

Committee Reports to the 2014 Kansas Legislature



Supplement

**Kansas Legislative Research Department
July 2014**

2013 Legislative Coordinating Council

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Supplement

Special Committee on Education

Robert G. (Bob) Bethell Joint Committee on Home and Community Based
Services and KanCare Oversight

Capitol Preservation Committee

Health Care Stabilization Fund Oversight Committee

Telecommunications Study Committee



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Foreword

This publication is the supplement to the *Committee Reports to the 2014 Legislature*. It contains the reports of the following committees: Special Committee on Education, Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, Capital Preservation Committee, Health Care Stabilization Fund Oversight Committee, and the Telecommunication Study Committee.

This publication is available in electronic format at <http://kslegresearch.org/Committees.htm>.

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Report of the Special Committee on Education to the 2014 Kansas Legislature

CHAIRPERSON: Representative Kasha Kelley

VICE-CHAIRPERSON: Senator Steve Abrams

LEGISLATIVE MEMBERS: Senators Tom Arpke, Jeff Melcher, Ralph Ostmeyer, Pat Pettey, and Kay Wolf, Representatives Marvin Kleeb, Jerry Lunn, Richard Proehl, Ron Ryckman Jr., Sharon Schwartz, Ed Trimmer, and Valdenia Winn

STUDY TOPIC

- Review and gather information on the funding sources and distribution methodologies used by other states for K-12 education.

Special Committee on Education

REPORT

Conclusions and Recommendations

The Committee met for the two days allotted and studied many issues related to school funding. The material was voluminous, dense and complex, and it took the entirety of the two days. The presentations provided fertile ground for considering how money matters, given the fact that significant achievement gaps still exist between groups of students in Kansas and all students could benefit from improving the education system. Additional time was needed to develop recommendations; however, the request for additional time was not granted by the Legislative Coordinating Council (LCC). This left the analysis and other information for the House and Senate Committees on Education to proceed with the topics presented.

Proposed Legislation: None

BACKGROUND

The study topic assigned to the Special Committee on Education (Committee) was to examine information on funding sources and distribution methodologies used by other states for K-12 education. The Legislative Coordinating Council granted the Committee two days to complete its work.

The Committee met on November 6 and 7, 2013. The agenda covered a number of K-12 funding-related topics, including the following:

- An examination of funding formulas across the nation, with a closer look at funding mechanisms in nearby states and Kansas' formula;
- An examination of the policy history behind school finance litigation in the United States, from 1970 to the present;
- An in-depth review of school finance litigation nationwide, from 1970 to the present;
- Analyses of Kansas public school staffing growth rates; and

- Analyses of national test scores among Kansas students.

Funding Formulas

The Committee heard two presentations on public school funding formulas across the nation. The first, from the Kansas Legislative Research Department (KLRD), reviewed a policy brief that summarized a 50-state survey of school finance systems.¹ According to the brief, no fundamentally new state finance systems have been developed in recent years. Most states use systems that have been in place for nearly a century, although most states have modified these systems. Generally, according to the brief, "... states are moving to weighted systems to tailor funding streams to individual student needs and characteristics and providing additional funding for remote schools [or] districts."

The types of funding formulas are explained briefly and distributed as shown in the following list:

- Foundation programs – "... [S]upport education through a set state guarantee of

¹ Deborah A. Versteegen, *Policy Brief: State Inventories of Public Education Finance Systems in the United States*, University of Nevada, October 30, 2013 (Draft for Comment; update of a previously issued brief.)

funding per pupil or per teacher, which historically was intended to pay for a basic or minimum education program.” School districts contribute generally through a uniform tax rate, which usually, but not always, is based on property taxation. The state makes up the difference between the uniform tax rate and the guaranteed amount per pupil, which often is called “equalization.” While the states’ foundation programs differ in a number of ways, 37 states including Kansas used foundation formulas as of 2013.² (Note: Kansas also has a second level of funding, also equalized, called the supplemental general fund or local option budget. The policy brief indicated many states have a second level but most of those are not equalized.)

- District power equalizing systems – “Unlike [foundation programs], district power equalizing systems support taxpayer equity, rather than pupil equity, by providing *equal yield in the form of funding for similar tax rates (effort)* across the state.” There are different types of power equalizing mechanisms, including a guaranteed tax base system, guaranteed yield approach, and percentage equalizing. According to the policy brief, these systems are “quickly becoming obsolete, most likely because they permit differential funding per pupil across the state based on variations in tax rates.” As of 2013 only two states (Vermont, Wisconsin) used district power equalizing systems to fund their public schools.³
- Flat grants – Used in only one state (North Carolina), the flat grant provides a set dollar amount per student or per teacher regardless of a district’s wealth. According

² Versteegen, *Policy Brief*, pp. 2-3 The states are Alaska, Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Indiana, Iowa, **Kansas**, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, Washington, West Virginia, and Wyoming.

³ Versteegen, *Policy Brief*, p. 4.

to the report, “Flat grants were used by states as an initial means of assistance for schooling but have since been abandoned as a major approach for state funding because they provide low levels of aid and drive inequalities because of the excess local funding permitted.”⁴

- Combination or tiered systems – According to the policy brief, nine states (Georgia, Illinois, Kentucky, Louisiana, Maryland, Montana, Oklahoma, Texas, and Utah) provide combination approaches. For example, Georgia uses both a foundation system and a guaranteed yield formula.
- Full state funding – Only one state (Hawaii) reported using full state funding, wherein all public education funding is collected and distributed by the state.

KLRD staff also detailed the following growth nationwide in state revenues to public elementary and secondary schools in the U.S.⁵:

- 1919-1920 – \$160 million
- 1949-1950 – \$2.2 billion
- 1970-1971 – \$17 billion
- 2000-2001 – \$200 billion; and
- 2006-2007 – \$264 billion

Finally, KLRD staff summarized Kansas’ funding formula, referred to as the School District Finance and Quality Performance Act. The review included a summary of all amendments to the Act since its enactment in 1992.

A representative of the Friedman Foundation for Educational Choice presented a report titled “K-12 Public Education Profile: Kansas vs. Neighboring States.” The representative compared

⁴ Versteegen, *Policy Brief*, p. 4.

⁵ 2012 Edition Digest of Education Statistics, National Center for Education Statistics.

a number of factors including demographics and school funding formula elements.

School Finance Policy History

The Committee received a presentation from KLRD staff regarding the history of school finance policy beginning in 1970. The presentation illustrated how policy decisions made several decades ago still influence school finance litigation and policy today. The following provides excerpts from that presentation.

The theme of the presentation was stated at the beginning: How does money matter in education? Equity and adequacy have been important principles in school finance policy historically. “Equity” generally refers to fairness in the distribution of goods and services, while “adequacy,” though less well defined, usually refers to the sufficiency of resources available for students to reach a performance level. Chronologically, equity was the first concern addressed in school finance litigation, followed by adequacy court cases. Both groups of cases have had a strong influence on public policy.

In 1970 a book was published, titled *Private Wealth and Public Education*.⁶ The authors (John E. Coons, William H. Clune III, and Stephen D. Sugarman) also had written a lengthy law review journal article on the same topic.⁷ The focus of the publications was equality of educational opportunity, and the authors’ purpose was to actively engage in the litigation process, a departure from most previous scholarly works. Their work was used in the first successful school finance lawsuit in the nation – *Serrano v. Priest*. The *Serrano* decision sparked numerous school finance lawsuits across the United States, including in Kansas.

Coons, Clune and Sugarman delved into the issue of equity. In doing so, the authors also began to explore early ideas that were related to

6 John E. Coons, William H. Clune III, and Stephen D. Sugarman, *Private Wealth and Public Education*, Cambridge, Mass.: The Belknap Press of Harvard University Press, 1970.

7 Coons, Clune and Sugarman, *Educational Opportunity: A Workable Constitutional Test for State Financial Structures*, 57 *Cal Law Review*, 305 (1969).

adequacy, the second widely used principle in school funding litigation.

The Coons, Clune and Sugarman publications examined school funding systems based on their concept of “fiscal neutrality” – “The quality of public education may not be a function of wealth other than the wealth of the state as a whole.” At that time, public school funding was based primarily on local property taxes. This dependence on local wealth, which varied widely within a state, became the target of these authors, but only after they examined all possible forms of “equality of educational opportunity.” The authors explained, “It will be evident from [the precept of fiscal neutrality] that we do not aim to effect equality of educational opportunity in all its possible senses.... [T]o us, the state’s moral and legal imperative extends no further than those inequalities created by government itself. Discrimination by the state is our sole object; this excludes the duty to ameliorate cultural or natural disadvantages....”⁸

Upon closer examination of the fiscal neutrality concept, the “wealth” referred to was taxable wealth within a state. Because of the limitations existing at the time, of attempting to relate funding to achievement, the authors limited their definition of “quality” by stating, “Quality is the sum of district expenditures per pupil.”⁹ In the words of a later author, “... [T]he negative statement of fiscal neutrality largely sidestepped the complex and ever-controversial issue of whether and how money matters in education, then known as the cost-quality debate. Under Coons’, Clune’s, and Sugarman’s formula, there was no need to demonstrate the link between educational resources and educational outcomes.... At the time Coons, Clune, and Sugarman were writing their book, the question was wide open.”¹⁰

8 Coons, Clune and Sugarman, *Private Wealth and Public Education*, pp. 1, 2, and 9.

9 Coons, Clune and Sugarman, *Private Wealth and Public Education*, p. 25.

10 William S. Koski, *Of Fuzzy Standards and Institutional Constraints: A Re-Examination of the Jurisprudential History of Educational Finance Reform Litigation*, 43 *Santa Clara L. Rev.* 1185, 1209 (2003).

However, as mentioned previously, the authors went on to acknowledge that the future might bring other forms of equality into consideration. In their words, the concept of fiscal neutrality became “a concession to the possibility that other forms of discrimination in public education will arise once the existing wealth determinants of quality are eliminated under this standard.”¹¹

The Committee was presented with comments from those who supported and disagreed with the Coons, Clune and Sugarman approach to equity in funding. The authors themselves defended the “fiscal neutrality” concept as “a standard appropriate to the rigors of judicial proof...” since “... the only convincingly quantifiable item in the spectrum is money available for the general task of education in each district.”¹² Among the opponents was former U.S. Senator Daniel P. Moynihan, who stated, “The simple proposition is the more tax money you spend on education, the more tax money you give to the middle class. About 68 per cent of the operating costs of elementary and secondary education goes to teachers’ [and others’] salaries.... These salaries are paid to middle-class people with college degrees, teaching certificates, and licenses of various kinds.... [T]he median income of taxpayers is lower than the median income of teachers.”¹³

As stated previously, the first lawsuit sparked numerous court cases across the nation, and many of these dealt with school funding equity. But only about half of the cases were successful.¹⁴ Additionally, a concern arose that “...to achieve equality the state would level down spending of the wealthy districts rather than level up spending

11 Coons, Clune, and Sugarman, *Educational Opportunity: A Workable Constitutional Test for State Financial Structures*, 57 Cal. L. Rev. 305 (1969), p. 311.

12 Coons, Clune and Sugarman, *Private Wealth and Public Education*, P. 26.

13 Daniel P. Moynihan, *Solving the Equal Educational Opportunity Dilemma: Equal Dollars Is Not Equal Opportunity* adapted from U. of Ill. Col. of Law symposium speech, 2/23/72.)

14 Commentary: *Beyond School Finance: Refocusing Education Reform Litigation to Realize the Deferred Dream of Education Equality and Adequacy*, Jared S. Buszin, Ed. in Chief, 62 Emory L.J. 1613 (2013), p. 1620.

of the poorest.....” Finally, school reform advocates continuously sought better means for improving the position of the least advantaged students.¹⁵ Some analysts surmised these and similar factors led to a change in policy direction from equity to adequacy concerns.

Although there were preceding court cases which touched upon adequacy issues, the first widely recognized adequacy case was *Rose v. Council for Better Education* (790 S. W2d 186 (Ky, 1989)). The Kentucky case became an important, and often-cited, adequacy case; in fact, the Kansas Supreme Court has referred to this case specifically in its recent decisions. In this case, “The [Kentucky Supreme] Court defined an adequate education as one that instills in its beneficiaries seven capabilities, including, for example, sufficient oral and written communication skills to enable them to function in a complex and rapidly changing society and sufficient levels of academic or vocational skills to enable them to compete favorably with their counterparts in surrounding states.”¹⁶

According to some analysts, the focus had moved from the school level, in the early cases, to the student level. With the shift to adequacy came “...an emphasis on how the schools can be required to provide an adequate education, a shift from concern for finance to concern for education. The groundwork for this shift had been laid in the early adjudication which centered on proving that changes in financing practices would result in changes in educational results. The dispute revolved around whether the real objective was equal expenditure, equal treatment, or equal results. While the dispute was never settled, it transformed the school finance reform movement into an educational reform movement. In the

15 Rob Reich, *Equality and Adequacy in the State’s Provision of Education: Mapping the Conceptual Landscape*, a report prepared for *Getting Down to Facts*, a research project released in March 2007 consisting of more than 20 studies designed to provide California’s citizens with comprehensive information about the status of the state’s school finance and governance systems. For more information, see: <http://irepp.stanford.edu/projects/cafinance.htm>. P.8.

16 William S. Koski and Rob Reich, *When “Adequate” Isn’t: The Retreat from Equity in Educational Law and Policy and Why It Matters*, 56 Emory L.J. 545 (2003), p 560.

process, the concern for equity gave way to a concern for adequacy.”¹⁷

The Committee was provided comments by proponents and opponents in the “adequacy” argument. The question generally came down to whether the money has mattered, *i.e.*, whether the additional money has had a positive impact on student achievement. Individuals identified as weighing in on both sides of this question – those who say the additional money has made a difference and those who say it does not matter – were reported to have drawn similar conclusions. In both groups, money was said to make a difference if, or only if, it was spent in ways proven to have an effect on pupil achievement. Among these, teacher and other personnel quality was an important spending component.

School Finance Litigation

Attorneys from the Office of Revisor of Statutes provided a national and state overview of school finance litigation, as well as updates on *Gannon v. State* (*Gannon*) and *Petrella v. Brownback* (*Petrella*). *Gannon* and *Petrella* are currently before the Kansas Supreme Court and the Kansas federal district court, respectively.

The Assistant Revisor reviewed a large number of noteworthy school finance cases, such as *Serrano v. Priest* (5 Cal. 3d 584, 487 P.2d 1241 [1971]), *San Antonio Independent School District v. Rodriguez* (411 U.S. 1, 12, 93 S. Ct. 1278, 1285, 36 L. Ed. 2d 16 [1973]), *Robinson v. Cahill*, 62 N.J. 473, 303 A.2d 273 [1973] and *Rose v. Council for Better Education* (790 S.W.2d 186 [Ky. 1989]). In reviewing these court decisions, the Assistant Revisor discussed equity and adequacy-based constitutional challenges which were made to various states’ school financing systems. Figures 1 and 2 (included at the end of the report) provide a graphic explanation of the presentation.

¹⁷ Arthur E. Wise, *Minimum Educational Adequacy: Beyond School Finance Reform*, *Journal of Education Finance*, Vol. 1, No. 4 (Spring, 1976, pp. 468-483), pp. 468-469.

Staffing Surge in Kansas and the U.S.

Three presentations were given regarding the growth in school district staff in the state as well as the nation. A representative of the Friedman Foundation (also a professor at Georgia College & State University) noted that, nationally, the number of students grew by 96 percent from FY 1950 to FY 2009; however, the total number of school personnel grew by 386 percent during that time. Further, while the numbers of teachers grew by 252 percent, numbers of administrators and other staff grew by 702 percent.

The Friedman Foundation representative tracked growth in Kansas public school staff from FY 1993 to FY 2011. He stated the student population grew by 7 percent but total staff numbers grew by 25 percent during that time; among staff, the number of teachers grew by 16 percent while that of administrators and other staff grew by 36 percent. He then reported that, if Kansas had increased non-teaching staff at the same rate as its increase in students, this would have saved Kansas public schools \$346.7 million per year in annual recurring savings. The representative also addressed the period between FY 2005 and FY 2011, during which numbers of students increased by 3.1 percent while numbers of total staff increased by 5.7 percent, with the number of teachers increased by 5.2 percent and that of administrators and other staff by 6.2 percent. During a part of the Great Recession the number of teachers in Kansas shrank by 56 percent from FY 2010 to FY 2011, while administrators and other non-teaching staff grew by 276 percent. Other information was covered as well, including (1) information questioning the benefit of paraprofessionals in the classroom, and (2) a comparison of pupil-teacher ratios versus pupil-non-teaching staff ratios.

A Kansas Policy Institute (KPI) representative followed with a comparison of Kansas school district staffing data between two years. The growth between FY 1993 and FY 2013 was 6 percent for student enrollment, 16 percent for teachers, and 40 percent for non-teachers. The data were further disaggregated, both by percentage change for smaller time intervals within that period and for specific types of staff. The KPI representative left the Committee with several

questions, such as whether district hiring practices (specifically, considering the hiring of teacher aides versus teachers) indicates that districts believe aides are more beneficial than smaller classes or higher teacher pay, and upon what studies these staffing decisions are made.

The final presentation came from KLRD staff. Data from previous presentations were reviewed and confirmed; added to the previous analyses was a year-by-year analysis which showed that, in the past five fiscal years, the upward trend had reversed slightly. KLRD staff indicated that non-teaching full-time-equivalent (FTE) staff had increased by 40 percent overall between 1993 and 2013 (a conclusion reached by a prior conferee); however, between 2008 and 2013 non-teaching FTE staff decreased by 1 percent. KLRD staff presented additional information regarding which staff groups grew the most, and a breakdown over time of the change in student-to-teacher ratio.

NAEP Data and Interpretations

Presentations were made on Kansas data from the National Assessment of Educational Progress (NAEP) by representatives of two organizations: the Kansas Association of School Boards (KASB) and KPI. The KASB representative first summarized the advantages and disadvantages of using NAEP data. NAEP is the single standardized student achievement measurement across all states over time. However, it assesses only a small sample of students and is given only at two grade levels (Grades 4 and 8). The KASB representative explained the NAEP “Basic” level of achievement closely matches high school completion, and the NAEP “Proficient” level tends to predict college readiness. He then pointed out Kansas was ranked 9th in 2011 in average number of scores at the Basic level. Kansas also was among the top 12 states in percentage of students scoring at the Proficient level or higher. Looking only at low-income students (*i.e.*, those qualifying for free or reduced-price lunch in the National School Lunch Program), Kansas ranked 7th in the average percentage of low-income students scoring at the Basic level and 6th in the percentage at the Proficient level. However, the percentages were lower of low-income students scoring at the Basic or Proficient level. (Note: The 2013 NAEP scores

were released while the Committee meeting was held.)

A representative of KPI provided information on disaggregated NAEP scores in the U.S. and Kansas. The KPI representative analyzed NAEP scores both in terms of average score and percent scoring at the Proficient level. Achievement gaps exist when comparing across income as well as racial and ethnic groups. Based on the data presented, many Hispanic and black students, as well as free/reduced lunch-eligible students, are two to three years behind their white or non-eligible peers. This is true in Kansas as well as in the U.S. as a whole. Gaps have persisted since at least 1998 or 2000, when comparing average scores of those students eligible and not eligible for free or reduced-price lunch. The KPI representative pointed out that demographic weightings skew state and school district averages. Mathematically, the composite scores for the state will be weighted in favor of the demographic group(s) that represent(s) the larger proportion of the population. The conferee noted, if a state’s population is largely white or higher income, the composite scores will be weighted toward the (generally higher) scores of those student groups. The representative stated Kansas was an example of this phenomenon.

Committee staff provided information regarding NAEP’s Long-Term Trend database. The significance of this NAEP measure is that it tracks achievement from 1971 (or, about the time the school finance litigation began) to the present.

Budget Projections

Upon request, KLRD staff projected what could result if the Kansas Supreme Court ordered the Legislature to appropriate the maximum estimated additional funding for K-12 education sought in the *Gannon* case (\$600 million). KLRD staff presented a number of scenarios, including the following:

- A 9.8 percent, across-the-board reduction in State General Fund (SGF) appropriations if all agencies and operations were to be reduced equally;
- A 19.4 percent SGF reduction for all agencies and operations except for K-12 education;

- A 28.0 percent SGF reduction for all agencies and operations except for K-12 education and full funding of human services consensus caseloads; and
- A 33.0 percent reduction for all agencies and operations except for K-12 education and full funding of human services consensus caseloads and corrections.

Video Presentation: PBS's *TED Talks Education*

The Committee viewed a Public Broadcasting System television special titled *TED Talks Education* (<http://video.pbs.org/video/2365006219/>).

The segment presented a number of education experts offering ideas and opinions about the direction education should take.

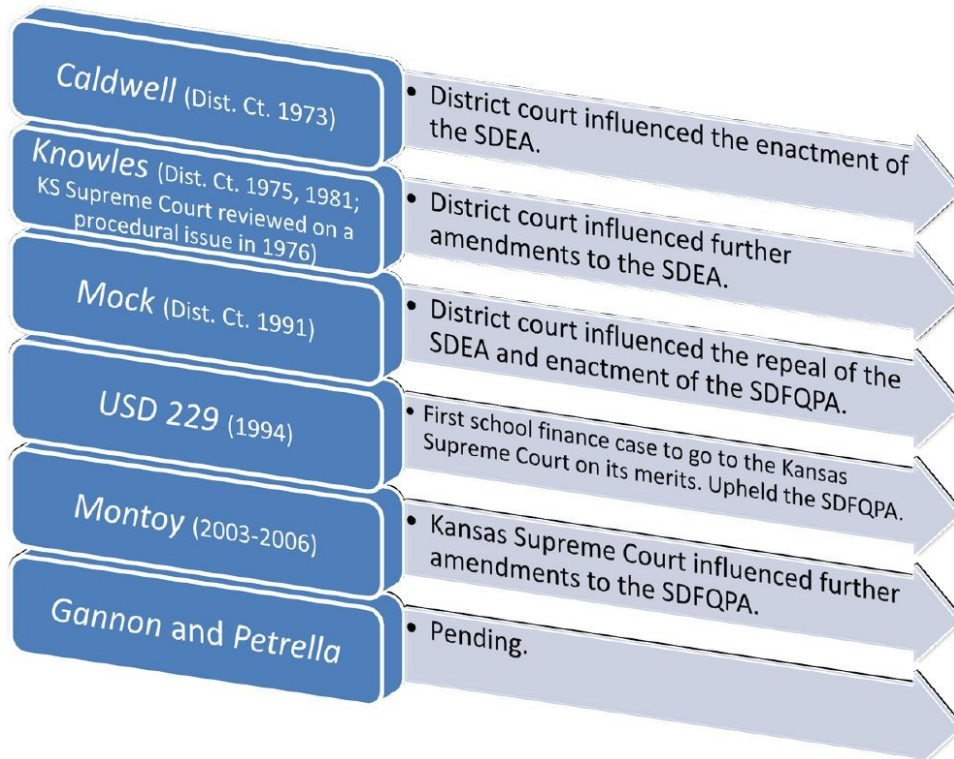
Request for Additional Meeting Time

Prior to adjourning the meeting at the end of the second day, the Chairperson and Vice-Chairperson indicated a request would be made for additional meeting time. A letter was sent to the LCC requesting two additional meeting days. The request was not granted. (A communication from the chairperson to committee members regarding additional meeting days and topics for consideration is attached to this report.)

School Finance Litigation

Constitutional challenges against state school financing systems →	Court's analysis
Equity-based lawsuits violating equal protection under the U.S. Constitution → →	Is the <u>unequal funding</u> among school districts rationally related to a legitimate governmental interest?
Equity-based lawsuits violating the state constitution → →	<p>Does <u>unequal funding</u> among school districts render the school finance system unconstitutional under a state's constitution?</p> <p>Plaintiffs will argue that education is a fundamental right under the state constitution's equal protection clause <u>or</u> that the unequal school funding violates the state's constitutional provision concerning education.</p>
Adequacy-based lawsuits violating the state constitutional provision for education → →	<p>Is the <u>level of funding</u> under the state school finance system <u>sufficient to meet the state's constitutional standard of educational quality</u>?</p> <p>Courts have analyzed the language in the state constitution to determine the standard of educational quality.</p>

Kansas School Finance Litigation



Provided by Revisor of Statutes

Email transmitted December 31, 2013

To: Members of the 2013 Special Committee on Education

From: Chairperson Kasha Kelley

I want to extend my genuine appreciation for your investment of time and work on this important issue, along with your willingness to be flexible in scheduling a tentative second meeting. The second meeting, requiring the two additional days which were not approved, would have been used to develop recommendations intended to address the alarming achievement gap between various groups of Kansas students, as well as to improve educational opportunities for all Kansas students. In our second meeting two groups of items were central to the agenda. First, we planned to discuss the following items for which the research appeared to indicate a positive relationship with student achievement:

Quality teaching and quality school leadership. We heard in Committee that, in studies nationwide, **both groups** on the "money matters" question – *i.e.*, those who believe money makes a difference and those who believe money does not make a difference – have said that money does matter if it is spent on quality school personnel. We planned to invite experts to testify on the relationship between funding and achievement to better understand the exact relationship and execution thereof. These experts have conducted research that drills down into the "money matters" discussion and which spending choices promote achievement and which have little or no impact. We further planned to discuss objective mechanisms and indicators of successful quality teachers and principals, and how to infuse or proliferate that consistent quality into/in the Kansas educational system. We had planned to invite experts who have addressed teacher and principal training, professional development, evaluation, and systems that underpin consistent achievement – in other words, the gamut of preparing for and ensuring quality school personnel.

Perseverance ("grit") and its relationship to students' academic success. You might recall Angela Lee Duckworth's research concerning "grit" from the PBS video. We planned to invite experts to discuss how and why "grit" matters in success and the degree to which it matters, as well as how to measure the characteristic of perseverance, and more importantly, how to impart it among students who -- being at risk of not achieving to their full potential -- need the support of learning how to find intrinsic motivation.

Second are those items for which more research is very possibly necessary to understand the full spectrum of their relationships to achievement. The goal of our second meeting would have been to further examine existing research, or request research be conducted, that is specific not only to student achievement trends and rates nationwide, but also to Kansas students. This body of work would focus on actual, student-specific correlation factors on national information already presented (*i.e.*, test scores, money, class size, teacher quality, demographics, and perhaps other factors) by having statistical analyses conducted. Such research would allow legislators to readily see the highest and lowest correlations to student success in relationship to dollars expended.

Unfortunately, the LCC fell a vote short, with one member absent. Therefore, our report will not contain recommendations. In the next few days I will ask you to review our report, which will be a summary of what we covered in our early November meetings.

For those serving on the standing education committee, you will likely see some of the above-mentioned issues as part of our committee agenda as they indeed deserve further review.

Once again, I thank each of you for making your schedules available for the meetings, for your input, questions and suggestions, and for your interest in and dedication to the students of Kansas.

Report of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight to the 2014 Kansas Legislature

CHAIRPERSON: Senator Mary Pilcher-Cook

VICE-CHAIRPERSON: Representative Dave Crum

LEGISLATIVE MEMBERS: Senators Jim Denning, Marci Francisco, Laura Kelly, and Michael O'Donnell, Representatives Barbara Ballard, Willie Dove, John Edmonds, Ron Ryckman Jr., and Jim Ward

STUDY TOPIC

- In addition to existing statutory oversight, the Committee is required to monitor and study the implementation and operations of Home and Community Based Service (HCBS) programs; the Children's Health Insurance Program (CHIP); the Program for All-Inclusive Care of the Elderly (PACE); and State Medicaid programs, including, but not limited to, access to and quality of services provided and any financial information and budgetary issues.
- Meet as required by statute, once in the third quarter and once in the fourth quarter of calendar year 2013.

Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight

REPORT

Conclusions and Recommendations

Based on testimony heard and Committee deliberations, the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight makes the following conclusions and recommendations.

Funding the Developmental Disability Waiting List

- With the delay in inclusion of long-term services and supports for individuals with developmental disabilities under KanCare until February 1, 2014, the Committee recommends passage of FY 2014 and FY 2015 additional funding for the Kansas Department for Aging and Disability Services (KDADS) to include the following:
 - An appropriation of \$4,000,000 to replace the \$4,000,000 which was lapsed from the mental health and retardation services aid and assistance account of the State General Fund for individuals with developmental disabilities;
 - Individuals with developmental disabilities and physical disabilities who were removed from the waiting list and provided services based on the FY 2014 and FY 2015 budget appropriation should continue to receive services; and
 - Any unspent funds appropriated for FY 2014 and FY 2015 for developmental disabilities and physical disability services should be directed to provide services to the individuals on the developmental disabilities underserved waiting list.

Inclusion of LTSS for Individuals with Developmental Disabilities

- The Committee reaffirms the importance of moving long-term services and supports (LTSS) for individuals with developmental disabilities into the KanCare managed care system by February 1, 2014.

KanCare Ombudsman

- To support the KanCare consumer's experience receiving medical assistance and long-term services and supports in a managed care environment, the Committee recommends the State maintain a permanent system of KanCare Ombudsman supports to assist consumers in understanding the managed care model and in the resolution of problems regarding services,

coverage, access, and rights. The core elements of the KanCare Ombudsman Office are recommended in detail in the Committee Report and include organization structure, accessibility, functions, and data collecting and reporting.

Medical and Surgical Claims Processing

- The Committee is concerned with reports of excessive administrative costs borne by KanCare providers and recommends changes be sought in the processing of medical and surgical claims to reduce those requirements. The following specific recommendations are made:
 - Hospital claims issues, including those revolving around those individuals with retroactive eligibility, need to be monitored, with the goal of finding a solution to resolve or reduce delays in payments.
 - To reduce personnel costs, high expense claims should be placed in the medical review process by managed care organizations (MCOs). Providers also are encouraged to consider the electronic transfer of data to MCOs or the placement of data in a secure registry to facilitate the timely review of those claims.
 - The Kansas Department of Health and Environment (KDHE) should review the accounts receivable percentages for providers for claims over 90 days past due. To determine whether payments of accounts receivable are improving or deteriorating, the Committee recommends a comparison be made of the ratio trends to the “commercial payor mix” obtained from information voluntarily provided by providers for use as a benchmark between Medicaid payers and commercial payors.

Claims Payments in Developmental Disability Long Term Services and Supports Inclusion

- If the inclusion in KanCare of LTSS for the developmentally disabled population occurs, it is expected that claims payment issues will arise related to credentialing, contract loading, coding, and place of service errors. Also anticipated are issues related to pre-authorization from case management, third-party liability, and coordination of benefits. The Committee recommends all three MCOs relax all possible edits for at least 90 days to allow the claims to pass through and be adjudicated the first time. The Committee recommends the edits be turned on slowly, one at a time, and enough resources be dedicated to permanently correct any issues that arise. Further, the Committee recommends the MCOs have advance payment procedures in place as a final safety net for providers.

Kansas Health Care Prompt Payment Act

- The Committee recommends introduction of legislation to provide for the inclusion of MCOs in the Kansas Health Care Prompt Payment Act.

Medicaid and CHIP Information

- The Committee requests KDHE provide monthly reports to the Committee on Medicaid and the Children’s Health Insurance Program (CHIP), including the number of Medicaid and CHIP applications by population group, those found ineligible and those found eligible for Medicaid and for CHIP by category, applications not resolved which are carried over month to month,

monthly Medicaid and CHIP enrollment by population, and the number of Medicaid and CHIP cases terminated and the reasons for termination.

Paperwork Reduction in Application Process

- The Committee is concerned with the administrative burden on consumers applying for services. The Committee recommends KDHE investigate methods to reduce this burden on those applying for services. In particular, KDHE should coordinate with the Department for Children and Families to explore options to reduce paperwork for Temporary Assistance to Needy Families applicants to also apply for Medicaid services.

Reporting of Emerging Concerns

- The Committee requests KDADS and KDHE provide frequent reports to the Committee on emerging concerns in KanCare, including issues identified by the MCOs.

Proposed Legislation: One bill to include MCOs in the Kansas Health Care Prompt Payment Act was proposed.

BACKGROUND

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services (HCBS) and KanCare Oversight operates pursuant to KSA 2013 Supp. 39-7,159, *et seq.* The previous Joint Committee on Home and Community Based Services (HCBS) Oversight was created by the 2008 Legislature in House Sub. for SB 365. In HB 2025, the 2013 Legislature renamed and expanded the scope of the Joint Committee on HCBS Oversight to add the oversight of KanCare (the State's Medicaid managed care program). The Committee oversees long-term care services, including home and community based services, which are to be provided through a comprehensive and coordinated system throughout the state. The system, in part, is designed to emphasize a delivery concept of self-direction, individual choice, services in home and community settings, and privacy. The Committee also oversees the Children's Health Insurance Program (CHIP), the Program for All-Inclusive Care for the Elderly (PACE), and the state Medicaid programs.

The Oversight Committee is composed of 11 members, 6 from the House of Representatives and 5 from the Senate. Members are appointed for terms that coincide with their elected or appointed

legislative terms. The Committee is to meet at least once in January and once in April when the Legislature is in regular session and at least once during both the third and fourth calendar quarters, at the call of the chairperson. However, the Committee is not to exceed six total meetings in a calendar year, except additional meetings may be held at the call of the chairperson when urgent circumstances exist to require such meetings. In its oversight role, the Committee is to oversee the savings resulting from the transfer of individuals from state or private institutions to HCBS and to ensure that any proceeds resulting from the successful transfer be applied to the system for the provision of services for long-term care and HCBS, as well as to review and study other components of the state's long-term care system. Additionally, the Committee is to monitor and study the implementation and operations of the HCBS programs, CHIP, PACE, and the state Medicaid programs including, but not limited to, access to and quality of services provided and any financial information and budgetary issues.

As required by statute, at the beginning of each regular session, the Committee is to submit a written report to the President of the Senate, the Speaker of the House of Representatives, the House Committee on Health and Human Services, and the Senate Committee on Public Health and

Welfare. The report is to include the number of individuals transferred from state or private institutions to home and community based services, as certified by the Secretary for Aging and Disability Services, and the current balance in the Home and Community Based Services Savings Fund. (See Addendum A for the 2013 Annual Report.) The report also is to include, but not be limited to, information on the KanCare Program as follows:

- Quality of care and health outcomes of individuals receiving state Medicaid services under KanCare, as compared to outcomes from the provision of state Medicaid services prior to January 1, 2013;
- Integration and coordination of health care procedures for individuals receiving state Medicaid Services under KanCare;
- Availability of information to the public about the provision of state Medicaid services under KanCare including, but not limited to, accessibility to health services, expenditures for health services, extent of consumer satisfaction with health services provided, and grievance procedures, including quantitative case data and summaries of case resolution by the KanCare Ombudsman;
- Provisions for community outreach and efforts to promote public understanding of KanCare;
- Comparison of caseload information for individuals receiving state Medicaid services prior to January 1, 2013, to the caseload information for individuals receiving state Medicaid services under KanCare after January 1, 2013;
- Comparison of the actual Medicaid costs expended in providing state Medicaid services under KanCare after January 1, 2013, to the actual costs expended under the provision of state Medicaid services prior to January 1, 2013, including the manner in which such cost expenditures

are calculated;

- Comparison of the estimated costs expended in a managed care system of providing state Medicaid services under KanCare after January 1, 2013, to the actual costs expended under KanCare after January 1, 2013; and
- All written testimony provided to the Committee regarding the impact of the provision of state Medicaid services under KanCare upon residents of adult care homes.

All written testimony provided to the committee is available at Legislative Administrative Services.

In developing the Committee report, the Committee also is required to consider the external quality review reports and quality assessment and performance improvement program plans of each managed care organization providing state Medicaid services under KanCare.

The Committee report must be published on the official website of the Kansas Legislative Research Department. Additionally, the Kansas Department for Aging and Disability Services (KDADS), in consultation with the Kansas Department of Health and Environment (KDHE), is required to submit an annual report on the long-term care system to the Governor and the Legislature during the first week of each regular session.

COMMITTEE ACTIVITIES

The Oversight Committee held two days of meetings during the 2013 Interim (October 7 and November 25) and met briefly on January 13, 2014, to discuss and approve Committee recommendations to be included in this report. In accordance with its statutory charges, the Committee's work focused on specific topics described in the following sections.

KanCare overview and update. At the October 7, 2013 meeting, the Secretary of Health

and Environment provided an overview of Kansas' Medicaid system prior to the implementation of the State's managed care program, known as KanCare. He noted key concerns and the rationale for the implementation of KanCare. The Secretary summarized KanCare's goals and composition and reviewed comparisons in program costs and provider payments. The Secretary explained the statistical comparisons utilize a calendar year, which coincides with the authority granted the State from the federal Centers for Medicare and Medicaid Services (CMS) under the state's Section 1115 waiver demonstration proposal. The 1115 waiver operates concurrently with the state's section 1915(c) HCBS waivers. The Section 1115 waiver requires enrollment into a managed care delivery system for the majority of aged, disabled, and some dual-eligible Medicaid beneficiaries.

The Director of the Division of Health Care Finance (DHCF) in KDHE discussed aspects of KanCare, including access to services; KDHE monitoring activities and oversight; quality measures; membership; capitation payments; provider payments; value-added services; denials; and costs compared to projections. She briefly reviewed the managed care organizations' (MCOs') responses to identified issues or concerns, as well as the state's request to amend the Section 1115 waiver. The Director reported that the Kansas Foundation for Medical Care, Inc. (KFMC) will complete the KanCare measurement evaluation to ensure the plan's effectiveness and usefulness in complying with federal Medicaid health care delivery systems and policies. KDHE and KDADS are charged with measuring the State's contractual, statutory, and regulatory requirements related to how each MCO has implemented KanCare to comply with State standards. A summary of KanCare Quality Measures was discussed. The DHCF Director reported data showing the rate of claim denials by MCOs, 16.68 percent (excluding HCBS claim denials), is comparable with denial rates of the state's former HealthWave managed care company and less than the 28.0 percent denial rate when the state handled most of the Medicaid claims.

The DHCF Director stated two changes to the 1115 demonstration waiver will be requested and one additional change already has been approved. These changes will become effective January 1, 2014, pending CMS approval:

- The inclusion of Long-Term Services and Supports (LTSS) for persons with intellectual and developmental disabilities (I/DD) into KanCare;
- The establishment of three pilot programs to support employment and alternatives to Medicaid; and
- The change in the timeline for implementing the State's Delivery System Reform Incentive Program (DSRIP) pool already has been approved. The DSRIP pool involves supplemental payments to the Kansas University Hospital and Children's Mercy Hospital to enhance and support access to care, quality of care, and the health of their patients and families.

During the November 25, 2013, meeting, the DHCF Director stated the State remained engaged in discussion with CMS on the I/DD LTSS element of the 1115 demonstration waiver amendment. She stated the agency had received a response and formal questions from CMS and had responded to those clarifications. The DHCF Director also stated CMS participated in an on-site DD readiness review at one of the MCOs. She noted the State continued to remain on course for the January 1, 2014, implementation, but it would be official only when final approval was received. [Note: CMS approval was not received prior to the anticipated January 1, 2014 implementation date.]

The DHCF Director reported the discussion around the pilot projects to support employment and alternatives to Medicaid had been less than robust, and the state agency chose not to send pilot details to members during open enrollment. She stated her best estimate was implementation of the employment and off-ramp pilots might be deferred until later in 2014, even if CMS approval was received.

Open enrollment. The DHCF Director reported on the status of open enrollment at the November 25, 2013, meeting, stating the members who joined KanCare in January 2013 would receive open enrollment materials in November. She also stated the members who enrolled after January 1, 2013, who became eligible at some

point during the year, would have an open enrollment period in 2014 during the month corresponding to their original enrollment.

Quality improvement standards. At the November 25 meeting, the DHCF Director stated the MCOs' pay for performance measures were reviewed. Pay for performance enables the MCOs to earn 3.0 percent of capitated payments withheld when the MCOs perform above the contractual standard. A review of common consumer-identified issues and resolutions was provided. She referred Committee members to the KanCare website, <http://www.kancare.ks.gov>, for a complete list of quality improvement standards and measures.

For clarification, the DHCF Director indicated that KanCare capitation payments are paid one month in arrears. She also noted dual-eligible beneficiaries (eligible for both Medicaid and Medicare) are excluded from the tracking statistics. Additionally, HCBS waiver denials are included within the "Denials Summary" table in the KanCare Summary portion of her testimony. She commented that prior to KanCare implementation, HCBS waiver denials were not tracked separately in the State's tracking system; rather they were tracked in the State system as Medical. With regard to the Pay for Performance metrics in the KanCare Summary, the Director indicated there is a 60-day lag time in reporting statistics as the metric established is "100 percent of all claims are processed within 60 days."

KanCare enrollment. At the November 25, meeting, the DHCF Director stated one of the early concerns of KanCare implementation was a possible negative effect on enrollment. In fact, total enrollment has been up more than 2.0 percent. There has been an increase in the number of applications and a modest increase in the applications through the clearinghouse on the self-service portal. There also are a couple of thousand applications assessed eligible for Medicaid or for the CHIP pending from the federal Marketplace. In Kansas, the federal Marketplace does not determine Medicaid eligibility; the applications are transferred to the state for eligibility determination. The DHCF Director stated if all of those individuals actually were eligible for Medicaid or CHIP, the state would continue to see

an increase in those numbers, a sort of head start of the woodwork effect.

The DHCF Director reported the FY 2014 Medical Assistance Report (MAR) was available on the KDHE website (http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2014.pdf). She explained there were some technical difficulties reporting the consumer count because of some system issues, so that count will be a little different until finalized. However, the beneficiary count was accurate. A new page has been added to the MAR to reflect retroactive eligibility determinations. With the addition of the information on retroactive eligibility, the report would provide an actual picture of total eligibility over the course of the year.

KDHE and KDADS oversight activities. During the October 7, 2013, meeting, the DHCF Director summarized all KDHE and KDADS inter- and intra-agency oversight activities, as well as those conducted by the MCOs and KFMC, some of which are reported to CMS as required by the demonstration waiver. She acknowledged key issues have arisen, such as:

- Issues with the MCOs' prior authorizations for beneficiary services were identified, which resulted from the AuthentiCares Electronic Visit Verification (EVV) system. The MCOs and AuthentiCare have enhanced the system to eliminate or reduce identified issues, while allowing for additional oversight activities;
- Providers have expressed concern regarding the untimely adjustment to claims. The MCOs have instituted additional logs, which are submitted to KDHE for resolution monitoring;
- Beneficiaries may experience an issue at a pharmacy due to eligibility confirmation and prior authorization for benefits (due to eligibility being put into the State system and a possible lag in time to migrate information from the state system into the MCO system). The workaround was for the pharmacy to access the Kansas

Medical Assistance Program (KMAP) to authenticate and verify eligibility. The MCOs and KDHE have collaborated to ensure prior authorizations for pharmaceuticals match the state's expectations.

- Beneficiaries were concerned that a change in the beneficiary's MCO could limit services or providers within the MCO network. MCOs are responsible for ensuring an adequate provider network within the MCO's mileage and distance requirements. When issues exist and a resolution is unachievable, KDHE could grant a cause for change to the beneficiary. An MCO's goal is to ensure access to services;
- There is a need for the MCOs and agencies to continue collaborating to ensure the accuracy of information;
- KDHE collaborates with and monitors the MCOs to ensure accurate spenddown and client obligations are applied correctly. Targeted training has occurred to ensure there are no under- or over-payments;
- Critical issues tracking ensures the top ten issues are being reported; and
- The state's rapid response call system was eliminated in June 2013. However, the State hosts targeted response calls, such as those related to durable medical equipment (DME), to resolve the providers and MCOs' outstanding issues. MCOs were asked to enhance their rapid response calls structure in August 2013 to elevate and escalate all issues reported.

The DHCF Director reported on 2013 provider payments and non-claim provider payments compared to the same time period in 2012, as well as KanCare costs compared to projections. Total program costs (Medicaid, CHIP, and others) are included in the statistics reported. Cost projections are based on the August 2012 KanCare demonstration waiver application. She indicated a report could be provided to Committee members

concerning KanCare costs per person to ensure costs do not exceed budgetary caps, which were part of the agreement between CMS and the state.

At the November 25, 2013, meeting, the DHCF Director explained the Committee had previously suggested looking at the Budget Neutrality Agreement between the state and CMS as another possible way of measuring costs with or without KanCare. She stated though she did not know if that was the best tool to use to compare costs, the information was provided as requested by the Committee.

In response to questions from the Committee, the DHCF Director stated CHIP had approximately 55,000-56,000 members. She clarified because CHIP was previously included in the HealthWave program, it is excluded from the CMS 1115 demonstration waiver requirements. Therefore, CMS quarterly reports exclude CHIP participants and reflect only Medicaid beneficiaries.

Referring to the "KanCare Cost Versus Projections" table in her October 7 testimony, the DHCF Director noted Kansas Medicaid expenditures have grown approximately 5.0 percent yearly since 2006. The projection without KanCare in August 2012 was 10.0 percent growth; the KanCare projection in August 2012 was 7.0 percent. The current estimate, which includes legislative appropriations and spring Human Services Consensus Caseload estimates, is 4.7 percent. A question was asked as to what factor drives the growth in Medicaid. The DHCF Director responded that 2010 provider cuts and programmatic changes in calendar year 2012 reduced growth estimates. Historically, from 2006 to 2011, an actual annual average growth of 7.5 percent can be seen, and current estimates over the same time period are approximately 6.5 percent. She commented the trend analysis is unadjusted for program changes and is based upon utilization and population growth.

Implementation of Health Home Model. The DHCF Director also reported that the health home model is scheduled to begin in July 2014. The MCOs will integrate this model, which includes targeted case management, into the KanCare program to provide enhanced care for beneficiaries

with chronic conditions such as diabetes and severe mental illness. She noted a large group of stakeholders was then working to provide input into the model's design and implementation phase.

In response to a Committee member question at the November 25, 2013, meeting, the DHCF Director explained how the health homes model would operate within the KanCare system.

Another Committee member inquired whether the basic benchmark to be a medical health home required providers to have meaningful electronic medical records and to participate in an electronic health information exchange, and whether providers would receive grant money to pay for the cost of services to be delivered. The DHCF Director stated the providers would need to have electronic systems that could communicate to allow for the sharing of data between the home health partners. She asked for clarification on the second part of the question. The Committee member said that in the private sector, not the Medicaid market, medical groups were receiving some grant money either from the insurance companies or from CMS to develop medical health homes or accountable care organizations. The Committee member wondered whether grant money was available for this for health homes, or if the MCOs were using only their working capital. The DHCF Director stated she knew some provider groups already have been engaged and have received some grants for the overall development of medical health homes. The primary federal funding support for the health home model would be through the enhanced federal match for health home services.

PACE Program. The Secretary for Aging and Disability Services provided an update on PACE in Kansas. Two programs serve approximately 300 seniors, one in Wichita and one in Topeka. PACE operates similarly to KanCare in that it is a fully at-risk, capitation payment program to care for all the enrollees' needs. Kansas is in the process of expanding PACE as a dual enrollment option to KanCare. An award was expected to be made soon to the successful bidder or bidders to extend PACE's coverage in 55 counties, which is an expansion in four markets: Johnson and Wyandotte counties; counties north and south of those areas; Southeast Kansas; and counties surrounding the Manhattan and Junction City area.

Following announcement of the bid award, a timeline will be generated for the 12-18 month federal approval process. The expanded PACE program is anticipated to begin in 2015.

Human Services Consensus Caseload Fall Estimates. At the November 25 meeting, a Kansas Legislative Research Department (KLRD) staff member presented an update on the Human Services Consensus Caseload Fall Estimates. She stated the combined estimate for fiscal year (FY) 2014 and FY 2015 is an all funds increase of \$66.6 million and a State General Fund (SGF) increase of \$32.2 million. For FY 2014, the revised estimate is an all funds increase of \$31.4 million and a SGF increase of \$10.8 million above the budget approved by the 2013 Legislature. For FY 2015, the estimate is \$2.7 billion, including \$1.1 billion from SGF. This is an all funds increase of \$35.2 million and a SGF increase of \$21.4 million above the budget approved by the 2013 Legislature.

In response to a Committee member question as to how much of the Human Services Consensus Caseload Fall Estimates \$21 million SGF increase for FY 2015 was directly related to the woodwork effect, the KLRD staff member stated she could not specify an amount but that the woodwork effect was factored into the caseload estimate, and impact on the population growth was considered. She indicated there was no way to extrapolate out individual factors to arrive at the specific woodwork effect amount.

A Committee member inquired whether the \$10 million increase in SGF for FY 2014 that had to be repaid to CMS included any penalties. The KLRD staff member stated the amount was more of a deferral because the State had received federal funds for expenditures that CMS subsequently disallowed. Some of the federal payments to be received by the State would be deferred to CMS to make up for that difference, but there were no penalties.

A request was made for the algorithm used to determine the woodwork effect. The KLRD staff member stated there were various studies that looked at the woodwork effect. Individuals involved in the Fall 2013 Human Services Consensus Revenue Estimates brought in a

different amount or impact for the woodwork effect. She indicated it would be difficult to say specifically what was included in the estimate because it was a consensus of all the estimates considered, and different accounting methods were used to calculate the woodwork effect.

Quality Improvement Measures. At the October 7, 2013, meeting, the Secretary for Aging and Disability Services reported on the HCBS Quality Improvement measures submitted to CMS that include additional comprehensive quality measures for HCBS waivers. He indicated HCBS waivers were created to offer some 20,000 Kansas beneficiaries a community alternative to nursing facilities and other institutional environments. Beginning January 2013, Frail Elderly (FE), Physical Disability (PD), and Traumatic Brain Injury (TBI) waiver beneficiaries were included in KanCare. With that change, a shift in case management to the MCOs was achieved, as well as the implementation of Aging and Disability Resource Centers (ADRCs) for the purpose of determining an applicant's functional eligibility. ADRCs are not allowed to serve in a provider role within a MCO network. The Southwest Area Agency on Aging was awarded the initial ADRC contract, and it subsequently sub-contracted with ten other state area agencies on aging to provide ADRC services. With KanCare's implementation, financial mechanisms were put in place to incentivize MCOs to move beneficiaries into community placement under HCBS waivers. Quality measures within KanCare include:

- Amendments to include improvements to statistical analysis and data collection;
- KDADS Quality Management Specialists resuming ride-alongs with MCO care coordinators to observe the care coordinators' interactions with HCBS beneficiaries; and
- The National Indicators Initiative, which is a collaboration among states and national associations to implement a systematic approach to performance and outcome measurements for HCBS waiver utilization. Through the collaboration, participating states pool their resources

and knowledge to create performance-monitoring systems, identify common performance indicators, work out comparable data collection strategies, and share results. These developed tools will assist in providing Kansas with more accurate and comparative information on a national level and, once completed, the measures will be integrated into KanCare Quality Measures.

A question was asked concerning National Core Indicators (NCI) data collection efforts and whether those standards would determine the provision of quality care through KanCare. The Secretary for Aging and Disability Services stated that CMS has 30 to 35 HCBS standards for each of the 6 waivers that states manage. CMS has revised some of the quality measures. In addition, several states utilize NCI measures for their HCBS systems to determine performance for ten core outcomes. (As of the meeting date, Kansas was in the process of implementing this initiative.)

A Committee member referred to the "KanCare Summary," which tracks MCO claims processing quality indicators and asked whether KDHE intended to create trend analysis for these quality measures. The DHCF Director commented the indicators were intended to be above the contractual baseline and to enable MCOs to earn back a portion of capitated payments. The Committee member suggested information could be more meaningful if claims processing percentages were graphically shown by MCO by month.

Provider reimbursement issues. At the October 7 meeting, a Committee member reported that hospitals around the state have expressed concerns relating to MCO claims processing. Many of these hospitals are rural, critical-access facilities with sizable accounts receivable balances from 91 to 241 days old. The Committee member inquired whether this issue was related to a swing-bed program. A swing-bed program allows certain small, rural hospitals to use its beds, as needed, to provide either acute or skilled nursing facility care. In some instances, the hospital was asked by the MCO to bill the primary insurance provider (Medicare) prior to billing Medicaid. The DHCF Director explained the standard policy requires a denial from the primary insurance provider or an

Explanation of Benefit (EOB) prior to billing Medicaid, since it is the payer of last resort. However, Medicaid rules do not require a Medicare EOB for a swing-bed program. She reported one of the MCOs failed to code its system for a blanket denial so that an EOB was not required for a swing-bed program; the issue has been corrected, and the MCO is retroactively processing those claims.

With regard to a question concerning an identified pattern of excessive claims denial to a large, metropolitan hospital that resulted in additional administrative activity to refile claims, the DHCF Director indicated the MCOs are concentrating on this issue and targeting work on systemic issues such as retroactive claims processing. Another issue is whether claims were paid appropriately, and the MCOs have been encouraged to address this issue. She commented that the State's expectation is for the MCOs to improve claims processing and "big picture" issues in order to improve provider satisfaction.

Following several questions, the DHCF Director indicated that KDHE is satisfied with reimbursement rates to providers, as KanCare reimbursement is required to be set at 100 percent of state Medicaid rates. While improvement has been seen with the timeliness of claims processing, the DHCF Director stated KDHE is less satisfied with this performance measure. A Committee member expressed concern on behalf of constituent hospitals who contend that claims processing is more difficult than prior to KanCare implementation. The administrative burden of hiring additional staff to process, reprocess, and appeal denied claims is adversely affecting hospital operations and cash flow. The DHCF Director stated tracked data demonstrates that overall percentages of denials within the KanCare program are similar to those of the HealthWave program. The Committee member requested that KDHE furnish dollar amounts of denials by MCOs, as well as information on the number of denials satisfied in favor of the provider and the MCOs. The DHCF Director indicated that information could be provided over time; however, KDHE could furnish reasons for denials (for example, improper bundling) and dollar amounts associated with them.

At the November 25, 2013, meeting, the DHCF Director provided a monthly and plan-specific comparison of denials by the KanCare providers requested by the Committee at the October 7, 2013, meeting. She stated the overall denial rate for the year for the three MCOs was about 16.7 percent, which was in line with previous Coventry and UniCare denial rates. Additional details provided in her written testimony showed the denial rates by program, by category, and by month for each MCO. She also provided a comparison of the top denial reasons by MCO and service.

With regard to complaints concerning MCOs' remittance advices and the difficulty providers have in matching the providers' billing to the reimbursement, the DHCF Director acknowledged this has been a known issue. MCOs have been requested to resolve this issue.

Testimony regarding KanCare payment processing issues was provided at the October 7, 2013, meeting by representatives of Sabetha Community Hospital, Kansas Health Care Association (KHCA), Kansas Center for Assisted Living, Kansas Home Care Association, LeadingAge Kansas, Kansas Association of Centers for Independent Living (KACIL), JENIAN, Inc., Delaware Highlands Assisted Living, Preferred Family Healthcare, Kansas Association of Addiction Professionals, and the Kansas Psychological Association. Payment processing issues identified included reimbursement delays, claims denials, and prior authorization requirements.

The Chief Executive Officer (CEO) of the Sabetha Community Hospital stated the level of prior authorizations required and the amount of dollars being held in the Hospital's accounts receivable is problematic. She noted reimbursement problems when rural hospitals own or network with other providers, such as a physician practice, hospice, home health, or a skilled nursing facility. She provided examples of prior authorization problems and noted that prior authorizations are taking much longer than under the previous system.

Concerns also were expressed regarding the impact of KanCare on providers when delayed

reimbursement creates an inability to manage cash flow appropriately and the increase in administrative costs, including the time required to process, reprocess, and appeal denials, particularly for smaller rural facilities. A request was made that the Committee and the 2014 Legislature formulate a plan to address the increased administrative costs to providers.

The KHCA representative indicated home care and hospice providers have seen an increase in denials for patients since KanCare was implemented. She stated her fear is that some of these providers could close or cease to provide services, which would lead to access issues for Kansas citizens. The LeadingAge representative also expressed concerns about hospice prior authorizations and administrative burdens to providers, and expressed appreciation to KDADS for its responsiveness and assistance in working through issues.

Another concern expressed was related to KanCare reimbursement to a fiscal management service (FMS) provider. The FMS is accountable to administer payment to a Direct Service Worker (DSW) for KanCare beneficiaries who have chosen to self-direct their care. The problem is created when a DSW fails to submit a time sheet to the FMS provider within 90 days. The DSW is paid, but the FMS provider is out of KanCare compliance and is not reimbursed. The representative for KACIL recommended that an exemption for DSW time records past 90 days be created. Another issue is that third-party insurance held by beneficiaries require that a third-party liability blanket claim must be filed monthly, which can cause delayed billing past the 90-day claim period. Prior to KanCare, those blanket claims were filed annually. The KACIL representative recommended the third-party liability blanket claim be filed by the MCOs rather than by the FMS.

At the November Committee meeting, the KACIL representative indicated that several of the concerns identified for discussion were in the process of being resolved, but asked the Committee to keep watch on the waiting lists to ensure receipt of accurate numbers.

The owner of JENIAN, Inc., a targeted case management agency that provides services to 128 HCBS I/DD waiver clients and 7 Working Healthy/Work Opportunities Reward Kansans (WORK) program clients, testified before the Committee on October 7, 2013. She stated MCOs did not have the WORK procedure code entered into their systems until April or May 2013, which caused a manual work intervention to override denials and delayed payments. Third-party liability information was not included in at least one MCO's billing system. Therefore, the MCO denied payment because the system did not recognize the insurance as Medicare. For clients whose third-party liability insurance does not provide a blanket denial letter, JENIAN is required to wait for a denial then resubmit the claim to the MCO, which creates another payment delay. Because JENIAN is a small agency that cannot absorb the delay in payments, she expressed concern the business will not survive.

At the October Committee meeting, the Secretary for Aging and Disability Services provided information on third-party liability. He stated that, generally, Medicaid was responsible or was supposed to be the payer of last resort. When a person had Medicare or was dual-eligible for Medicaid and Medicare and had other supplemental insurance, CMS required the state to try to receive payment from those other parties first. CMS required cost avoidance on services where there was a possibility that another payer, insurance company, or Medicare should be paying for that service. The Secretary also updated the Committee regarding items on which KDHE staff and others had been working to address third-party liability issues.

The Chief Operating Officer of Delaware Highlands Assisted Living discussed the Kansas gap in its continuum of care for seniors living in assisted living facilities. He noted many other states have a *per diem* reimbursement that covers core aspects of assisted living communities. He recommended activation of CMS codes for assisted living care, which would allow MCOs to negotiate *per diem* rates with providers.

A Committee member requested the Secretary respond to the testimony by the Delaware Highlands representative concerning assisted living (AL) reimbursement for HCBS clients. The

Secretary acknowledged there is a reimbursement gap for AL facilities, which has not been bridged through MCO contracts. He indicated this is a priority, and KanCare could provide the flexibility for MCOs to create AL access and reimbursement. KDADS and the MCOs have scheduled meetings within the next several months to address the issue.

In testimony provided by the Executive Director of the Kansas Medical Society at the October 7 meeting, he stated that throughout the planning phase and early implementation of KanCare, the administrative team at KDHE, led by the Secretary of Health and Environment, has done an exceptional job under a tight timeline and difficult circumstances. The Executive Director stated the managed care model gives the state the ability to predict, and fix, its costs in the program with some certainty. He noted it also gives the state an opportunity to improve care through better care coordination and reduced program fragmentation, improved quality outcomes, slower growth in costs, and the avoidance of further provider payment cuts.

At the November meeting, the Senior Vice President for Government Relations for the Kansas Hospital Association (KHA) referred to testimony provided at the October meeting that highlighted the KanCare implementation issues most commonly identified by the Association's hospitals: reimbursement, prior authorization, and credentialing. He discussed the work of the KHA KanCare Implementation Technical Advisory Group (TAG) that, besides hospital representatives, includes staff from KDHE and representatives from each of the MCOs. He stated the TAG has been very committed to not only assisting with the identification of the issues, but also in bringing forth suggestions for resolutions. Some of the items discussed and their subsequent plan of action included prior authorization requirements, claims payment and denials, and reimbursement related matters. He stated KHA has appreciated the continued support by KDHE on matters of interest to KHA and the renewed efforts by the KanCare MCOs to address several unresolved hospital-related issues in the near term.

The Secretary for Aging and Disability Services provided information at the November meeting about AL reimbursements under KanCare.

He stated AL reimbursements have been a concern for several years, and it had not changed with KanCare. He also stated KDADS was working with the MCOs, providers, and different consumer advocacy groups to develop a new reimbursement system for AL in HCBS and those involved were looking at systems used in other states.

Testimony from the representative of the Kansas Association of Addiction Professionals (KAAP) noted that the KanCare implementation has worked well for substance abuse treatment consumers. She noted KAAP consumers have greatly benefited from value-added services, such as the addition of care coordinators for pregnant women and men with chronic needs. The representative stated MCO staff have worked toward quick problem solutions.

A Committee member noted a recurring issue with providers is the lack of timely payments and questioned the existence of consequences to the MCOs. The DHCF Director responded that the pay-for-performance metric is one consequence for untimely payments. There is no metric for claims denial; however, there is a contractual standard, and the state could execute liquidated damages and pursue similar mechanisms.

At the November 25, 2013, meeting, the DHCF Director provided a Provider Payment Comparison for 2012 and 2013, with information reflecting both claims specific to and payments not related to claims. She stated the provider payment levels were in aggregate, and the payments were very close to those for the same period in 2012 for all payers. A chart showing the provider payments made by the state outside of the claims process also was provided.

A Committee member inquired about the provider payment comparison. The member stated it was her understanding in January 2013, the new providers were not billing until February for services provided through the end of January. There was a question as to whether the member would have to look at the information and determine if those were the most appropriate months to try to compare the two systems. The DHCF Director explained all provider payments were included. For example, those payments in January being made by the KMAP system or

payments from the previous MCOs were included. For that reason, a breakdown of the KanCare MCOs' payments relative to that time period was provided.

A Committee member referred to the non-claims provider payments, and asked if the Disproportionate Share Hospital regular payments shown were only the State's portion. The DHCF Director responded the data reported is the all funds amount for January through October for 2012 and 2013.

A significant drop in payment to the Federally Qualified Health Centers (FQHCs) was noted by a Committee member. The DHCF Director confirmed the Committee member's statement and explained that previously the FQHCs would have monthly settlements because the MCO initially would pay at the fee-for-service level and then the payments would be increased to the Prospective Payment System (PPS) level. The MCOs now were required to pay at the PPS level up front, so the rates were adjusted. Another Committee member asked if the same was true of some of the other entries listed on the non-claims payment chart. The DHCF Director responded that Graduate Medical Education was another such example.

There was discussion at the November 25, 2013, meeting regarding the difference in the payer totals between 2012 and 2013. A Committee member noted the numbers were much the same as the previous year. The DHCF Director confirmed the numbers were very similar, about 99 percent. There were some concerns expressed by a Committee member regarding reimbursement under KanCare. The Committee member stated a representative of one of the largest hospitals in the state had said the hospital's worst month of reimbursement was October 2013. The DHCF Director stated this was not the experience for every provider, and it was not even the experience for every provider type. She also stated the Kansas Hospital Association, KDHE, and the MCOs continue to work on systems issues that would improve the timeliness of payments.

Discussion was heard at the November 25, 2013, meeting regarding work by Committee members to address some of the hospitals'

concerns regarding payments. It was stated that a few of the Committee members, joined by representatives of some of the MCOs, visited with the hospital systems in Wichita. The Committee members involved in the visits felt much progress was made, not only in identifying problems but in determining solutions to those problems. The Chairperson expressed her appreciation for the Committee members' involvement in trying to find solutions and expediting communication.

One Committee member expressed concern when it was said the hospitals were making mistakes and that was the reason they were not being paid. The DHCF Director stated the providers have never been blamed. She noted the providers are appreciative of KDHE's work with provider organizations, associations, and individual providers in working through these issues.

Other KanCare stakeholder reimbursement concerns. A representative of Oral Health Kansas presented testimony relating to the Kansas Cavity Free Kids initiative, which is a grant through the Kansas Head Start Association. She described the program and its pre-KanCare operations and the barriers experienced during the transition to KanCare particularly for Head Start programs.

The immediate past President of the Kansas Pharmacists Association provided a brief history of the Kansas Pharmacists Association and KDHE's collaborative approach to the creation of a managed-care Medicaid program. He expressed appreciation for KDHE's program oversight and recommended continuation of that process. He noted the KDHE staff responsible for bringing KanCare into existence were very open to Association suggestions and recommendations. The Secretary of Health and Environment and his staff, in the pharmacist's opinion, have done an excellent job in establishing KanCare. The Association meets with the KanCare Pharmacy team quarterly to discuss some of the issues he shared in his testimony and they work closely together to resolve these issues. He noted, although concerns with DME and MAC have always been a problem with the Medicaid program, the provision in the KanCare contracts for the MCOs to tell the state how its subcontractors compute their MAC lists was seen by the Association as a step in the right direction.

He noted the Kansas Pharmacists Association wanted to point out that other states that transitioned to managed care Medicaid programs have had more problems and of greater magnitude in those transitions than has occurred in Kansas. He indicated the Association's experience in working with the state KanCare pharmacy team had made the transition to KanCare much smoother than originally anticipated.

The CEO of the Kansas Independent Pharmacy Service Corporation (KPSC) reported that KPSC's membership has seen timely processing of pharmacy claims; however, there have been problems with MACs being updated in a timely manner, which have produced payment losses for generic products. He noted, however, this issue is being resolved through work with KDHE. DME products are processed directly through KanCare, and pharmacies have reported slow payment, and the KPSC is grateful to the KDHE pharmacy staff for their hard work on this issue. He reported medication therapy management, a program for beneficiaries who meet set utilization criteria, is now being expanded into KanCare guidelines. Initial effectiveness reports should be forthcoming in six to nine months. The CEO stated KPSC is thankful for the opportunities to interact with the KDHE staff and to provide its input to try to build an effective pharmacy program with the contracted MCOs and their respective pharmacy benefit management (PBM) vendors. He noted KanCare pharmacy claims are processed in real time and verification of eligibility, as well as any plan limitations, are seen by the pharmacies as claims processing is completed. KPSC members report reimbursements for KanCare pharmacy claims are generally made in a timely manner, relative to what would be expected for commercial prescription benefit plans. He stated KDHE's goal also has been to provide timely updates of MACs for all generic products, and KDHE has worked with the PBMs on providing that information. Two of three PBMs are reporting full MAC lists, with updated MAC prices on the KanCare website. Pharmacies are able to review MACs on the site and also are able to go back to the effective date of the claims that paid less than their cost and reprocess them. As of the meeting date, KPSC is not aware that the third PBM has made the same information available. He also noted the KDHE pharmacy staff recognizes the DME problems and has worked with KPSC

and other parties to work toward a better resolution.

The representative of the Kansas Chapter of the National Association of Social Workers (NASW) recommended KDADS revise the KanCare reimbursement policy to allow all persons licensed by the Behavioral Sciences Regulatory Board to provide substance abuse services. She noted current policy requires that licensed social workers must obtain a secondary license in order to provide services to substance abusers.

Subsequent to the October 7, 2013, meeting, a memorandum was mailed to Committee members by the Executive Director of the Association of Community Mental Health Centers of Kansas, Inc., regarding testimony received by the Committee at the October 7, 2013, meeting from NASW and the Kansas Psychological Association. His testimony expressed disagreement with the position of NASW and the Kansas Psychological Association that the reimbursement for substance abuse services provided by licensed social workers was a KanCare reimbursement issue. He stated it was an attempt to negate all aspects of the Addiction Counselor Licensure Act and the work of the Kansas Legislature three years ago.

Access to and quality of services under KanCare. The representative for the Kansas Health Consumer Coalition recommended three improvements to ensure consumers' access to services and quality care: provide additional resources and independence to the KanCare Ombudsman, ensure the Committee reviews summaries and recommendations from the KanCare Workgroup meetings and considers those recommendations, and ensure access to services or pharmaceuticals by closely monitoring the MCOs' pre-authorization requirements.

A representative of the Kansas Advocates for Better Care testified concerning observations regarding quality and access issues within the KanCare program, providing specific HCBS examples in her written testimony. She expressed concern over the lack of a good consumer support and information network, inadequate trending analyses and information from the KanCare Ombudsman's Office, inadequate consumer input,

and the lack of program utilization information. Her recommendations included development of basic program utilization data by care plan, by hours and services, and by waiver population groups; development of KanCare Ombudsman program data to identify trends in consumer outcomes and services, as well as provide for consumer input and evaluation of the assistance received; creation of an evaluation database from consumers regarding satisfaction with services and KanCare effectiveness; and strengthening processes for consumer feedback on quality and access. (See KanCare Ombudsman information on page 22.)

A representative of KACIL stressed the need for MCOs to improve the timeliness of written authorizations for direct service workers to the FMS providers; education and training to assist MCOs in understanding the difference between self-directed and agency-directed care; and improved communication concerning service changes, such as transportation. In addition, she suggested that as many FMS providers are assisting clients with filing appeals and Medicaid reapplication, there should be an increased reimbursement to FMS providers of \$140 per member per month.

The Executive Director of InterHab submitted written testimony and recommendations regarding access to and quality of care issues. He testified at the November meeting and expressed concern about the number of administrative decisions still to be made regarding the roles of Community Developmental Disability Organizations (CDDOs) and MCOs and noted, though the I/DD Pilot Project was winding down, there was little evidence indicating a smooth transition for the carve-in of I/DD LTSS.

Other testimony provided by stakeholders at the November 25, 2013, meeting included the following:

- The representative for Kansas Advocates for Better Care testified on rebalancing and access to LTSS, healthcare outcomes for frail elders on the waiver and in nursing facilities, and the proposed 1115 waiver amendment, as it related to the KanCare Ombudsman. She requested the

Committee ask the KanCare program to collect data specific to KanCare's impact on healthcare outcomes and whether the outcomes had improved under KanCare. She also asked the Committee to advocate for a stronger ombudsman, who could advocate as ombudsmen do in healthcare settings in other states.

- A co-owner of Options Services, Inc., expressed concern for her company's future under KanCare. She stated she did not feel the MCOs and the assistance needed were in place and ready for the inclusion of I/DD LTSS in KanCare. She asked the Committee to consider delaying LTSS in KanCare until the systems were ready.
- The representative for Kansas Action for Children testified Kansas appears to be losing coverage for the state's poorest children, the data being received was not definitive, and there was a need for reliable access to data in the future. She noted 4,000 kids had fallen off the Medicaid rolls, and that a just-released study showed one in four Kansas children were living in poverty. She indicated it would be helpful to know when children lose coverage why they were losing coverage, as well as whether children were moving from Medicaid to the CHIP population.
- The CEO of Meadowbrook Rehabilitation Hospital testified regarding challenges the hospital was facing in receiving accurate and timely reimbursement for its Medicaid patients in the TBI unit through the new MCO arrangement.
- A representative of the Big Tent Coalition addressed a DD waiver issue involving Serious and Persistent Mental Illness (SPMI) and whether someone who has physical disabilities serious enough to qualify for the PD waiver and happens to have SPMI, still could get PD waiver services. He discussed the underserved issue with the DD Waiting List and said, according to data from the State, the state

had not been serving the number of people that were supposed to be served under the PD waiver.

- A representative of the Kansas Optometric Association stated the MCOs had been willing to listen to the concerns of the providers. He stated the workgroups were dealing with how to arrive at data that would be helpful in the future.
- A private citizen shared her positive experience with KanCare.
- Written testimony was received from representatives of the Kansas Hospital Association, Kansas Health Consumer Coalition, LeadingAge Kansas, and the Kansas Home Care Association.

In response to the concerns expressed by the representative of the Big Tent Coalition, the Secretary for Aging and Disability Services commented on the mental health screening language on forms completed by those on the PD waiting list. During the 2013 Legislative Session, money was allocated to move 100 people off the PD list and 100 off the DD list. The Secretary stated that several weeks previously KDADS sent a letter to the last verifiable address for those 460 people on the PD waiting list. Because of past problems with persons on the PD waiting list who did not have a physical disability and who could have been receiving services from a mental health center, a questionnaire was developed as part of this form letter sent to these 460 people. He indicated he believed the questionnaire was what was referenced by a few conferees. KDADS worked in concert with KACIL to get feedback on the questionnaire before it was mailed. Information was received from 53 individuals. The Secretary stated much work needed to be done in the next six weeks to better assess why the remaining 407 people did not contact KDADS, so that would be accomplished through a number of different avenues. Part of the questionnaire asked if the individual had a mental illness. In part, that was due to the history over the past year where some individuals without a disability were on the waiting list. Those with a mental illness could have been receiving appropriate services and

wrap-around services from their respective mental health centers during that time.

In response to the statement that the state had not been serving the number of people it was supposed to under the DD waiver, the Secretary stated he had seen a report in two articles that was somewhat erroneous in questioning whether the state was breaking a promise to CMS on the number of people it was supposed to serve on the DD waiting list. He stated there were six different amendments to the 1915(c) waiver for the DD waiver application that was submitted in 2009. The 1915(c) waiver is the authorization mechanism for each HCBS program. The Secretary stated that in 2009, there was a projection on the number of people the State would serve each year, which essentially serves as more of a cap. Also there were differences in interpretation between the average number of people served and the unduplicated number of people served. KDADS staff said it was more of a cap than a maximum, and it was subject to Legislative appropriations. The DHCF Director stated the 1915(c) amendments made before last year were available on the KanCare website. She stated she did not believe the numbers included DD, but she would confirm that. If the DD numbers are not included, the proposed 1915(c) waiver for DD should be on the KanCare website.

The DHCF Director followed up on questions posed by Kansas Action for Children about children's eligibility for services. She stated she would provide a table listing some additional information over several months regarding the total number of children enrolled in the poverty level eligibility (PLE) of temporary assistance for families and the CHIP program. She stated there had been a decrease in Temporary Assistance to Needy Families and PLE enrollment from December 2012 to November 2013, particularly for the PLE children ages one to five. But in the same time frame, there had been a greater increase in the CHIP eligibility. The net difference was an increase of about 1,800 children who were covered from December 2012 to date under KanCare. There was shifting both directions, as some CHIP children became PLE, and the opposite. The DHCF Director noted that Kansas Action for Children had referred to the need for a full understanding of how the services were being provided, so as to ensure the process was working

correctly. She indicated that was occurring because KDHE actually was making more accurate determinations.

The DHCF Director stated there was no difference in eligibility benefits for PLE and CHIP under the KanCare program. Technically, the CHIP program was separate from the Medicaid program and operated under different state plan amendments. However, in KanCare, the benefits were identical. She stated the only time it would be different was if the income was at a level that would require a premium associated with the CHIP program, but the benefits and eligibility remained the same. The DHCF Director noted during the previous year KDHE had seen a sizable decrease in the number of children who lost eligibility for CHIP because of unpaid premiums.

In response to whether the PLE or CHIP programs had a different impact on taxpayers, the DHCF Director stated the CHIP program had a higher federal reimbursement match but also had a cap on the amount of federal funds available.

Plans of care reductions. Plans of care reduction concerns also were expressed to the Committee. A Committee member inquired how and who determines the levels of assistance and hours of service required for a HCBS beneficiary. The DHCF Director stated it is the expectation of both the State and CMS that the MCO complete the beneficiary's plan of care within the first six months of KanCare eligibility. The Secretary of KDADS responded that the determination of needs is a multifaceted process involving the MCOs assessing the beneficiaries' comprehensive needs, health risks and reviewing the prior HCBS plan of care. When the MCO determines fewer hours of care are required, the care coordinator begins the plan of care process, which ends with three HCBS review managers (within KDADS) quantitatively reviewing the plan of care and assessing the narrative portion of the tool to determine whether the hours reduction request is approved, approved with recommendation, or denied. State policy is followed with factors such as whether family members can perform certain functions for the beneficiary, changes in family situations, or changes in the beneficiary's functionality being considered. The Secretary noted MCOs have requested reduction of plan of care hours in 8.0 percent of all plans. Of that 8.0 percent reduction,

12.0 percent involve individuals on the HCBS/PD waiver and between 6.0 and 7.0 percent involve HCBS/FE beneficiaries; KDADS approves approximately 90.0 to 92.0 percent of reduction requests submitted by the MCOs.

A Committee member asked about the appeals process available when a reduction request has been approved and the beneficiary desires to appeal that decision. The Secretary Aging and Disability Services responded there are three grievance mechanisms to challenge a reduction in plan of care hours for an HCBS waiver recipient: through the MCO, through the KanCare Ombudsman, or through the State Fair Hearing Process. The Ombudsman process would offer the most immediate access and resolution. The State Fair Hearing process includes 33 days to file an appeal, with another 30 days before the hearing process begins. He indicated there are no service reductions until the grievance and appeal process has been exhausted.

A private citizen shared his story and KanCare experience, which he stated will result in a reduction in his plan of care from 168 hours weekly to 40 hours weekly, starting November 1, 2013. He is appealing the reduction in service. He updated the Committee on the status of his plan of care reduction at the November meeting, at which time he was asked if he would be willing to provide a release of information to allow the Committee access to his medical information. He noted three delays in his appeals hearing. He indicated he did not understand why the appeals process was moving in such a fashion, but it raised a very serious question about the appeal process. He expressed concern he was allowed to keep his full-time care during the appeal process but if he lost the appeal, he would be financially liable for the cost of full-time care minus the 40 hours of care the State said that he should be receiving. Because of the hearing delays, he stated he could be facing \$10,000 to \$15,000 of debt for standing up for his rights. He stated he believed the appeal process was fundamentally flawed and the Committee needed to review it.

At the October meeting, in response to the private citizen's testimony, the Secretary of Aging and Disability Services indicated that, due to privacy standards, specifics could not be discussed. However, he stated that he and five

members of his staff had reviewed the plan of care and determined the MCO's action was appropriate. The Secretary stated that each HCBS plan of care is unique and depends on the family situation, the family's needs, the beneficiary's circumstances, the required levels of support, and other conditions.

At the November meeting, the Secretary of KDADS provided an agency response to a private citizen's plan of care reduction, as requested by the Committee. He stated that KDADS, as of a week or two ago, had a HIPAA release from the individual allowing the agency to provide his specific information to the Legislature. With that, he stated that he did not intend or want to make this forum a public debate with the individual, nor would he do that with any consumer. He noted KDADS would continue to follow up with the individual on this matter.

The Secretary of KDADS noted the individual said he was to receive 40 hours of attendant care in the plan of care proposed by his MCO, which he said equated to less than six hours of care a day. The Secretary stated such was not the case with the proposed plan of care reduction, which the individual equated to a 76 percent reduction. According to the Secretary, what had been proposed was attendant care of 42 hours, sleep cycle support for up to 12 hours a night, and 7 hours of skilled nursing a week for 1 hour a day. When added, 133 hours of care was being proposed as compared to the 168 hours he believed the individual was receiving at this time. The Secretary indicated the agency would continue to try to communicate that information to the individual. The Secretary stated he had unsuccessfully attempted to contact the individual a number of times in the past five or six weeks to meet with him, but arrangements had been made at the meeting to meet in the next few weeks.

The Secretary of KDADS clarified for the individual with the proposed plan of care reduction and others going through the appeals process, either through the MCO or the State Fair Hearings process, that losing an appeal would not make them accountable or responsible to pay for the cost of care that would have been reduced during that intermediate time period. One of the State's special terms and conditions on the 1115 waiver with CMS was that a person in a state fair

hearings process would continue to receive the services under their existing plan of care, so that would continue for the individual. He stated he hoped the conversation between KDADS and the individual would continue to move forward in a collaborative manner.

Committee members requested additional information including: number of service hours reductions, reasons for reductions, number of reductions approved by waiver, nursing facility utilization, caseload trending information, numbers of service hours reductions compared to increases, and any objective criteria or standards used for decision-making with regard to plans of care reduction requests.

A Committee member asked if there were plans to keep track of reductions and increases in services for plans of care and if the Secretary of KDADS had a feel for how that process was going. The Secretary stated information was provided to the Committee on the number of plans of care reductions, and the numbers were similar to what he reported to the Committee last month. He stated KDADS was working on that information and would provide it to the Committee.

Quarterly HCBS Report. The Secretary of KDADS provided information on average monthly caseloads and average census for state institutions and long-term care facilities at the October and November meetings. He explained that HCBS savings are realized when an individual is moved into a community setting from an institutional setting and the bed is closed behind them. There are zero savings resulting from individuals moving to HCBS, as Kansas does not close a bed in the institutional setting after the individual moves to the community.

The quarterly report provided on November 25, 2013, indicated in FY 2013 there were 8,600 Kansans who received HCBS I/DD waiver services per month, and presently 3,253 persons were awaiting services, with 94 of those having future date requests. An additional 1,718 additional persons were on the "underserved list," and slightly over 300 of those had future date requests. There were slightly over 1,400 additional requests to date. Also in FY 2013, on average there

were 5,902 Kansans receiving HCBS PD waiver services per month. Approximately 2,000 people currently were on the PD waiting list. The Secretary of KDADS restated an announcement from mid-September 2013 that new money would be released to remove additional people from the waiting lists, and 250 names from the DD waiting lists were released to the 27 CDDOs. To date, 163 persons had accepted that funding, 65 had declined it for various reasons, and 23 had been offered funding but had not responded. In response to a question from a Committee member regarding a decline of 211 persons in nursing homes as compared to the prior year, the Secretary stated there had been some success in returning people to the community and in ensuring only those who needed nursing care were placed in nursing homes.

The Secretary of KDADS informed the Committee of two pending issues that could impact HCBS services: the impact of the Affordable Care Act (ACA) large employer mandate on FMS workers and a new Department of Labor (DOL) mandate addressing the companionship rule.

ACA large employer mandate impact on FMS workers. The Secretary of KDADS discussed how the FMS role fits within the employer mandate of the ACA requiring the provision of health insurance for employees. In Kansas, 60.0 percent or more of PD waiver recipients self-direct their own care, and the FMS provider serves in an administrative payroll function for direct service workers caring for those beneficiaries. Currently, there are 60 FMS agency providers with more than 50 employees, which fits within the ACA large employer health insurance mandate. KDADS and FMS stakeholders are working to examine current state policies to ensure compliance with the ACA. KDADS has requested clarification from federal regulatory agencies.

Additional information was provided by the Secretary of KDADS at the November Committee meeting regarding the possibility FMS providers could be subject to the ACA employer mandates, which take effect on January 1, 2015. The FMS providers in Kansas are paid administrative rates of \$115 per client per month to function as a payroll agent for payment of the direct care workers. The Secretary noted the general concern had been that if the requirement to pay for health

insurance and benefits became the responsibility of FMS providers, the \$115 per client per month would not be able to cover the added expense.

The Secretary of KDADS noted State agencies had been working with a FMS workgroup of 15 providers and others to address this issue and to seek clarification regarding the applicability of the employer mandates. The workgroup recommended a change in the State's FMS program model with CMS; the State concurred with the proposed change. The Secretary explained the State had an agency with choice model (AWC), a co-employer model where both the FMS payroll agent and the HCBS consumer were the employers of the direct care worker. After review, the State and workgroup believed the Internal Revenue Service (IRS) and others would use the common law definition of employer of record to determine whether the employer mandate, requiring any company with 50 or more employees to provide health benefits, would apply to FMS providers. The State and workgroup believed some FMS providers probably would meet that common law definition as applied by the IRS and some would not, based on how an FMS provider followed the State's FMS policy procedures. The FMS work group recommended moving toward a new model called a fiscal/employer agent, which specifically named the client served as the employer of record. It removed any reference to FMS providers as the employer of record. He indicated that in 2014, the State would submit to CMS an amendment to move forward with the fiscal/employer model, placing providers on safer ground for the employer mandate.

A Committee member inquired how other states were dealing with the FMS issue. The Secretary of KDADS stated he believed Kansas was only one of three states with the AWC model where providers and clients are co-employers, and almost every other state had the fiscal/employer agent model that Kansas would be proposing going forward.

A Committee member asked if KDADS had analyzed the impact of the ACA employer mandate on the FMS agency providers and the people providing home and community based services. The Secretary of KDADS stated if the State did not change its model and if the agency providers were designated as an employer of

record by the IRS, agency providers with 50 or more employees would be mandated to pay for health insurance. He noted this would result in significantly higher costs, which would require the State to pay a significantly higher administrative fee than the \$115 currently paid. The Secretary indicated he could provide data to the Committee.

Companionship Rule. The Secretary of KDADS discussed the issue surrounding a new Department of Labor mandate, which affects the companionship rule in Kansas. For many HCBS waiver recipients, KanCare pays family members to care for their loved one. KDADS is working to determine the potential impact.

At the November Committee meeting, the Secretary of KDADS addressed a request made to discuss recent DOL rules that impact the HCBS system. In September 2013, the DOL revised the companionship services rule in the Fair Labor Standards Act (FLSA). The Secretary indicated the final rule prevented third-party employers, such as home health agencies, from filing an exemption for overtime for employees. Domestic service workers fall under the FLSA's minimum wage, overtime, and record-keeping provisions. The result of this change could be increased cost for employers and a possible decrease in hours for the workers. He stated KDADS was unclear how the revised rule would impact the future financial picture of the HCBS program, but they would continue to monitor the issue.

Waiting list reduction. At the October meeting, the DHCF Director stated KanCare savings will be used to reduce the HCBS waiting list; savings are attributed to new human services caseload estimates made during Spring 2013, which were projected to be greater than previously budgeted. The Secretary of KDADS stated, last year, Kansas moved 100 people from the PD waiting list, and 2,000 PD waiver-eligible individuals are currently waiting for services. In addition, 2,997 HCBS I/DD waiver-eligible individuals are waiting for services.

In the waiting list update provided at the November meeting, the Secretary of KDADS stated 1,706 people were on the DD underserved waiting list and 1,402 of those had current requests for services. The top three requests were

residential services, which 1,104 had requested; day services, with 668 requests; and in-home services, with 112 requests. The Secretary stated the 1,402 individuals had not necessarily been assessed as needing those services, as this was done when funding was secured.

According to the Secretary, the state had considered what to do about the 1,402 individuals on the DD underserved waiting list with current requests for services, as a growing list was not desired. The Secretary noted the state has had discussions with CMS about this issue. First, of the 8,600 served on the DD waiver, no new persons would be placed on the underserved request list. Secondly, as KanCare LTSS starts for the I/DD population, whether it be January 2014 or after that, the MCOs (through the budget proviso and also through special terms and conditions with CMS) would have 180 days to complete the initial assessments to develop each KanCare plan of care. That plan of care would be developed jointly by the community targeted case manager and the MCO care coordinator. These individuals would have to assess 8,600 persons by June 30, 2014, assuming a January 1, 2014, start date. Of the 8,600 to be assessed, assessments first would be completed for those 1,402 persons on the underserved list. After the first 180 days of assessments, KDADS would have a better estimate on the cost to remove the 1,402 persons with current requests from the underserved waiting list. The CDDOs also had been working on the 3,000 unserved persons list for the previous two months.

Written testimony provided by the Secretary noted that \$18.5 million in KanCare savings was released on September 11, 2013, and would go toward waiting list reductions. The funds would bring 418 individuals off the PD waiting list and 235 individuals off the DD waiting list.

A representative of the Self-Advocate Coalition of Kansas encouraged Committee members to reinvest KanCare savings into reducing the I/DD waiting list for HCBS services.

A Committee member stated monthly updates on the waiting lists had been discontinued. The Secretary stated the legislators still should be receiving the DD waiting list update and he would

check on that. The PD update has been more of a reflection of caseloads and nursing facilities as a whole. He stated the agency former based the monthly information on claims paid. Since the State no longer paid claims, the agency had not felt comfortable until the past month or two that the KDADS encounter data coming in could be reported with certainty. The data would be changed to be based more on eligibility than on claims paid. He indicated the change was more a function of the transition than anything else. The Secretary stated the agency would get those reports started before the end of 2013 and keep reporting monthly in 2014.

Historical spending for HCBS waivers and historical waiting lists. At the November 25 meeting, a KLRD staff member reviewed HCBS waiver expenditures from all funding sources and from SGF for FY 2008 through the agency's estimate for spending for FY 2015. She also reviewed the HCBS Historical Waiting List for each fiscal year and each omnibus period from 2008 through November 2013. A Committee member asked about the funding provided to decrease the number of persons on the HCBS DD and PD waivers waiting lists during the 2013 Legislative Session. The staff member responded that \$18.5 million was added, including \$8 million from SGF for both FY 2014 and FY 2015. The funding was split between the HCBS/PD and the HCBS/DD Waivers. In addition, \$639,000 was added in a separate action, including \$276,000 from SGF for the HCBS/DD Waiver for both FY 2014 and FY 2015.

I/DD Pilot Project and inclusion of LTSS for individuals with I/DD. The Secretary for Aging and Disability Services provided an update on the I/DD pilot project at the October 7, 2013, meeting. He reviewed participant levels, the goals of the pilot program, the project advisory group, and the proposed billing, which began October 1, 2013, for 25 participating pilot providers. The Secretary noted the advisory group has been engaged and active in the process and education. Educational sessions have been held across the state, with national experts brought to Kansas to work with State and MCO employees, the advisory group, pilot providers, and others.

At the November 25, 2013, meeting, the Secretary stated the readiness reviews for the I/DD

LTSS transition to KanCare had been completed for the three MCOs. A list of the topics discussed during the readiness reviews was provided in his testimony.

With regard to the pending request to CMS for inclusion of I/DD LTSS in KanCare, a Committee member asked for the agency's plan should the request be denied. The Secretary replied the plan was to continue with the current system until a waiver was obtained.

The Secretary provided information about the differences in I/DD responsibilities between the 3 MCOs and the 27 CDDOs with which the State contracts, as requested at the October Committee meeting. He stated the CDDO would continue to be the single point of entry within the system. The CDDOs would continue to complete initial and annual Basic Assessment and Service Information System (BASIS) assessments (level of care determinations) and also would continue with information, assistance, and community service referral. The MCOs would be responsible for working with targeted case managers and providers on care coordination between all the systems. Second, the MCOs would continue to be responsible for the physical and behavioral health services they are paid to provide. Third, pending CMS approval, the MCOs would be responsible for HCBS I/DD LTSS inclusion in January 2014. Fourth, the MCOs would work closely with the targeted case managers that are on the community side, with either the CDDOs or community service providers, to develop an Integrated Service Plan, which includes the HCBS plan of care.

The Secretary also updated the Committee on recent and upcoming education awareness efforts:

- A letter with general information was sent to persons-served and guardians in the middle of October. The letter may be accessed on the KDADS website (http://www.kdads.ks.gov/CSP/IDD/KanCare_Imp/IDD_Waiver_Consumers_Letter_10_15_13.pdf);
- A number of provider trainings were held in October and attended by approximately 650 individuals across Kansas;

- Providers were notified in November of some changes in policy regarding KanCare;
- Weekly “Lunch and Learn Rapid Response Calls” for persons served and providers would begin in December;
- A number of educational tours for consumers would be held in eight locations statewide from December 2 through 5;
- Monthly HCBS forums would continue, with the next one on December 17; and
- A consumer brochure would be available on December 1, 2013.

KanCare Ombudsman. The KanCare Ombudsman discussed emerging issues, clarified his role, and reviewed case data at the October 7 meeting. He noted the area of data collection and statistical report preparation has been a recent focus, and the office is in the process of hiring an administrative assistant to aide in reporting functions.

The KanCare Ombudsman responded to questions regarding his role. He stated the words “independent,” “impartial,” “objective,” and “informal resolution” apply to the KanCare Ombudsman role. The word “advocate” applies to those persons who take an active role in advocacy for the KanCare member and does not apply to the KanCare Ombudsman role. The Ombudsman described the process when a beneficiary contacts his office with a grievance; the process includes interviewing the consumer and the MCO care coordinator; reviewing the plan of care; and assisting the beneficiary in the grievance process through the MCO or the State Fair Hearing process by providing administrative support, furnishing appropriate information, and assuring accommodations are made. He explained his role is one of facilitation, collaboration, communication, and informal dispute resolution.

A Committee member expressed concern that the KanCare Ombudsman’s office had 857 contacts from consumers without a subject or

category attached to the contact. The KanCare Ombudsman explained the office practice of contact categorization and indicated that to adequately categorize all resolution statistics was unrealistic. The Committee member suggested a category of “denials” be added to those already created on the contact log. With 20,000 HCBS constituents, additional concern was voiced by the Committee member that the KanCare Ombudsman’s Office lacks the resources to cover the workload.

A representative of the Big Tent Coalition distributed testimony concerning the Wisconsin Ombudsman model for comparison with the Kansas KanCare Ombudsman Office. He emphasized the importance of the KanCare Ombudsman’s Office and indicated independence, impartiality, and advocacy are critical to its operations.

A Committee member expressed concern regarding the testimony from the KanCare Ombudsman particularly related to the role of advocacy, which is expected in models from Minnesota, Colorado, and Oregon. The suggestion was made to reopen the discussion about the position, its role, job description, and the resources allotted to that Office. The Secretary for Aging and Disability Services suggested the role of protection and advocacy is more appropriate to ADRCs. He stated KDADS will continue to monitor the effectiveness of the KanCare Ombudsman Office closely. According to a Committee member, concerns from constituents indicate the KanCare Ombudsman Office has unsuccessfully represented their interests. The Secretary indicated that while many beneficiaries reported the KanCare Ombudsman has served them well, he is willing to set up consumer surveys or other reporting mechanisms to evaluate satisfaction levels.

At the November 25, 2013, meeting, the KanCare Ombudsman presented some consumer concerns regarding KanCare and reported on the assistance he provided to the consumers with these concerns. He also reported on this year’s activity in his office and the recently hired KanCare Ombudsman Assistant. He informed the Committee that a random customer satisfaction survey was being conducted. The KanCare Ombudsman provided case data regarding his

individual performance and the activities of the KanCare Ombudsman Office.

A Committee member expressed concern about the role of the KanCare Ombudsman in Kansas not being that of a true ombudsman. The Committee member noted that in other states an ombudsman was an advocate, there was separation between the ombudsman and the state agency, and more staff are available to assist the ombudsman. The member further expressed his belief the KanCare Ombudsman was appointed to meet a CMS requirement, but did not follow the standard role of an ombudsman. The KanCare Ombudsman responded the representation that Kansas does not have an ombudsman was incorrect, and the position was not appointed to simply comply with a CMS requirement. Kansas is the state integrating managed care for long-term services and supports. He noted the uniqueness of the Kansas program and the needs of Kansas consumers, which could not be compared to those of other states. The KanCare Ombudsman stated he believed the Committee could measure the usefulness of the ombudsman by hearing from the consumer. He hoped to provide that information at the next meeting through results of the independent survey of KanCare consumers being conducted.

Modified Adjusted Gross Income (MAGI) Conversion. The KDHE Director of Medicaid Services presented a report on MAGI conversion. She explained, with the passage of the ACA, there was a change in how eligibility was determined for three major categories of individuals: pregnant women, children, and childless adults. The change affected how income was counted and what constituted a household. MAGI was based on a tax household and did not include income disregards. She stated if the State did not make any changes in its eligibility determination, fewer people would be eligible. KDHE worked with CMS to convert the State's income limits. She provided a table in her written testimony containing the MAGI eligibility standards for Kansas. These standards are equivalent to the state's present eligibility standards, so a previously eligible individual likely would be eligible again. She also stated the MAGI conversion would have no net financial impact on the Medicaid program in Kansas. The Director of Medicaid Services also discussed three different MAGI scenarios. She also confirmed the state was

required to move to the MAGI eligibilities and standards.

There was Committee discussion about whether a report could be created to document an increase or decrease in Medicaid enrollees as a result of the MAGI conversion. Some Committee members stated such a report would document any impact and allow the Legislature an opportunity to change the standards as needed.

A Committee member requested the Committee be provided with a list of deductions allowable under MAGI.

When asked about the effective date for the MAGI conversion, the Director of Medicaid Services stated Kansas was an early MAGI eligibility determination state. When the Kansas Eligibility Enforcement System (KEES) goes live, Kansas would be doing MAGI eligibility determinations. She stated the latest effective date for MAGI conversion was January 1, 2014, and the earliest effective date was October 1, 2013. She indicated determining eligibility through KEES would occur prior to January 1, 2014.

The DHCF Director responded to a question about the process for the MAGI determination that needed clarification. No currently eligible individual would be reassessed using the MAGI determination until the individual's actual review time. The reassessment would happen during the normal course of business. Until the full implementation of KEES in Phase 2, persons would be assessed using both the current eligibility method and the MAGI conversion. This could serve as a comparison tool by first assessing people on the current eligibility criteria and making them eligible for a full year. Then, if KDHE were to find the individual was not eligible under the current criteria, a MAGI eligibility determination would be completed through KEES. If determined eligible under MAGI, the person also would have a full year of eligibility.

MCO responses to stakeholder concerns. At the October meeting, the CEO of Amerigroup Kansas Health Plan addressed the Committee and explained Amerigroup's work with waiver consumers and nursing facility consumers. She reviewed claims payments, claim payment

turnaround times, access standards, and proactive improvement opportunities for issues resolution. She indicated Amerigroup's commitment to providers to assist with operational and complex care issues.

The Chief Operations Officer of Amerigroup provided an update at the November meeting on efforts Amerigroup had been making toward resolving some provider issues. He also provided an update on provider relations activities since the last meeting of the Oversight Committee. He stated Amerigroup was placing more focus on a number of outreach areas, particularly on hospital engagement.

With regard to a Committee member question about the third-party liability list previously discussed and whether the MCO could make an exception by code or a blanket third-party liability list, the Chief Operations Officer of Amerigroup stated Amerigroup was looking specifically at options for an easier coding transition.

At the November meeting, an Amerigroup LTSS Support Services Coordinator and Senior Case Manager read the testimony of the father of two sisters who are on the Technology Assistance Waiver describing the level of assistance being provided by Amerigroup. The father could not be present to give his testimony because of the intensity of the disease process of his daughters.

The CEO of Sunflower State Health Plan addressed three primary objectives of KanCare: access, quality, and costs. She described some of the earlier issues during KanCare's implementation phase and directed Committee members' attention to Sunflower's Top Ten System Issues and Status, included in her testimony. She reported that 80.0 percent of KanCare claims are auto adjudicated, which represents an improvement from earlier statistics. She committed to resolving issues in a timely manner to ensure quality care.

The CEO of Sunflower State Health Plan provided an update at the November meeting, which included a Provider Responsiveness Summary of some of the MCO's top issues, focusing on some of the wider issues Sunflower had identified. She also presented an update on the

readiness for the January 1, 2014, inclusion of LTSS in KanCare. She addressed how the pilot program had helped to work through problems and reviewed the top claim denial reasons. She stated although 30 percent of the claims were denied, the data would be reviewed to figure out how to make the system work better.

With regard to an issue that arose during the testimony from a representative of Meadowbrook Rehabilitation Hospital regarding coding for TBI, a member asked why two service codes were being cross-linked and whether anything could be done at the state level to alleviate that issue. The CEO of Sunflower State Health Plan stated that the issue arose on a call the week prior related to TBI services and skilled nursing. She stated what had been identified preliminarily during research was an individual goes from one eligibility category to another and the individual must be in the TBI eligibility category for those services to be paid at the higher level. She stated this was an opportunity to work closely with Meadowbrook, with KDADS, and with care managers for early identification to get the TBI eligibility in the system early, so those claims can be paid.

The President of UnitedHealthcare Community Plan of Kansas discussed the importance of engaging members and providers, communication, operational focus, and coordination of care. He indicated UnitedHealthcare is dedicated to the successful implementation of waiver services for individuals with disabilities, quality, and program innovation.

At the November meeting, the President of UnitedHealthcare stated he had continued to meet with community leaders, provider leaders, and associations with a goal of capturing more feedback, understanding more of what they can do to work together, and looking for ways to improve the support provided. He updated UnitedHealthcare's I/DD readiness and stated this was an area where the company has been trying to listen, collaborate with providers, work with the community, and work with targeted case managers to ensure that they are successful starting on January 1, 2014.

A Committee member asked how much time providers were being asked to contribute to

understanding the KanCare system, and whether MCOs work together, or if providers had to meet individually with all three MCOs. The President of UnitedHealthcare stated that he thinks the MCOs had all been working hard to create their own forums for discussion and ways to engage. He stated there also should be member sessions across the state in which all three MCOs, as well as care coordinators and provider representatives from all three MCOs, participate. Information on those forums could be found at both the MCO and the state's website. He stated the amount of time an individual provider spent getting the information needed to work with the MCO probably would be dependent on the provider, and the level of sophistication, comfort, and knowledge of the system.

A Committee member noted a common theme from providers has been the ability to collaborate with KDHE, KDADS, and MCO staff to reach common goals related to identified KanCare issues. The CEO of Amerigroup noted a retraining initiative with customer service representatives had begun. The Plan President of UnitedHealthcare commented that as key issues are identified, they are used as training tools. The CEO of Sunflower also stressed the importance of both MCO retraining and provider training. All MCO representatives expressed commitment to improvement.

During the October meeting, a Committee member asked MCO representatives to identify what is unique in the KanCare process that causes the level of dissatisfaction among providers with claim payments, denials, and administrative overhead. In addition, the member asked why there is difficulty in reconciling remittance advices (coding) to payment, compared to the previous system. The CEO of Sunflower acknowledged her responsibility to ensure support to the front-line provider staff. She indicated working through coding differences and educating providers (and internal MCO staff) to billing and processing issues is of primary importance. Coding is always changing, and she noted the importance of good communication with providers. The CEO of Amerigroup stated extenuating circumstances do exist that have caused denials; her organization continues to work towards understanding provider perspectives, identifying root causes, and developing improvement opportunities.

With regard to coding, a Committee member asked what the National Provider Identifier (NPI) number is and how it is used. The CEO of Amerigroup explained the NPI is a unique identification number issued to a health care provider or organization by CMS. The NPI follows the practitioner, provider, or organization and is the required identifier for Medicare and Medicaid services; it also is used by other payers, including commercial health care insurers. She noted that some HCBS providers are not required to obtain NPI numbers. For Amerigroup, a small, control group is accountable to input NPI information. A Committee member indicated a provider has identified recurring denials related to the NPI number. The CEO of Amerigroup requested follow-up from the Committee member in order to facilitate a resolution to the issue.

During the November meeting, the three MCO representatives discussed four global questions presented by a Committee member regarding whether they sold private insurance, how their denials compared from the public side to the private side, whether there were standardized codes between the three MCOs, and what would be used for the baseline to determine whether KanCare had improved the quality of care.

The MCO representatives also were advised of a specific billing issue in the I/DD Pilot for LTSS in which there was a large accounts receivable with pending or denied claims, and they were asked to look into the situation.

Federal Health Insurance Marketplace Update. The Kansas Insurance Department (KID) Health Insurance Ombudsman updated Committee members on the progress of the federal health insurance exchange under the ACA. She commented the federal exchange system opened on October 1, 2013, and many technical issues had occurred to date, such as log-in errors and slow page loads, which have prevented many consumers from completing the process. The Chairperson requested that additional information be provided weekly concerning the number of consumers completing the process of purchasing benefits, the number of consumers receiving subsidies, and other pertinent information if available. The KID Health Insurance Ombudsman indicated she would contact CMS to ascertain the availability of the information requested.

The KID Health Insurance Ombudsman explained that all levels of health insurance plans (Bronze, Gold, Silver, and Platinum) include the essential health benefits. She noted the differences in plans are in the maximum out-of-pocket expenses, deductibles, co-pay, and co-insurance costs. She indicated there also is a catastrophic plan for consumers under age 30.

At the November Committee meeting, the KID Special Counsel provided information regarding health insurance cancellation notices issued to Kansas consumers and the mandate lite health insurance legislation enacted during the 2013 Legislative Session. She stated Blue Cross/Blue Shield of Kansas had issued the most substantial number of cancellation letters. The Special Counsel stated Blue Cross had indicated those cancellations would be rescinded and consumers would be given an opportunity to renew those plans for 2014.

A Committee member noted a statement was made Blue Cross/Blue Shield had issued 10,000 cancellation notices and inquired about the number of cancellations from other insurance companies. The KID Special Counsel responded that most of the other major insurance companies with a large share of the state's market had not issued those cancellation notices.

Discussion was heard regarding the employees of the city of Bel Aire, Kansas, whose health insurance plans through Blue Cross/Blue Shield had been canceled. The KID Special Counsel stated the City could terminate the policy purchased through Coventry and renew the Blue Cross plan previously canceled, and could do so without a penalty.

Mandate Lite Policies. A Committee member asked about the Commissioner's position regarding the mandate lite legislation passed during the 2013 Session. The KID Special Counsel stated the Commissioner recognized and understood passage of the legislation might result in filings from insurance companies. However, to date, KID had received no such filings. The Committee member asked if KID would be supportive if an insurance company applied for such a policy. The Special Counsel responded she believed the KID would need to do what the

Legislature had asked. At the same time, KID was aware that any insurance company operating in the state that attempted to sell that product in the small group market would be violating federal law. The Special Counsel stated, even if KID were to take no action on the attempted sale of such a policy, the insurance company would be subject to federal enforcement. The Committee member asked, because the U.S. Supreme Court declared the individual mandate was a tax and not a penalty, whether technically it would be illegal for the insurance companies to sell these policies. The Special Counsel responded that an individual who bought an individual policy not in compliance with the ACA would be subject to the individual mandate penalty under the law as it exists. She stated her earlier reference was that an insurance company that attempted to sell a product that did not comply with the ACA would be subject to additional enforcement by the federal government for the sale of products in violation of the law. The Committee member asked the Special Counsel about what that enforcement and penalties would be. The Special Counsel responded the insurance companies would be subject to dollar penalties for selling those products and stated that she did not know what other enforcement might occur as that issue had not arisen, but would look into it. The follow-up discussion indicated the sales of these policies in the short-term market are allowed.

High-Risk Pool. At the November meeting, responding to whether a final decision had been made on the high-risk pool, the Special Counsel confirmed the Board was moving forward with the cancellation of that coverage as of December 31, 2013. She stated on January 1, 2014, no one would meet the eligibility criteria for the high-risk pool because no one could be denied health coverage due to a pre-existing condition.

A Committee member expressed concern that the difficulties with the federal Marketplace website might effect those individuals needing a subsidy and wondered if those currently in the high-risk pool would be left without coverage. The Special Counsel stated the individuals in the high-risk pool had been paying high premium rates, so the majority of these individuals were not expected to qualify for a tax credit as they previously had been able to afford high-risk pool coverage.

In response to a Committee member question on the number of persons in the high-risk pool and their options upon the pool's cancellation, the Special Counsel stated the last report showed just under 1,350 people in the high-risk pool. She explained these individuals could obtain coverage effective January 1, 2014, through the private market or in the Marketplace if they thought they might qualify for a tax credit.

At the request of a Committee member, the Special Counsel provided details regarding the InsureKS.org website created by the Kansas Insurance Department.

The Committee received the Annual Report to the 2014 Legislature from KDADS, which is included in this report as Addendum A.[pending]

CONCLUSIONS AND RECOMMENDATIONS

Based on testimony heard and Committee deliberations, the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight makes the following conclusions and recommendations:

Funding the Developmental Disability Waiting List

A proviso in the 2014 budget bill (SB 171) directed that \$4,000,000 from the mental health and retardation services aid and assistance account of the State General Fund (HCBS/DD waiver funding) for fiscal year (FY) 2014 would be lapsed if those services were not provided under KanCare on January 1, 2014.

Because there was every indication that the Centers for Medicare and Medicaid Services would approve the 1115 Medicaid waiver prior to January 1, 2014, as a gesture of good faith, the Kansas Department for Aging and Disability Services (KDADS) began providing services in September 2013 to individuals with developmental disabilities who had been waiting for services.

With the delay in inclusion of long-term services and supports (LTSS) for individuals with developmental disabilities under KanCare until February 1, 2014, the Committee recommends

passage of a FY 2014 and FY 2015 additional funding for the Kansas Department for Aging and Disability Services to include the following:

- Appropriate \$4,000,000 to replace the \$4,000,000 which was lapsed from the mental health and retardation services aid and assistance account of the State General Fund for individuals with developmental disabilities;
- Individuals with developmental disabilities and physical disabilities who were removed from the waiting list and provided services based on the FY 2014 and FY 2015 budget appropriation should continue to receive services; and
- Any unspent funds appropriated for FY 2014 and FY 2015 for developmental disabilities and physical disability services should be directed to provide services to the individuals on the developmental disabilities underserved waiting list.

Inclusion of LTSS for Individuals with Developmental Disabilities under KanCare

The Committee reaffirms the importance of moving LTSS for individuals with developmental disabilities into the KanCare managed care system by February 1, 2014.

The managed care system would enhance coordination of behavioral health, physical health, and LTSS. While Kansas has a proven track record of providing excellent support for individuals with developmental disabilities, the past 20 years has seen little improvement in health outcomes. An important study, commissioned by the Kansas Health Policy Authority (now the KDHE Division of Health Care Finance), revealed deficiencies in the treatment of chronic disease among the state's developmental disability population.

Another important consideration is that, under the present system, no entity is held accountable for repeated hospitalizations of beneficiaries with developmental disabilities. Under KanCare, the managed care organizations (MCOs) would be

held contractually responsible for improved health outcomes and reduced costly hospitalizations of individuals with developmental disabilities. The savings to the Medicaid system would be the state's best opportunity to reduce the waiting list and provide services for more individuals.

KanCare Ombudsman

To support the KanCare consumer's experience receiving medical assistance and LTSS in a managed care environment, the Committee recommends the State maintain a permanent system of KanCare Ombudsman supports to assist consumers in understanding the managed care model and in the resolution of problems regarding services, coverage, access, and rights. The core elements of the KanCare Ombudsman Office are recommended to include the following:

- **Organization Structure:** The KanCare Ombudsman Office should operate independently of the state Medicaid agency located at the Division of Health Care Finance at KDHE. The Committee supports the placement of the KanCare Ombudsman's Office at KDADS and recommends that it continue to be housed in that agency, with the KanCare Ombudsman reporting directly to the Secretary for Aging and Disability Services.
- **Accessibility:** The services of the KanCare Ombudsman Office should be available to all Medicaid consumers, but focus on the Kansans receiving LTSS (institutional, residential, and community based). The KanCare Ombudsman Office should be accessible through multiple entryways (telephone, internet, office) and must reach out to consumers and authorized representatives through various means (mail, telephone, in person), as appropriate.
- **Functions:** The KanCare Ombudsman Office should assist consumers in navigating and accessing covered KanCare services and supports and assist in the resolution of problems and concerns that may arise between the consumer and

a MCO. The Ombudsman Office should serve as an access point for complaints and concerns with KanCare. The Ombudsman Office should assist consumers to understand the fair hearing, grievance, and appeal rights and processes within the MCO and at the state level. The Ombudsman Office should refer consumers to organizations that already provide assistance with representation through the state appeals process.

- **Data Collecting and Reporting:** The KanCare Ombudsman Office shall track the volume and nature of contacts and the resolution of such contacts on a quarterly basis or as requested by the Committee.

Medical and Surgical Claims Processing

The Committee is concerned with reports of excessive administrative costs borne by KanCare providers and recommends changes be sought in the processing of medical and surgical claims to reduce those requirements. The following specific recommendations are made:

- Hospital claims issues, including those revolving around those individuals with retroactive eligibility, need to be monitored, with the goal of finding a solution to resolve or reduce delays in payments.
- To reduce personnel costs, high expense claims should be placed in the medical review process by MCOs. Providers also are encouraged to consider the electronic transfer of data to MCOs or the placement of data in a secure registry to facilitate the timely review of those claims.
- KDHE should review the accounts receivable percentages for providers for claims over 90 days past due. To determine whether payments of accounts receivable are improving or deteriorating, the Committee recommends a comparison be made of the ratio trends to the "commercial payor mix" obtained from information voluntarily provided by

providers for use as a benchmark between Medicaid payers and commercial payors.

Claims Payments in Developmental Disability Long Term Services and Supports Inclusion

If the inclusion in KanCare of LTSS and supports for the developmentally disabled population occurs, it is expected that claims payment issues will arise related to credentialing, contract loading, coding, and place of service errors. Also anticipated are issues related to pre-authorization from case management, third-party liability, and coordination of benefits. The Committee recommends all three MCOs relax all possible edits for at least 90 days to allow the claims to pass through and be adjudicated the first time. The Committee recommends the edits be turned on slowly, one at a time, and enough resources be dedicated to permanently correct any issues that arise. Further, the Committee recommends the MCOs have advance payment procedures in place as a final safety net for providers.

Kansas Health Care Prompt Payment Act

The Committee recommends introduction of legislation to provide for the inclusion of MCOs in the Kansas Health Care Prompt Payment Act.

Medicaid and CHIP Information

The Committee requests KDHE provide monthly reports to the Committee on Medicaid

and the Children's Health Insurance Program (CHIP), including the number of: Medicaid and CHIP applications by population group, those found ineligible and those found eligible for Medicaid and for CHIP by category, applications not resolved which are carried over month to month, monthly Medicaid and CHIP enrollment by population, and the number of Medicaid and CHIP cases terminated and the reasons for termination.

Paperwork Reduction in Application Process

The Committee is concerned with the administrative burden on consumers applying for services. The Committee recommends KDHE investigate opportunities for methods to reduce this burden on those applying for services. In particular, KDHE should coordinate with the Department for Children and Families to explore options to reduce paperwork for Temporary Assistance to Needy Families applicants to also apply for Medicaid services.

Reporting of Emerging Concerns

The Committee requests KDADS and KHE provide frequent reports to the Committee on emerging concerns in KanCare, including issues identified by the MCOs.

Proposed Legislation

- The Committee recommends introduction of legislation to include MCOs in the Kansas Health Care Prompt Payment Act.

Report of the Capitol Preservation Committee to the 2014 Kansas Legislature

CHAIRPERSON: Jennie Chinn, State Historical Society

SENATE PRESIDENT'S APPOINTEES: Senator Elaine Bowers, Ryan Gilliland

HOUSE SPEAKER'S APPOINTEES: Lana Gordon, Secretary of Labor

SENATE MINORITY LEADER'S APPOINTEE: Timothy Graham

GOVERNOR'S APPOINTEES: Peggy Palmer, Landon Fulmer, Richard Kyle

HOUSE MINORITY LEADER'S APPOINTEE: Representative Valdenia Winn

OTHER MEMBERS (*EX OFFICIO*): Barry Greis, Statehouse Architect, Peter Jasso, Kansas Creative Arts Industries Commission

STUDY TOPIC OR CHARGE

- Continue plans on the placement of a mural in the State Capitol commemorating the U.S. Supreme Court decision in the case of *Brown v. Board of Education*;
- Finalize guidelines for temporary displays;
- Discuss the completion of the Visitors Center; and
- Address exterior landscaping.

Capitol Preservation Committee

ANNUAL REPORT

Conclusions and Recommendations

The Committee recommends the Capitol Landscape Plan to the Legislative Coordinating Council (LCC) for its consideration and approval. The Committee also recommends modifications to the Capitol Landscape Plan pertaining to the trail, conversation clusters, wayfinding and vehicular signage, the monument sign, and site lighting.

The Committee approves procedures, as specified in this report, for future architectural modifications and requests to display permanent exhibits and artwork.

In the future, in addition to overseeing the selection process for the *Brown v. Board of Education* Mural, the Committee intends to consider procedures pertaining to the display of temporary exhibits and artwork in the Capitol.

Proposed Legislation: None.

BACKGROUND

The Capitol Preservation Committee was created by the Legislature in 2010. As provided by KSA 2013 Supp. 75-2269, the Committee has 12 members, with the Governor appointing three, the President of the Senate and the Speaker of the House each appointing two, and the Minority Leaders of the Senate and House each appointing one. The Committee's three *ex-officio* members are the Statehouse Architect, the Executive Director of the Kansas State Historical Society (KSHS), and the Director of the Creative Arts Industries Commission. The Governor has the authority to appoint the chairperson from amongst the Committee's membership.

COMMITTEE ACTIVITIES

The Capitol Preservation Committee met on November 19 and December 16, 2013.

On **November 19**, the Committee received updates on the *Brown v. Board of Education* Mural and the Capitol renovations. After hearing a

proposal regarding landscaping on the Capitol grounds, the Committee made plans to develop application procedures for architectural modifications and displays for permanent exhibits and artwork.

***Brown v. Board of Education* Mural**

Staff from the Legislative Research Department reported on the status of the *Brown v. Board of Education* Mural. Of the 34 artists who applied, 14 were invited as semi-finalists to submit a rendering. The deadline set by the Committee to receive proposals was April 1, 2014.

Capitol Landscape Plan

The Committee heard a proposal from representatives of Treanor Architects and Bartlett and West, a landscape architectural firm, regarding a Capitol Landscape Plan for the grounds. Topics addressed included trails and sidewalks, benches and seating areas, barrier arms and bollards, sculptures and memorials, water features, lighting, and way-finding signage. To develop the proposed landscape plan, a review was made of historic

photographs and the original landscape plan of 1895. The plan strives to include year-round color. It also was important to select plants requiring low water usage. An inventory of existing vegetation was taken, and a listing was created which recommends trees that need to be removed due to either poor health or to address adjacent plant health issues.

Capitol Renovations

The Statehouse Architect indicated the northeast, southwest, and southeast quadrants of the grounds were scheduled for completion by December 31, 2013. The schedule for the northwest quadrant indicated work continuing in February 2014 to complete the concrete sidewalks, curbs, ceremonial drive and lighting. Work in this area cannot proceed until removal of the crane has been completed. The entire grounds were scheduled to receive new sod, with 60 percent of that cost paid by the renovation project and 40 percent paid by the Department of Administration. By the end of 2013, 95 percent of the landscaping was to be completed, and the remaining 5 percent in spring 2014.

The goal is to have the Visitor Center completed by January 2, 2014. Items highlighted included:

- A map of the state embedded in the floor, designating the name of each county;
- A display of large banners with images from the 1890s, illustrating how the state was advertising itself;
- A series of banners with quotes from famous Kansans with a focus on government and civic responsibility;
- A multipurpose auditorium;
- A corridor containing construction photos from both the original construction and the renovation. The original construction took 37 years to complete. Some of the tools from the original construction will be displayed, as well as items found in the walls during the renovation process;

- A dining area containing images of Kansas, displaying the diversity of landscape in the state;
- A display of historic posters from various county fairs;
- The dome, scheduled to open on January 2, 2014. There will be a display of photos of the dome, as well as views from looking out the windows at the top of the dome, both from when it opened in 1904 and what it looks like now;
- A series of historic portraits representing the Native American tribes that originally resided in the state, as well as tribes that were relocated to Kansas;
- Information concerning the process of becoming a free state versus a slave state; and
- Information on the government process in Kansas.

On **December 16**, the Committee heard an enhancement proposal to the Capitol Landscape Plan, an update on the Visitor Center and Capitol dedication, and proposed procedures pertaining to architectural modifications and permanent displays of exhibits or artwork.

Landscape Enhancement

The Committee heard a proposal from representatives of Treanor Architects and Bartlett and West regarding an enhancement proposal to the Capitol Landscape Plan which included a trail, fountains, conversation clusters, signage, a monument sign on the north side of the grounds, and site lighting.

Visitor Center and Dedication Ceremonies

A representative of the Governor's Office provided an update on the plans for the opening of the Visitor Center and dedicating the renovated Capitol. Two separate events were planned. On January 2, at 10:00 a.m., there would be a ribbon cutting at the Visitor Center. This would be the

first opportunity for the public to see the ground floor area. On January 29, Kansas Day, from noon to 1:00 p.m., a dedication ceremony was planned to mark the completion of the entire renovation project. It has been discovered the Capitol was never dedicated. The event would be a formal dedication ceremony with a plaque, entertainment, and a large cake to serve 1,000 people. Dignitaries would be invited to attend, including legislative leadership and former legislators who were instrumental in the renovations.

A representative of KSHS provided an overview of how the classroom and auditorium in the Visitor Center would be utilized, as well as an outline of the eight guided tours to be available. A tour for fourth graders would be developed on the three branches of government, and a tour for seventh graders would be available concerning how a bill becomes a law. An eight-minute orientation video would be available, starting in the spring, for visitors to the Capitol.

KSHS, Legislative Administrative Services, and the Department of Administration will continue to meet in order to determine ways to make the process of scheduling Capitol space more efficient. KSHS planned to submit a grant to obtain funding to provide a single public interface for scheduling the use of the Capitol.

Architectural Modification Process

The Committee reviewed the proposed procedure for requesting a future architectural modification. KSA 75-2715 through 75-2725, inclusive, establishes historic preservation as an official policy of the State of Kansas and designates the Kansas State Historical Society as the State's historic preservation agency. The Kansas State Capitol was listed on the National Register of Historic Places in 1971. Under federal and state law, modifications proposed for the Capitol must be reviewed under the guidelines of the *U.S. Secretary of the Interior's Standards for the Treatment of Historic Properties*. In Kansas, preservation work is reviewed by the Kansas State Historical Society. The procedure would include:

- The person, public official, or state agency initiating the change submits a written request to the Statehouse Architect (Department of Administration).

- The Statehouse Architect consults with the State Historic Preservation Office (SHPO), which is the Kansas State Historical Society, to determine one of the following:
 - The project does not in any way alter the historic character of the Capitol and may proceed under the direction of the Statehouse Architect; or
 - The project has the potential to alter the historic character of the Capitol and is therefore submitted to the SHPO for review. The SHPO review is provided to the Committee which determines whether the project is approved or denied; and
 - If any project approved by the Committee consists of permanent displays or monuments to be located in the Capitol or on the grounds, pursuant to KSA 75-2269, the project must be authorized by the passage of a bill of the Legislature.
- Records of all requests and actions by the Capitol Preservation Committee would be kept by the Legislative Research Department for the number of years determined by the Department's records retention schedule.

Permanent Exhibits and Artwork Process

The Committee next reviewed the proposed procedure for requesting permanent exhibits, including artwork, in the Capitol. The procedure would be as follows:

- Person initiating the request submits a written proposal to the Chairperson of the Committee.
- The Chairperson places the request on the Capitol Preservation Committee agenda for review.
 - In advance of the Capitol Preservation

Committee meeting, the Chairperson, working with staff, may request additional information on the proposal if the Chairperson feels that more information would benefit the discussion.

- The Committee may approve, deny, or defer consideration of the request.
- If the request is approved, the proposal is submitted to the appropriate legislative committee or state agency.

CONCLUSIONS AND RECOMMENDATIONS

Based on testimony and discussion, the Committee recommends the Capitol Landscape Plan to the Legislative Coordinating Council

(LCC) for approval. The Committee also recommends modifications to the Capitol Landscape Plan pertaining to the trail, conversation clusters, wayfinding and vehicular signage, the monument sign, and site lighting.

The Committee approves procedures, as specified in this report, for future architectural modifications and requests to display permanent exhibits and artwork. With assistance from the KSHS, Legislative Administrative Services, and the Department of Administration, the Committee will develop forms for interested parties to use when wanting to request modifications or propose permanent exhibits and artwork.

At its next meeting, the Committee intends to consider procedures pertaining to the display of temporary exhibits and artwork in the Capitol.

Report of the Health Care Stabilization Fund Oversight Committee to the 2014 Kansas Legislature

CHAIRPERSON: Gary Hayzlett

LEGISLATIVE MEMBERS: Senators Laura Kelly and Senator Vicki Schmidt, Representatives Dave Crum and Representative Jerry Henry

NON-LEGISLATIVE MEMBERS: Darrell Conrade, Dr. John R. Eplee, Dennis George, Dr. Paul Kindling, Dr. Terry “Lee” Mills, Jr., Dr. James Rider

STUDY TOPIC OR CHARGE

- Review the operation of the Health Care Stabilization Fund, report and make recommendations regarding the financial status of the Fund.

Health Care Stabilization Fund Oversight Committee

ANNUAL REPORT

Conclusions and Recommendations

The Committee addressed the two statutory questions posed annually to the Oversight Committee. The Health Care Stabilization Fund Oversight Committee continues in its belief that the Committee serves a vital role as a link among the Fund Board of Governors, the health care providers, and the Legislature, and should be continued. Additionally, the Committee recognizes the important role and function of the Health Care Stabilization Fund (HCSF or Fund) in providing stability in the professional liability coverage marketplace, which allows for more affordable professional liability coverage to health care providers in Kansas.

Actuarial Review. The Committee reviewed the need to contract for an independent actuarial review in 2014. The Committee considered the information presented by the Board of Governors' actuary and discussed the additional state agency audits and reviews routinely conducted on behalf of the Health Care Stabilization Fund Board of Governors and the Fund.

- While the Committee continues in its belief that the ability to contract for an independent actuarial review is necessary for the safety and soundness of the Fund, the Committee does not see, at this time, a need for such review in 2014.

Other Recommendations. The Committee then considered information presented by the Board of Governors' representatives and health care provider and insurance company representatives. The Committee agreed to make the following recommendations:

- **Reimbursement of the Fund.** The Committee notes the Fund reimbursement schedule created by 2010 SB 414. This law allowed for the reimbursement payments to the HCSF for administrative services provided to the self-insurance programs for the University of Kansas Foundations and Faculty and the University of Kansas Medical Center (KUMC) and the Wichita Center for Graduate Medical Education (WCGME) residents for state Fiscal Years 2010, 2011, 2012, and 2013. The Committee notes the first payment (totaling 20.0 percent of the deferred amounts) has been made; payments are to be made annually through July 1, 2017.

The Committee further recommends the continuation of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the HCSF:

- **Fund To Be Held in Trust.** The Committee recommends the continuation of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the HCSF:
 - The Health Care Stabilization Fund Oversight Committee continues to be concerned about and is opposed to any transfer of money from the HCSF to the State General Fund (SGF). The HCSF provides Kansas doctors, hospitals, and the defined health care

providers with individual professional liability coverage. The HCSF is funded by payments made by or on the behalf of each individual health care provider. Those payments made to the HCSF by health providers are not a fee. The State shares no responsibility for the liabilities of the HCSF. Furthermore, as set forth in the Health Care Provider Insurance Availability Act (HCPIAA), the HCSF is required to be “. . . held in trust in the state treasury and accounted for separately from other state funds.”

- Further, this Committee believes the following to be true: All surcharge payments, reimbursements, and other receipts made payable to the Health Care Stabilization Fund shall be credited to the HCSF. At the end of any fiscal year, all unexpended and unencumbered moneys in such Fund shall remain therein and not be credited to or transferred to the SGF or to any other fund.
- ***Miller v. Johnson – the outlook for professional liability coverage.*** The Committee recognizes the Court’s findings about the *quid pro quo* relationship between the purposes of the HCPIAA and the requirement for certain health care providers to carry professional liability coverage and participate in the HCSF, coupled with the guaranteed source of recovery for persons seeking to recover pain and suffering damages. The Committee acknowledges the discussion of potential legislation for the 2014 Legislature to consider. The Committee encourages a continued dialogue between the Fund Board of Governors, the health care provider groups and representatives, and the Oversight Committee, with particular attention to the definition of “health care provider” specified in the HCPIAA and the associated risks and benefits analysis needed. The Committee also acknowledges the HCPIAA requirements for Kansas health care providers, including tail coverage, paired with the noneconomic damages cap, and requests the monitoring of, for comparative purposes, the activities and regulatory environments in other states.

Proposed Legislation: None.

BACKGROUND

The Health Care Stabilization Fund Oversight Committee was created by the 1989 Legislature and is described in KSA 40-3403b. The 11-member Committee consists of 4 legislators; 4 health care providers; 1 insurance industry representative; 1 person from the public at large, with no affiliation with health care providers or with the insurance industry; and the Chairperson of the Board of Governors of the Health Care Stabilization Fund (HCSF) or another member of the Board designated by the Chairperson. The law charges the Committee to report its activities to the Legislative Coordinating Council and to make recommendations to the Legislature regarding the Fund. The reports of the Committee are on file in the Legislative Research Department.

The Committee met October 16, 2013.

COMMITTEE ACTIVITIES

Report of Towers Watson

The Towers Watson actuarial report serves as an addendum to the report provided to the Fund Board of Governors dated April 16, 2013. The actuary first addressed forecasts of the Fund’s position at June 30, 2013, and June 30, 2014. The forecast of the Fund’s position (discounted) at June 30, 2013, is as follows: the Fund held assets of \$259.93 million and liabilities of \$192.11 million, with \$67.82 million in reserve. The projection for June 2014 is as follows: assets of \$265.38 million and liabilities of \$197.54 million, with \$67.84 million in reserve. The report notes the forecasts were based on a review of Fund data as of December 31, 2012. The actuarial report indicated assets at June 30, 2013, were \$1.1 million higher than anticipated. The actuary noted the forecasts assume an average 5 percent decrease

in surcharge rates for FY 2014; \$24.5 million in surcharge revenue in FY 2014; continued full reimbursement for KU/WCGME claims, but with reimbursement from the state delayed until FY 2014; and no change in current Kansas tort law or applicable Fund law. The actuaries had suggested the Board either maintain current rates or implement an overall decrease involving changes by class to improve rate adequacy in certain classes. The actuary noted the Board changed surcharge rates for FY 2014 at an average rate of decrease of five percent. The actuary stated, given the Fund's FY 2013 results and the 2012 Kansas Supreme Court decision in *Miller v. Johnson*, "the Fund is in as strong a financial position as ever in its 37-year history."

The actuary next reviewed the Fund's liabilities at June 30, 2013, noting the complexity of the Fund's liabilities and the settlement of claims. The actuary pointed to inactive providers and those claims known at June 30, 2013, (\$8.9 million) and the liability assigned to present events that may arise as claims at a future time (\$76.3 million). The actuary also highlighted future payments, totaling \$13.6 million, for resolved cases where payments are pending. A Committee member asked about the determination of tail coverage estimates, and the actuary indicated the estimates are set using two models; the models are based on Fund experience and document when claims are reported and paid. In the case of future claims, cash flow is not paid out until 2050. The actuary then reviewed the Fund's rate level indications for FY 2014; the indications assume a break-even target. He commented on item 6, investment income, noting the assumption of a reasonably high yield (4.00 percent on average assets).

The actuary provided additional observations for the Committee's consideration:

- Claim settlements in the July 2012 – December 2012 period were much higher than in recent 6-month periods, but (in the actuary's view) were overdue;
- There were 674 Plan insureds in FY 2006, but the count has dropped every year since then. In FY 2012, there were 398 Plan insureds; and

- The Fund's investment income continues to show a reasonably high yield (3.9 percent annual rate in FY 2013), given market interest rates.

The actuary's report addressed the findings by provider class. He commented on the loss experience by class, noting analysis continues to show differences in relative loss experience among classes. The actuary further noted there are more classes in the "middle" (experiencing an increase or decrease of 10 percent or less) than in prior years. Two classes were highlighted among those groups "undercharged" – Class 3 (Physicians—Minor Surgery; +12 percent) and Class 15 (Plan insureds; +50 percent). It was confirmed that, in order to be actuarially sound, Class 15 would need to change from 40 percent to 60 percent. (There was no change in Class 15.) The actuary next provided a review of surcharge rate changes, from FY 2002 – FY 2014, noting over time the Missouri modification (surcharge) increased from 20 percent when implemented in 2002 to 25 percent in 2008; for FY 2014, the rate is 30 percent. The actuary then reviewed five options presented to the Board regarding FY 2014 surcharge rates. The Board selected surcharges in line with Option 5. The actuary concluded his presentation by noting the Fund is in "a very sound position."

Following the presentation, the actuary responded to an inquiry regarding the statutory question posed each year regarding an independent actuarial review and protections afforded should there be an issue with the Fund and information contained in the actuary's report. The actuary indicated that, if there was great uncertainty, a second opinion could be sought. One such report was provided in the mid-1990s. The Executive Director noted that the Legislature addressed the issue of credibility regarding actuarial reports, allowing for the request of an independent review. The Board hired Tillinghast several years ago (now Towers Watson) and credibility was restored. There is no indemnity (issues arising with the Fund stability), so the Board carefully reviews a number of factors, including the margin of unassigned reserves. If the need arose for an independent actuary, the Committee could hire another firm; the HCSF would pay for such services. The Committee discussed the necessity for an independent review; its recommendation to

not request an independent actuarial analysis is included in this report.

Comments

In addition to the report from the Board of Governor's actuary, the Committee received information from Committee staff detailing resource materials available for consideration including information regarding the reimbursement of the Fund for administrative services provided to self-insurance programs, the Committee's prior conclusions and recommendations, and the FY 2014 and FY 2015 subcommittee and budget committee reports adopted by legislative committees. The analyst highlighted some of the findings specific to the Fund and the cap on noneconomic damages presented in the syllabus for the October 5, 2012, Kansas Supreme Court decision in *Miller v. Johnson*. The analyst also updated the Committee on the status of legislation in Missouri, issued in response to the *Watts v. Lester E. Cox Medical Centers* decision. In response to a Committee member's question about the case and current Missouri law, the analyst indicated that, in 2005, the Missouri Legislature had set a \$350,000 cap on noneconomic damages. This tort reform law replaced what had been a cap adjusted for inflation. The *Watts* decision struck down the \$350,000 cap and legislation to reinstate the cap is being considered; HB 112 has passed the Missouri House of Representatives and remains in the Senate.

The Deputy Director and Chief Attorney for the Health Care Stabilization Fund Board of Governors next addressed the FY 2013 medical professional liability experience (based on claims resolved in FY 2013 including judgments and settlements). The conferee began her presentation by noting jury verdicts. Of the 18 cases involving 22 Kansas health care providers that were tried to juries during FY 2013, 15 were tried to juries in Kansas courts and three cases were tried to juries in Missouri. The largest number of trials were held in the following jurisdictions: Sedgwick County (6), Johnson County (4), and Jackson County, Missouri (3). Of those 18 cases tried, 14 resulted in complete defense verdicts. Three cases returned verdicts for the plaintiff and resulted in expenditures from the Fund, with one of those

cases now on appeal. The Chief Attorney stated a noneconomic damages cap in Missouri has an influence on the number of cases taken to trial in Jackson County. With no cap in place, this translates to a more difficult environment to take new cases (on behalf of health care providers) until a new cap is enacted.

The Chief Attorney then highlighted the claims settled by the Fund, noting in FY 2013, 79 claims in 62 cases were settled involving HCSF monies. Settlement amounts for the fiscal year totaled \$27,610,000—these figures do not include settlement contributions by primary or excess insurance carriers. The conferee spoke to the \$6.2 million increase from the prior fiscal year, noting there were more claims in the higher dollar amounts, with a big component of these amounts due to past and future medical expenses. Of the 79 claims involving Fund monies, the Fund provided primary coverage for inactive health care providers in eight claims. The Fund also “dropped down” to provide first dollar coverage for five claims in which aggregate primary policy limits were reached. In addition to the \$27.6 million incurred by the Fund, primary insurance carriers contributed \$13.3 million to the settlement of these claims. Further, testimony indicated, two claims involved contribution from an insurer whose coverage was in excess of Fund coverage; the total amount of these contributions was \$6.0 million. The Chief Attorney's testimony also indicated, in addition to settlements involving Fund contributions, the HCSF was notified that primary insurance carriers settled an additional 88 claims in 76 cases. The total amount of these reported settlements is \$6.7 million. The Chief Attorney also provided a report of new cases, noting this was the fifth year in a row for reduced claims. She encouraged the Committee to look to Missouri and the financial incentive for cases filed there. The Committee and the Chief Attorney discussed the involvement of the federal courts and the consideration of medical costs in settlements. (The conferee's testimony also included a report of HCSF total settlements and verdicts, FY 1977 to FY 2013.)

The Chief Attorney also addressed the self-insurance programs and reimbursements for the University of Kansas (KU) Foundations and Faculty and residents. She highlighted the FY 2013 KU Foundations and Faculty, and University

of Kansas Medical Center (KUMC) and Wichita Center for Graduate Medical Education (WCGME) program costs. The Chief Attorney first noted the settlements for KU Foundations and Faculty were down, from 12 to 5, and pursuant to state law, \$1,037,668.29 was not reimbursed from the State General Fund (SGF). While there were no FY 2013 settlements or judgments for KU and WCGME (Wichita and Salina campuses), the Chief Attorney noted the fees and expenses for WCGME and KU residents had seen a healthy increase, as certain injury cases can be costly to defend. The Committee and the conferee then discussed the impact of having no statutory cap (noneconomic damages) on the University of Kansas Foundations Faculty and other facilities deemed “health care providers” under the law that are located in the Kansas City area.

The Chief Attorney also highlighted the historical expenditures by fiscal year for the Foundations and Faculty and the KU and WCGME residents, noting the allotment (accrued SGF receivables) as of June 30, 2013, totaled \$7,720,422.23. Under the law, established in 2010 SB 414, the Fund received reimbursement for 20 percent of the authorized amount (\$1,544,084.43) in July 2013. The Chief Attorney’s report concluded with a review of moneys paid by the Fund for excess coverage claims. Committee members then discussed a number of items with the conferee, including health care providers living in Kansas and practicing in Missouri, costs associated with the WCGME program and differences between the two residency programs, the Missouri modification factor (surcharge), and allotment payments.

The Committee then reviewed the current marketplace for medical malpractice insurance. The Chief Executive Officer (CEO) of the Kansas Medical Mutual Insurance Company (KaMMCO) indicated several companies are writing the line of insurance for malpractice coverage for health care providers. A more competitive environment has evolved as physician groups continue to move toward contracts with hospitals. The conferee noted the *Miller v. Johnson* decision has provided predictability and allows the charging of lower rates to cover future claims. The CEO addressed the Availability Plan, noting there were 41 moonlighting residents in the Plan. He noted the Plan is paying one-third more than the regular

market cost. The Plan members may include those who retire, moonlight, restrict their practice, or have increased and often, extraordinary, claims experience; the Plan serves its intended purpose well, the conferee stated. The primary costdrivers are a few providers who have a number of claims and bring those experiences into the Plan. Responding to a question from a Committee member regarding the effectiveness of electronic health records, the KaMMCO CEO indicated the record is only as good as the data inputted and the physician and staff face time constraints. Another Committee member inquired about “frequent flyers” and the Plan; the conferee explained that the Availability Plan has a surcharge that can be applied based on the number of claims (over a specified amount), as well as restrictions on practice or hospital privileges. The conferee commented on the relationship with the Board of Healing Arts and its discipline and enforcement actions, noting the Board is aware of claim activity and restrictions on hospital privileges; a case of a physician with 32 claims was noted (the Board has taken action).

The Executive Director for the Kansas Medical Society (KMS) addressed the Committee and spoke to the partnership with the Kansas Hospital Association (KHA) in the Fund. The KMS Executive Director noted the legislative decision in Kansas to not transfer risks of this generation of physicians to future physicians in a comparison to other states facing large liabilities and unpredictability. He asked the Committee to consider three points in light of the *Miller v. Johnson* decision and its impact on the Fund and providers. First, the Legislature has the ability to balance the needs of individuals and health care providers and as the cap (noneconomic damages) was upheld, periodic review and adjustments, as necessary, should be considered. If no adjustments are made, the conferee stated, the cap could be lost. Second, the structure of the HSCF partnership with private insurance is solid, as it provides the plaintiff with surety of payment. Third, some provider groups are not covered by the Fund. KMS has met with 25 such groups to discuss the risks and benefits of the Fund. Discussions are ongoing about the accommodation of additional provider groups in the Fund. The KMS Executive Director addressed the legislation previously detailed by the HCSF Executive Director, indicating there is intention to make adjustments

to the law in response to *Miller v. Johnson*. Committee members and the conferee then discussed the potential amendments, the history of the cap on noneconomic damages and the wrongful death cap, and possible recommendations for the Committee's report. A representative of the KHA was recognized and indicated KHA officials are visiting with their Board members about the available proposals and will provide a response at the time the legislation is considered.

Statutory report, Fund history, and potential legislation. The Executive Director, Health Care Stabilization Fund, provided the Board's statutory report (as required by KSA 40-3403(b)) for FY 2013. Among the items detailed in the report:

- The balance sheet for the Fund, as of June 30, 2013, indicated assets of \$261,036,311 and liabilities of \$203,639,017;
- Net premium surcharge revenue collections amounted to \$26,185,100, with the lowest surcharge rate for a health care professional of \$50 (chiropractor, first year of Kansas practice; opting for lowest coverage option) and the highest surcharge rate of \$16,552 for a neurosurgeon with five or more years of HCSF liability exposure (selected highest coverage option)[application of the Missouri modification factor would result in a total premium surcharge of \$20,690 for this health care practitioner]; and
- The average compensation per settlement (62 cases involving 79 claims were settled) was \$349,494, a 9.3 percent increase compared to FY 2012. These amounts are in addition to the compensation paid by primary insurers (typically, \$200,000 per claim, unless the provider has become inactive and has prior acts "tail" coverage). The Executive Director noted that amounts reported for verdicts and settlements were not necessarily paid during FY 2013 and further informed the Committee that total claims paid during the fiscal year amounted to \$28,405,415. This amount was a 29.6 percent increase compared to the prior year.

The Executive Director also submitted historical information about the establishment and evolution of the Health Care Provider Insurance Availability Act (HCPIAA), including the professional liability insurance climate prior to adoption of the HCPIAA and original legislation to the more contemporary issues including the rules of civil litigation and tort reform and the costs associated with medical liability coverage.

The Executive Director highlighted the 2012 *Miller v. Johnson* decision, indicating there has been renewed interest in the HCPIAA. A task force was convened following the 2013 Session and review of the HCPIAA from minor, technical clarifications to a few significant policy decisions (including new providers under the Fund and coverage limit amendments) began. The Executive Director indicated preliminary draft legislation has been distributed to associations representing health care providers, the three major insurers of Kansas health care providers, and the 13 currently self-insured Kansas health care providers. The Board of Governors has invited each party to express support, opposition, or concerns. General consensus appears to have been reached on the tail coverage issue, the Executive Director reported, but there is hesitation on some of the other suggested amendments. As other health care professional groups and facilities' associations have not yet concluded their deliberations, the Executive Director noted, it was premature to present draft amendments to the Oversight Committee. The objective is to finalize draft legislation prior to the 2014 Session.

CONCLUSIONS AND RECOMMENDATIONS

The Committee addressed the two statutory questions posed annually to the Oversight Committee. The Health Care Stabilization Fund Oversight Committee continues in its belief that the Committee serves a vital role as a link among the Fund Board of Governors, the health care providers, and the Legislature, and should be continued. Additionally, the Committee recognizes the important role and function of the Health Care Stabilization Fund in providing stability in the professional liability marketplace, which allows for more affordable professional liability coverage to health care providers in Kansas.

Actuarial review. The Committee reviewed the need to contract for an independent actuarial review in 2014. The Committee considered the information presented by the Board of Governors' actuary and discussed the additional state agency audits and reviews routinely conducted on behalf of the Health Care Stabilization Fund Board of Governors and the Fund.

- While the Committee continues in its belief that the ability to contract for an independent actuarial review is necessary for the safety and soundness of the Fund, the Committee does not see, at this time, a need for such review in 2014.

Other recommendations. The Committee then considered information presented by the Board of Governors' representatives and health care provider and insurance company representatives. The Committee agreed to make the following recommendations:

- **Reimbursement of the Fund.** The Committee notes the Fund reimbursement schedule created by 2010 SB 414. This law allowed for the reimbursement payments to the Health Care Stabilization Fund for administrative services provided to the self-insurance programs for the University of Kansas Foundations and Faculty and the KUMC and WCGME residents for state Fiscal Years 2010, 2011, 2012, and 2013. The Committee notes the first payment (totaling 20.0 percent of the deferred amounts) has been made; payments are to be made annually through July 1, 2017.

The Committee further recommends the continuation of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund:

- **Fund to be held in trust.** The Committee recommends the continuation of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund:
 - The Health Care Stabilization Fund Oversight Committee continues to be concerned about and is opposed to any

transfer of money from the HCSF to the State General Fund. The HCSF provides Kansas doctors, hospitals, and the defined health care providers with individual professional liability coverage. The HCSF is funded by payments made by or on the behalf of each individual health care provider. Those payments made to the HCSF by health providers are not a fee. The State shares no responsibility for the liabilities of the HCSF. Furthermore, as set forth in the HCPIAA, the HCSF is required to be “. . . held in trust in the state treasury and accounted for separately from other state funds.”

- Further, this Committee believes the following to be true: All surcharge payments, reimbursements, and other receipts made payable to the HCSF shall be credited to the HCSF. At the end of any fiscal year, all unexpended and unencumbered moneys in such HCSF shall remain therein and not be credited to or transferred to the State General Fund or to any other fund.
- **Miller v. Johnson – the outlook for professional liability coverage.** The Committee recognizes the Court's findings about the *quid pro quo* relationship between the purposes of the HCPIAA and the requirement for certain health care providers to carry professional liability coverage and participate in the HCSF, coupled with the guaranteed source of recovery for persons seeking to recover pain and suffering damages. The Committee acknowledges the discussion of potential legislation for the 2014 Legislature to consider. The Committee encourages a continued dialogue between the Fund Board of Governors, the health care provider groups and representatives, and the Oversight Committee, with particular attention to the definition of “health care provider” specified in the HCPIAA and the associated risks and benefits analysis needed. The Committee also acknowledges the HCPIAA requirements for Kansas health care providers, including tail coverage, paired with the noneconomic damages cap, and

requests the monitoring of, for comparative purposes, the activities and regulatory environments in other states.

Finally, the Committee recommends this report be provided to the House Appropriations and Senate Ways and Means Committees.

Report of the Telecommunications Study Committee to the 2014 Kansas Legislature

CO-CHAIRPERSON: Senator Pat Apple

CO-CHAIRPERSON: Representative Joe Seiwert

LEGISLATIVE MEMBERS: Senators Jay Emler, Marci Francisco, Tom Hawk, Forrest Knox, Jeff Longbine, Julia Lynn, Robert Olson, and Mike Petersen, Representatives Rob Bruchman, Will Carpenter, John Doll, Randy Garber, Ramon Gonzalez, Annie Kuether, Ronald Ryckman Sr., Scott Schwab, Jack Thimesch, and Brandon Whipple

STUDY TOPIC OR CHARGE

- Study telecommunications issues including funding, uses, and sources of:
 - The Kansas Universal Service Fund (KUSF); and
 - The federal Universal Service Fund (FUSF);
- Review and make recommendations on the state's public policy on telecommunications; and
- Review possible need for funding sources of and uses of a Kansas Broadband Fund.

Telecommunications Study Committee

ANNUAL REPORT

Conclusions and Recommendations

The Committee's final report, which is due December 31, 2014, will contain its conclusions and recommendations.

Proposed Legislation: None

BACKGROUND

The Telecommunications Study Committee was created by 2013 HB 2201, a bill which also further deregulated telecommunications in Kansas, made changes to distributions from the Kansas Universal Service Fund (KUSF), and allowed the Board of Regents to charge fees for services provided by the Kan-Ed program.

The Committee's charge is to study telecommunications issues, the KUSF, the Federal Universal Service Fund (FUSF), the state's public policy on telecommunications, the possibility of establishing a Kansas Broadband Fund, and other issues determined by the Legislative Coordinating Council. In addition, the Committee is charged with determining the scope of an efficiency and effectiveness audit of the KUSF. The audit is to be administered by the Kansas Department of Revenue and submitted to the Committee by November 1, 2014.

The Committee is required to submit an annual report to the Senate Committee on Utilities and the House Committee on Utilities and Telecommunications and to submit a report and policy recommendations for telecommunications to those committees as well as to the Senate Committee on Ways and Means and the House Committee on Appropriations, prior to December 31, 2014. The Telecommunications Study Committee sunsets on June 30, 2015.

COMMITTEE ACTIVITIES

The Committee met twice during the 2013 Legislative Interim on November 6 and December 12. The Committee reviewed its charge and received presentations on topics including the history of telecommunications legislation in Kansas from 1996 through 2013, an overview of the KUSF, state and federal Do-Not-Call legislation, the process for determining KUSF high-cost support, and changes to the FUSF. In addition, the Committee received testimony from industry groups on the effects of changes to the KUSF and the FUSF, and determined the scope of an audit of the KUSF.

Telecommunications Legislation in Kansas, 1996 - 2013

Staff from the Kansas Legislative Research Department reviewed major telecommunications bills enacted by the Legislature beginning with 1996, the year federal telecommunications law significantly restructured the industry.

The telecommunications policy framework set out in the Kansas Telecommunications Act of 1996 remains in effect today. The Act declares it to be the public policy of the State to:

- Ensure every Kansan has access to a first class telecommunications infrastructure that provides excellent services at an affordable price;

- Ensure consumers realize the benefits of competition through increased services and improved facilities and infrastructure at reduced rates;
- Promote consumer access to a full range of telecommunications services, including advanced services that are comparable in rural and urban areas throughout the state;
- Advance development of a statewide infrastructure capable of supporting applications such as public safety, telemedicine, services for persons with special needs, distance learning, public library services, access to internet providers, and others; and
- Protect consumers of telecommunications services from fraudulent business practices and practices that are inconsistent with the public interest, convenience and necessity.

Among its many provisions, the Act required local exchange carriers to change a number of their business practices to increase competition, file network infrastructure plans that included schedules for deploying universal service capabilities and the capability to comply with quality of service standards, and rebalance intrastate and interstate switched access charges. The bill also required the Kansas Corporation Commission (KCC) to establish the Kansas Lifeline Service Program (to help low-income Kansans afford residential local service) and the KUSF.

Major legislation passed in subsequent years included the following:

- 1998 House Sub. for SB 212 reduced the size of the KUSF.
- 2002 Sub. for SB 296 established the Kansas No-Call Act, while other legislation that year conformed Kansas law to federal law to provide a uniform method of sourcing tax revenues from wireless services (SB 372) and created a new and separate city franchise procedure

for telecommunications local exchange service providers (SB 397). 2002 Sub. for HB 2754 further addressed access rate rebalancing by rural telephone companies; developed a procedure for determining affordable local telephone rates for residential and business service; and required rural telephone companies to calculate revenue requirements and KUSF support based on embedded costs.

- 2006 SB 360 established thresholds for price deregulation in exchanges served by price-cap carriers (AT&T and CenturyLink). Prices were deregulated for bundled service statewide, individual components of bundles in urban areas, and business and residential services in rural areas if the standard for competition was met. Lifeline services, the initial residential line, and up to four business lines at one location remained subject to price-cap regulation.
- 2008 SB 49 required Voice over Internet Protocol (VoIP) service providers to contribute to the KUSF, and SB 570 required broadband service providers to report information about service availability to the KCC, and the KCC to report broadband availability to the Legislature annually. HB 2637 authorized local exchange carriers to adjust rates for the initial residential line and up to four business lines at one location without KCC approval, required price deregulated carriers to automatically enroll eligible customers in Lifeline services, and allowed a carrier to be relieved of its responsibilities as carrier-of-last-resort in limited circumstances.
- 2011 Sub. for SB 72 allowed further deregulation of a price-cap carrier that has deregulated a majority of its local exchange access lines (only AT&T met this criteria). Such carrier, to be known as an “electing carrier” is subject to price-cap regulation only for Lifeline services, must allow reasonable resale of its retail service, is eligible to receive KUSF funding, cannot charge more for a single

residential or business line in its rural exchanges than in its urban exchanges, could choose to be relieved of its obligation to serve as carrier-of-last-resort in urban exchanges, must offer single residential local access lines in its exchanges, and must allow interconnection by a telecommunications carrier to transmit and route voice traffic.

- 2013 HB 2201 created the Telecommunications Study Committee and continued deregulation of the telecommunications industry. The legislation eliminated nearly all regulation of electing carriers and telecommunications carriers and changed distributions from the KUSF. Price-cap carriers (CenturyLink) were limited to the lesser of 90.0 percent of their 2011 KUSF level of support or \$11.4 million. Distributions to rate-of-return carriers as a group was limited to \$30 million annually, with the KCC authorized to modify carriers' KUSF support only based on changes in embedded costs, revenue requirements, investments, and expenses, until at least 2017. The identical support rule was discontinued for competitive eligible telecommunications carriers, whose KUSF high cost support was capped as of March 1, 2013, and will be reduced to zero beginning March 1, 2018.

Kansas Universal Service Fund

Staff from the Utilities Division of the KCC presented background information on the KUSF, including the programs funded, historical levels of support for programs and carriers, and audit processes carried out by the KCC. Presenters and respondents to questions included the Division Director, the Chief and the Assistant Chief of Telecommunications, and the Chief of Accounting and Financial Analysis.

Overview. The KUSF was created by the KCC in 1997, as directed by the 1996 Kansas Telecommunications Act. The purpose of the KUSF is to assure quality services are made available to all Kansans at affordable rates. Every telecommunications carrier, telecommunications

public utility, wireless service provider, and VoIP provider offering intrastate telecommunications service must contribute to the KUSF, but companies can pass the assessment through to customers.

The assessment rate for 2013 (assessment years run from March 1 through February 28) is 6.42 percent on intrastate revenue. The rate has ranged from a high of 9.0 percent in the Fund's first year of existence to a low of 3.7 percent in 2002.

Since the Fund's inception a total of \$1.1 billion has been awarded through five programs:

- High Cost Support, the largest program, accounts for 85.4 percent of total support provided since 1997. It provides affordable services in areas that are costly to serve, primarily because of low population density;
- Kan-Ed, funded primarily from KUSF for State FYs 2004 through 2013, was created to provide broadband Internet access and distance learning capabilities for schools, libraries, and hospitals. It accounted for 8.4 percent of total support provided, but KUSF support for Kan-Ed was eliminated as of June 30, 2013;
- Kansas Relay Service, Inc. (KRSI) provides intervention assistance between a hearing or speech impaired customer and a hearing person in order for them to communicate. KRSI has received 2.8 percent of the support;
- Lifeline provides a credit to eligible households to aid in payment of the bill for local telephone service. Historically, it has accounted for about 2.5 percent of support; and
- Telecommunications Access Program (TAP) helps pay for specialized equipment for persons with certified disabilities who need assistance in using the telephone. Over the years TAP accounted for 0.9 percent of the support.

Process for determining KUSF high-cost support. The KUSF initially was implemented on a revenue neutral basis — that is, it was set up to allow carriers to recover the revenue lost when intrastate access rates were reduced under the Kansas Telecommunications Act. The Act also required the KCC to periodically review the KUSF to determine if the cost to provide universal service justified modification of KUSF. For carriers that chose price-cap regulation (AT&T and CenturyLink), the KCC mirrored the federal approach that based support on the cost to provide service if the network were to be built given current technology, and a model was developed to calculate the forward-looking cost of providing service and support.

The KCC also mirrored the federal approach for the carriers that chose rate-of-return regulation (the rural independent companies) and based support on historical costs, which has been revised to include embedded costs, revenue requirements, investments, and expenses.

To implement the required periodic review, the KCC initiated KUSF audits based on the amount of KUSF support provided, working from largest to smallest amount of support. The first audit (AT&T) was conducted in 1998 and the last initial audit of a rate-of-return carrier was completed in 2013. In all, 16 of 36 rate-of-return carriers have undergone second audits. Based on a district court ruling, any change to KUSF support must be based on a KUSF audit. For example, a carrier with a large increase in access lines to remote locations would be required to request an audit to determine whether it was entitled to additional KUSF support.

Audits, conducted by KCC audit staff and consultants, consist of an in-house review of carrier data as well as an on-site review of carrier records and facilities. Staff recommendations are presented via the docket process to the Commissioners who make the final determination of KUSF support.

Detailed information was provided to the Committee regarding the types of expenditures reviewed during an audit and the process for determining a carrier's revenue requirement. Schedules from a recent audit demonstrated the

information reviewed and the types of adjustments and allocations made during an audit.

Do-Not-Call Legislation

Staff from the Kansas Legislative Research Department provided a briefing on telemarketing laws in response to questions raised by Committee members.

Federal laws were passed in the early 1990s to help protect consumers from unsolicited telephone marketing calls to their homes, including automated and prerecorded messages, and to restrict telemarketing calls a reasonable consumer would consider coercive or abusive of the consumer's right to privacy. These laws, enforced by the Federal Trade Commission, included requirements on the identifying information a telemarketer had to provide a consumer; a prohibition on placing calls before 8 a.m. or after 9 p.m.; and a requirement for the telemarketer to comply with any do-not-call request made during the call. In 2003, the National Do-Not-Call Registry was established.

The Kansas No-Call Act was established in 2002. It incorporates the protections of the federal laws and places additional restrictions on telemarketers. It clarifies the limited circumstances under which a telemarketer may contact a person whose phone number is on the No-Call List (For example, if expressly requested by the consumer, if the consumer and the telemarketer have a business relationship, or if the call is of a charitable nature.). Violations of the Kansas No-Call Act are enforced by the Kansas Attorney General and are subject to a civil penalty. The Kansas No-Call List is part of the National Do-Not-Call Registry, which is managed by the Federal Trade Commission.

Federal Universal Service Fund

The Chief of Telecommunications, KCC, provided an overview of the FUSF and the Federal Communications Commission (FCC) Reforms. Historically, the provisions in federal law to develop a fund to maintain and enhance universal service referred to telephone service. However, in 2009, Congress directed the FCC to develop a National Broadband Plan to ensure ubiquitous

access to broadband service, which has led to significant changes in the way federal universal service funds will be deployed in the future.

In 2012, the FUSF disbursed \$8.7 billion nationwide among its four component programs. Telecommunications providers must contribute to the FUSF through an assessment on their interstate and international revenues, and providers typically pass the cost of FUSF contributions to their customers. The programs are described below, along with the percent of funding each received in 2012:

- The High Cost Program allows carriers to recover part of the cost of providing service in areas too sparsely populated or too remote to otherwise have affordable telecommunications service (47.6 percent);
- The Lifeline Program provides a discount on the cost of service for qualifying low-income households (25.1 percent);
- The Schools and Libraries Program, commonly referred to as E-rate, offsets the cost of telecommunications in eligible schools and libraries (25.5 percent); and
- The Rural Health Care Program helps pay the cost of telecommunications service necessary for the provision of health care in rural areas (1.8 percent).

Kansas receives a large share of the total amount of FUSF support awarded. In 2012, Kansas was the 14th largest recipient of support from all FUSF programs, receiving \$218.4 million in all, and the 4th largest recipient of High Cost Support, receiving \$189.6 million for that program alone.

In November 2011, the FCC issued its Reform Order for the FUSF. The Order created the Connect America Fund (CAF) to support broadband and take the place of the legacy High-Cost Program, created a Mobility Fund to support 3G or better wireless coverage, reformed Intercarrier Compensation, and expanded the Lifeline Program to allow subsidies to be provided

for broadband. The Order identified support for broadband-capable networks as an express universal service principle and set five performance goals for reform of the FUSF, as follows:

- Preserve and advance availability of voice service;
- Ensure universal availability of modern networks capable of providing voice and broadband service to homes, businesses, and community anchor institutions;
- Ensure universal availability of modern networks capable of providing advanced mobile and broadband service;
- Ensure rates for broadband services and rates for voice services are reasonably comparable in all regions of the nation; and
- Minimize the universal service contribution.

The initial budget for the first six years of FUSF reform was set at \$4.5 billion. Price-cap carriers and rate-of-return carriers are treated differently under the Order.

For price-cap carriers (in Kansas, AT&T and CenturyLink), existing high-cost FUSF support was frozen at 2011 levels. An additional \$300 million in CAF Phase I funding was made available, but to qualify for that support a carrier had to provide broadband with actual speeds of 4 megabits per second (Mbps) download and 1 Mbps upload and deploy broadband to at least one currently unserved location for each \$775 in additional high-cost support received. Nationwide in 2012, carriers initially accepted only \$115 million of the \$300 million available — AT&T declined the \$47.9 million offered, and CenturyLink accepted \$35 million, none of which was spent in Kansas.

In the second round of Phase 1 funding for price-cap carriers, a minimum of \$300 million was made available. Criteria was modified, and nationwide, the FCC approved \$289 million in

support. AT&T was approved for \$95 million, none designated for Kansas; CenturyLink was approved for nearly \$40 million, of which \$81,474 will be spent in Kansas; and FairPoint Communications Missouri, Inc. was approved for \$2.9 million, of which \$91,612 will be spent in Kansas.

In Phase 2, in each state, each incumbent price-cap carrier will be asked to make a state-level commitment to provide affordable broadband to all high-cost locations in its service territory. If the incumbent declines to make the commitment, CAF support will be distributed through competitive bidding.

For rate-of-return carriers, the FCC adopted new rules including, elimination of FUSF support in areas completely overlapped by an unsubsidized competitor; capping total FUSF support at \$250 per line per month; and elimination of, or new limits on, reimbursement of various other costs previously eligible for support. Rate-of-return carriers receiving legacy high-cost support or CAF support to offset lost intercarrier compensation must offer broadband service with actual speeds of at least 4 Mbps download and 1 Mbps upload upon a customer's reasonable request.

Industry Comments on Changes to the KUSF and the FUSF

Representatives of different types of carriers were asked to address how changes in the KUSF and FUSF affect their business model as a telecommunications provider, and what the future holds.

The Legislative Director for AT&T Kansas noted that AT&T's support from the KUSF has been significantly reduced over the years as its number of residential retail lines decreased by 81.0 percent from 2000 to 2013. Currently, the company receives about \$5.5 million in KUSF support, but that support will be eliminated as of January 1, 2014, concurrent with the elimination of AT&T's remaining retail regulations and legacy obligations to serve. Because its wireless and landline customers pay into the KUSF, AT&T has a vested interest in seeing that the Fund is effectively and efficiently managed.

A Government Affairs representative for CenturyLink said the company receives KUSF support only where the cost to provide voice service exceeds 125.0 percent of the benchmark cost of \$36.45, which constitutes about 45.0 percent of the company's rural, high cost customers. CenturyLink receives no KUSF support for fiber, broadband, or incremental investment (the high cost associated with bringing service to the last few households).

The General Manager and CEO for Pioneer Communications spoke on behalf of the rural independent providers, noting that in order to access KUSF and FUSF support, a rural independent carrier must first spend money and invest in its network, then "prove" the investment to regulatory entities before cost recovery from universal service funding programs is allowed. Access to KUSF and FUSF support has allowed companies to build and maintain a robust rural network that provides service at affordable rates. Both the KUSF and FUSF need to be modernized and adapted to a broadband world. The independent carriers continue to experience high demand for wired broadband access, with high speeds and no limit on the amount of data that can be accessed during a billing period. However, the reforms put into place by the FCC in 2011 have caused a significant amount of regulatory uncertainty, have frustrated access to capital for network deployment, and have resulted in a significant slowdown of broadband deployment. The FCC reforms, combined with the effect of HB 2201, will slow investment by rural independent carriers dramatically. They will receive requests for more bandwidth that neither they nor any other carrier, including wireless, will be able to provide. Without access to broadband, businesses and young people are less attracted to rural areas, and the quality of life in rural areas suffers. Without a reliable KUSF, consumers in the most rural areas of the state will not be able to afford the cost of service.

The Senior Counsel and Director of State Government Affairs for Sprint said changes made in 2013 to limit the amount paid from the KUSF are positive, but Kansas wireless customers still pay too much for funds that go primarily to landline companies. Even with reforms fully implemented, the KUSF will give out more than \$40 million annually in high cost funds to

CenturyLink and the rural carriers. Sprint views the federal CAF, which is narrowly targeting its funds to companies to roll out broadband to unserved and underserved areas, as a good use of universal service funds. The KUSF should have goals consistent with the CAF, where efficiency is expected as access recovery amounts are reduced annually, and funding is conditioned on building out broadband in currently unserved areas. Sprint posed a series of questions for consideration by the Study Committee and KUSF recipients.

Scope Statement for the KUSF Audit

The Study Committee was charged with determining the scope of an efficiency and effectiveness audit of the KUSF. HB 2201 required the audit to be administered by the Kansas Department of Revenue, consistent with the scope determined by the Study Committee. The bill identified metrics that may be included in the audit, and the Committee agreed to a draft scope at its first meeting. The Committee then invited written comments on the draft from all interested parties and the draft was further discussed at the Committee's second meeting before being modified and adopted. The audit scope adopted by the Committee follows.

AUDIT SCOPE

In addition to such other measures as the auditors deem appropriate for determining the overall efficiency and effectiveness of the Fund, the audit should address broad oversight and structural questions, as well as detailed analysis of actual revenue, spending and operations of KUSF recipients (per recipient and per program). A detailed review of the Kan-Ed program is not necessary; a January 2012 audit by Legislative Post Audit that evaluated the effects of eliminating Kan-Ed addressed operations and effectiveness of the program, and a January 2013 needs assessment contracted by the Kansas Department of Commerce entitled "Building the Broadband Future" also contained an assessment of Kan-Ed outcomes.

Metrics for the oversight and structure assessments include:

- The adequacy of applicable Kansas statutes and governmental review processes to ensure the amounts of KUSF moneys disbursed to recipients are not excessive, including the possible need to redefine the types of expenditures eligible for reimbursement under the KUSF, and that appropriate incentives to produce efficiencies are created;
- Identification of the quantifiable benefits of the KUSF programs. (What has the program achieved, and what impact has it had on local rates?);
- Comparison of the KUSF programs to state-level universal service programs in other states (Are other states accomplishing the same thing in a different way? Are any other states in the process of changing their USF program? Do other states have the same mix of independent telephone companies that Kansas has?); and
- Comparison of FUSF distributions to states, including analysis of the basis for Kansas' share. (Why is Kansas one of the largest recipients of FUSF, and given that Kansas receives substantial federal assistance, why is there a need for additional aid in the form of KUSF?)

For the detailed analysis of revenues, expenditures and operations, specific metrics to be included in the report, to the extent they do not involve proprietary information and are not, in the auditor's opinion, unduly burdensome to collect, include the following:

- Historical information on which companies have received KUSF and in what amounts, including calculation of annual per line, per linear mile support (taking population density and/or geography into consideration in interpreting the results), or other metrics;
- Total amount of rural utilities service debt and other debt with a nexus to the KUSF, by recipient or related entity;

- Capital expenditures on each technology modality (eg. fiber, copper, wireless), including the supporting rationale;
- Affiliate transactions and transfers with a nexus to the KUSF;
- Expenditure assessment to ensure the KUSF is only being used to subsidize services authorized by Kansas statutes;
- The number of telephone competitors in each exchange, and whether the exchange is supported by the KUSF;
- Economic assessment per exchange, *i.e.*, how do the revenues paid into the KUSF and into the FUSF from each exchange compare with benefits each exchange receives from the KUSF and from the FUSF;
- Detailed review of the companies with high KUSF support per line, to identify the factors that contribute to this level of support;
- Documentation of the change in the number of landlines over time, with fax and data lines separated from voice lines; and
- “Stress test” on the KUSF as the number of landlines decreases by 10.0 percent, 25.0 percent, and 50.0 percent. (How does the KUSF distribution process respond to these types of decreases – do payments decrease correspondingly?)

Note: To the extent a KUSF recipient is part of a regional or national company, the analysis of spending and operations should focus on Kansas operations.

In addition, the report should include descriptive information that helps place the audit findings in context, such as:

- Historical background including when the KUSF was created and for what purpose, statutory changes that have taken place and why, and how the total size of the KUSF and the assessment rates have changed over time; and
- “Process” information describing the factors that determine how much KUSF support a company receives (including an explanation of how the cost of delivering two-way voice communication is separated out from costs of other services a company might provide, such as broadband or TV), the role of the third-party administrator vs the role of the KCC, the process for requesting and receiving support, and an explanation of the KUSF accounting processes for rate-of-return carriers, including depreciation of assets.

Finally, the audit report should include proposals for legislative consideration and action for adequate oversight of the KUSF.

CONCLUSION AND RECOMMENDATIONS

The Committee’s final report, which is due December 31, 2014, will contain its conclusions and recommendations.