification that frequently. The cost of the income/wage information is extremely high due to the cost per transaction and the request to run this process for everyone active every two weeks, as SB 363 outlines a semi-monthly basis for this data check. If DCF also wanted to use these new interfaces, separate tasks and forms will need to be created.

Section 1: Data Matching Agreements with State Agencies

It is essential for Medicaid programs to use the most accurate and updated data sources to verify applicant and member eligibility for the program, and **Kansas is currently using all required, available data sources which the state finds useful, accurate and efficient, and which meet the federal requirements.** Below is a table showing the type of data and sources used, and how frequently those sources are used.

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Data Match	Source(s) Used	Frequency
Income, changes in employment and wages	Kansas Department of Labor; CMS Hub	Daily from KDOL; Equifax data through the CMS Hub income checked at application and at review
Identity, citizenship and immigration status	CMS Hub; Verify Lawful Presence (VLP) interface; SAVE interface	Citizenship and identity checked at application; immigration status checked at application and anytime status may have changed
Bank account information	Asset Verification System (AVS)	At application and review.
Social Security Number	Social Security Administration interface	At application, when applicant supplies SSN, and prior to income verification during review
Date of death	Office of Vital Statistics (OVS); Social Security Administration	Weekly from OVS
Incarceration	Department of Corrections; APPRISS	Monthly from KDOC; daily from APPRISS.
Residency	PARIS file; monthly CMS file	Quarterly from PARIS; monthly from CMS.
Retirement	Kansas Public Employees Retirement System interface	At application and review
Unemployment	Kansas Department of Labor Unemployment Insurance interface	At application and review

There are areas in SB 363 where Kansas Medicaid is being asked to use important data less frequently than that data is used today. This also dictates Kansas Medicaid use specific data sources where more reliable data sources may be found outside agency data. For example, data from the Kansas Department of Revenue (KDOR) was previously used by

Medicaid and was less reliable when compared to our current sources to verify income as they can be accessed in real time and reflect more current data. The cost of systems updates and data matches may outweigh the benefits of the data.

Per 42 CFR 435.948, 435.949, and 435.945(k), any interface in addition to those required by CMS must "reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs." Kansas Medicaid would need to document any non-mandatory sources in our State Verification Plan, per CIB 11/20/2024. **If CMS determines the interface does not "reduce the administrative costs and burdens on individuals and States," the interface may not be approved for use.**

SB 363 also requires Kansas Medicaid to provide a 30-day notice of non-compliance or ineligibility. CMS requires states to provide 10 days' notice prior to reducing or discontinuing eligibility (42 CFR 431.211). **Allowing 30 days' notice would increase the state's costs, as eligibility would continue longer than it does today**. CMS requires that states allow the consumer 30 days to respond to a notice to clarify residency in response to a data match, such as the PARIS report (45 CFR 155.330). If the consumer fails to respond or reports an out-of-state address within that 30-day time frame, coverage is ended with 10 days advance notice.

Section 2: Data Submission to the Centers for Medicare and Medicaid Services (CMS)

Kansas Medicaid is already required to submit data to the Centers for Medicare and Medicaid Services (CMS) on a monthly basis. These data submissions are made through the Transformed Medicaid Statistical Information System (T-MSIS) and are measured each month for quality and timeliness; Kansas Medicaid is in compliance on all measures. Domains of data in T-MSIS include:

- Inpatient claims.
- Long term care claims.
- Other claims.
- Pharmacy claims.
- Eligibility data.
- Financial transactions.
- Managed care plan information.
- Provider data.

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- Third party liability data.

Data includes demographic and eligibility information for all Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and is used for national oversight, policy evaluation, and to assist in coordinating care for individuals enrolled in both Medicare and Medicaid.

In addition, KDHE routinely shares data outside of T-MSIS for activities related to system certification (monthly sharing of metrics related to activities across Medicaid systems), audits and required eligibility statistics.

Section 4: Prohibiting Self-Attestation

State Medicaid programs must outline their policies regarding self-attestation, as well as how eligibility information is verified, in the state verification plan. The verification plan is submitted to CMS for review and approval (42 CFR 435.940-435.965 and 457.380). States may accept self-attestation for state residency (435.956(c)), age, date of birth, and household size (435.956(f)).

Per 42 CFR § 435.952, if the information provided on the application is reasonably compatible with data sources, Kansas Medicaid must determine eligibility based on that information. By requiring proof of every item, Kansas Medicaid will be assuming that every response from the consumer is not reasonably compatible, and could be found noncompliant with that regulation, in which case the change will need to be reversed. In addition, changes to self-attestation would need to be approved by CMS in order for KDHE to implement these changes and if not approved, these changes could not be implemented.

The State must permit self-attestation when the needed documentation does not exist at the time of application or renewal or is not reasonably available (42 CFR 435.952). Examples of this could be that a consumer is unable to supply proof of income due to experiencing a natural disaster or because an employer refuses to provide pay stubs or a statement of wages.

Not accepting the consumer's attestation for items such as household size would result in holding every application and review to request documentation. This will add an automatic 12 or more days to processing every application/review and could impact overall quality and consistency if staff must request and analyze documentation to determine if it meets the standard. The additional days added to the application or renewal processing would also put Kansas at risk for not meeting the 45-day timeliness standard as required by CMS (CFR 435.912(c)(3)). If Kansas fails to meet that standard, the state would be put on a Corrective Action Plan which comes with risk to federal match and untimely processing increases the State's Payment Error

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Rate Measurement (PERM) error rate. **If the Kansas Medicaid error rate exceeds three percent, the State will owe money back to the federal government**. Additionally, beginning federal fiscal year 2030, the definition of improper payments will expand to include payments made when there was insufficient information to confirm eligibility, and there will no longer be a waiver for states demonstrating a "good faith" effort to improve their error rate. It is important to note that during the Clearinghouse backlog in 2017 and 2018, during which applications did not always meet the 45-day standard for timeliness, the Kansas Medicaid PERM error rate for that timeframe was 27.54%.

Additional burden of proof on consumers will likely result in higher procedural denials/closures for failure to provide the information, which in turn tends to increase application volumes as consumers attempt to reinitiate the application process. The increased volume of applications will also negatively impact the ability to maintain compliance with the 45-day requirement. **Increase in denials/closures will also increase the amount of uncompensated care being provided by Kansas providers.**

In some instances, Kansas Medicaid accepts attestation which will make the consumer ineligible, such as excess income or not being a caretaker of a child. If attestation is prohibited, we risk requiring the consumer to prove their ineligibility, again, increasing processing timeframes and burden on the consumer only to delay a determination of ineligibility.

<u>Section 5:</u> Requiring Redeterminations of Eligibility for Medical Assistance on a Quarterly Basis

The term renewal refers to a consumer's annual, scheduled determination of eligibility. **Kansas Medicaid can only complete a formal review or renewal of eligibility once every 12 months and no more frequently than every 12 months per 42 CFR § 435.916. Outside of the annual review, eligibility can only be redetermined or reevaluated based on a change in circumstance**. Kansas Medicaid can do this between scheduled renewals any time we have reliable information about a change in circumstances that impacts a beneficiary's eligibility, which could include results from a data match. **If the reliable information was not received directly from the beneficiary or representative and was instead received from a third-party, as done through data matching, the agency must request information from the beneficiary to verify or dispute the information received (42 CFR § 435.919)**. Outside of the 12-month renewal and reacting to a reported change in circumstance, states cannot conduct redeterminations.

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It is important to note that SB 363 is written to broadly cover all Medicaid beneficiaries, even those for whom federal law requires 12 months of continuous eligibility, such as children under 19, newborns and those on the Transitional Medical and Extended Medical programs. In addition, Kansas statutes provide 12-months of continuous eligibility to pregnant women. Because SB 363 would still require Kansas Medicaid to conduct data checks for those populations, if Kansas Medicaid were to receive information through data matching that made a child ineligible, for example, the agency would not be allowed to discontinue them. **That means Kansas Medicaid would still have to reach out to the beneficiary and expend money for the data match and staff time to do the outreach and processing that will ultimately not result in the immediate discontinuance of eligibility.**

Section 6: Limiting Retroactive Enrollment in the Medical Assistance Program.
This provision is consistent with H.R. 1, which will limit the retroactive period from three months to two months for non-expansion states effective with applications submitted on or after January 1, 2027. One consideration about putting this limitation in state law is if the federal law is ever changed then federal and state law would be in conflict just like we have with the current statutes regarding CHIP.

As stated in other testimony on H. R. 1, this change could impact **3,826 Medicaid members, and providers may be hesitant to treat individuals before their Medicaid coverage becomes active, fearing nonpayment**. **Hospitals, clinics and other safety-net providers may absorb more unpaid costs** if patients delay applying for Medicaid and their dates of service are outside the prior medical window, or if eligibility is denied.