Approved: April 22, 2004
Date

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE

The meeting was called to order by Chairman Melvin Neufeld at 9:00 a.m. on March 24, 2004 in Room 514-S of the Capitol.

All members were present.

Committee staff present:
Alan Conroy, Legislative Research
J. G. Scott, Legislative Research
Amy VanHouse, Legislative Research
Michele Alishahi, Legislative Research
Audrey Dunkel, Legislative Research
Jim Wilson, Revisor of Statutes
Mike Corrigan, Revisor of Statutes
Nikki Feuerborn, Administrative Analyst
Shirley Jepson, Committee Secretary

Conferees appearing before the committee:
Tom Bell, Kansas Hospital Association
Jerry Marquette, Coffeyville Regional Medical Center
Steven Scheer, Health Management Associates
Joy Wheeler, FirstGuard Health Plan
Jerry Slaughter, Kansas Medical Society
Laura Howard, Department of Social and Rehabilitation Services
Robert Day, Governor's Office
Debra Zehr, Kansas Association of Homes & Services for the Aging
Marilyn Page, Marion Clinic
Lee Eaton, Kansas Health Care Association
Karla Finnell, Kansas Association for the Medically Underserved
Shannon Jones, Statewide Independent Living Council of Kansas
Robert Nyquist, Kansas Pharmacists Association

Others attending:
See Attached List.

- Attachment 1 Testimony by Tom Bell, Kansas Hospital Association
- Attachment 2 Testimony by Jerry Marquette, Coffeyville Regional Medical Center
- Attachment 3 Testimony by Steven Scheer, Health Management Associates
- Attachment 4 Testimony by Joy Wheeler, FirstGuard Health Plan
- Attachment 5 Testimony by Jerry Slaughter, Kansas Medical Society
- Attachment 6 Testimony by Laura Howard, Department of Social and Rehabilitation Services
- Attachment 7 Testimony by Robert Day, Governor's Office
- Attachment 8 Testimony by Debra Zehr, Kansas Association of Homes & Services for the Aging
- Attachment 9 Testimony by Marilyn Page, Marion Clinic
- Attachment 10 Testimony by Lee Eaton, Kansas Health Care Association
- Attachment 11 Testimony by Karla Finnell, Kansas Association for the Medically Underserved
- Attachment 12 Testimony by Shannon Jones, Statewide Independent Living Council of Kansas
- Attachment 13 Testimony by Robert Nyquist, Kansas Pharmacists Association
- Attachment 14 Testimony by Penny Schwab, United Methodist Mexican-American Ministries, Inc
- Attachment 15 Testimony by Dennis Bush, Kansas Health Care Association
- Attachment 16 Testimony by Gilbert Cruz, Kansas Health Care Association
- Attachment 17 Testimony by Linda Berndt, Executive Vice President, Kansas Health Care Assoc
- Attachment 18 Testimony by Lew Ebert, President and CEO, The Kansas Chamber
- Attachment 19 Testimony by Carolyn Gaughan, Kansas Academy of Family Physicians
- Attachment 20 Budget Committee Report on **SB 487**
- Attachment 21 Proposed Amendment to **HB 2938**
- Attachment 22 Proposed Amendment to **HB 2938**
- Attachment 23 Budget Committee Report on **SB 527**

- Attachment 24 Proposed Amendment to **SB 527**
- Attachment 25 Proposed Amendment to **HB 2688**

Hearing on HB 2938 - Health care access improvement program, provider assessments.

Audrey Dunkel, Legislative Research Department, explained that **HB 2938** would create the health care access improvement fund. Money collected through the assessment process, federal matching funds, interest and penalties would be deposited in the fund. An annual assessment on inpatient services would be imposed on each hospital provider and health maintenance organization. **HB 2938** would establish a health care access improvement advisory panel for the purpose of administering and selecting the disbursements. The panel would make an annual report to the legislature regarding the collection and distribution of all funds received and distributed by the act. The fiscal note on the bill is $111.2 million all funds revenue.

Chairman Neufeld recognized the following participants who presented testimony in support of **HB 2938**:

- Tom Bell, Executive Vice President of the Kansas Hospital Association (Attachment 1)
- Jerry Marquette, CEO, Coffeyville Regional Medical Center and Chairman of the Board of Directors of the Kansas Hospital Association (Attachment 2)
- Steven Scheer, Principal, Health Management Associates (Attachment 3)
- Joy Wheeler, FirstGuard Health Plan (Attachment 4)
- Jerry Slaughter, Executive Director, Kansas Medical Society (Attachment 5)
- Laura Howard, Deputy Secretary, Department of Social and Rehabilitation Services (Attachment 6)
- Robert M. Day, Director, Governor's Office of Health Planning and Finance (Attachment 7)
- Debra Zehr, Vice President, Kansas Association of Homes & Services for the Aging (Attachment 8)
- Marilyn Page, Executive Director, Marion Clinic (Attachment 9)
- Lee Eaton, Kansas Health Care Association (Attachment 10)
- Karla Finnell, Kansas Association for the Medically Underserved (Attachment 11)
- Shannon Jones, Executive Director, Statewide Independent Living Council of Kansas (SILCK) (Attachment 12)
- Robert Nyquist, Kansas Pharmacists Association (Attachment 13)

Written testimony in support of **HB 2938** was received from the following:

- Penny Schwab, Executive Director, United Methodist Mexican-American Ministries, Inc. (Attachment 14)
- Dennis Bush, Kansas Health Care Association (Attachment 15)
- Gilbert Cruz, Kansas Health Care Association (Attachment 16)
- Linda Berndt, Executive Vice President, Kansas Health Care Association (Attachment 17)
- Lew Ebert, President and CEO, The Kansas Chamber (Attachment 18)
- Carolyn Gaughan, Executive Director, Kansas Academy of Family Physicians (Attachment 19)

During discussion, the Committee noted that the legislation is necessary to assist hospitals who provide medicaid services and to maximize the federal draw-down. The Committee felt that there may be a need to add some flexibility in the legislation to provide assistance to other areas of need. The Committee noted that there are two technical amendments proposed by the Department of Social and Rehabilitation Services testimony concerning the (1) deposit of federal matching funds and (2) removing the statutory requirement to pay the providers more before the assessment is applied, suggesting that the assessment and changes in reimbursement should be effective simultaneously. The Committee suggested adding an amendment to the bill to add one member to the board representing the medically underserved.

Chairman Neufeld closed the hearing on **HB 2938.**

Discussion and Action on SB 487 - Creating the gas valuation depletion trust fund and providing for distribution of moneys therefrom.

Amy VanHouse, Legislative Research Department, explained the Agriculture and Natural Resources Budget Committee report stating that **SB 487** would provide for a partial diversion of gas severance tax receipts from the State General Fund (SGF) beginning in FY 2007 relative to collections in fourteen counties. For the

counties with at least $500,000 in FY 2003 severance tax receipts, an increasing portion of receipts would be diverted from the SGF beginning in FY 2007 into a new fund, the Gas Valuation Depletion Trust Fund (GVDTF). Each participating county would have a separate trust account established on its behalf within the GVDTF (Attachment 20).

The Committee voiced concern that State General Fund moneys are being diverted to some counties for a specific industry when there are other areas and industries in the State that are also suffering from the economy.

Representative Schwartz, Chair of the Agriculture and Natural Resources Budget Committee, moved to accept the Budget Committee report to recommend **SB 487** favorable for passage. The motion was seconded by Representative Osborne. Motion carried.

The meeting was recessed at 10:30 a.m.

AFTERNOON SESSION

Chairman Neufeld reconvened the meeting at 1:15 p.m.

Discussion and Action on HB 2938 - Health care access improvement program, provider assessments.

Chairman Neufeld presented and explained a proposed amendment to **HB 2938** which would give more flexibility by allowing increased medicaid rates on designated procedures and codes for providers who are persons licensed to practice dentistry, or home and community-based services; and allows one member appointed to the advisory board by the Kansas Association for the Medically Underserved (Attachment 21).

Chairman Neufeld moved to adopt the amendment to **HB 2938.** The motion was seconded by Representative Feuerborn. Motion carried.

The Chair recognized Scott Brunner, Department of Social and Rehabilitation Services (SRS), who presented a balloon to **HB 2938** addressing issues of concern in the bill resulting in a compromise between the Department of Social and Rehabilitation Services and FirstGuard Health Plan (Attachment 22).

Representative Feuerborn moved to amend **HB 2938** by adopting the balloon presented by the Department of Social and Rehabilitation Services. The motion was seconded by Representative Bethell. Motion carried.

Representative Shriver moved to add language to Section 12 stating that warrants and deposits shall not be subject to fees by the State Treasurer. The motion was seconded by Representative Pottorff. Motion carried.

Representative Feuerborn moved to recommend **HB 2938** favorable for passage as amended and allow technical corrections as necessary. The motion was seconded by Representative Shultz. Motion carried.

Discussion and Action on SB 527 - Establishment of water supply storage assurance fund and local water project match fund administered by the Kansas Water Office.

Amy VanHouse, Legislative Research Department, explained that **SB 527** would create the Water Supply Storage Assurance Fund and the Local Water Project Match Fund administered by the Kansas Water Office. The bill also specifies the uses of each fund (Attachment 23).

Representative Schwartz moved to adopt the Agriculture and Natural Resources Budget Committee report on **SB 527**. The motion was seconded by Representative Gatewood. Motion carried.

Representative Schwartz moved to amend **SB 527** by adding language clarifying the authority of nonvoting members ex officio of the Kansas water authority (Attachment 24). The motion was seconded by Representative Osborne. Motion carried.

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE at 9:00 a.m. on March 24, 2004 in Room 514-S of the Capitol.

Representative Schwartz moved to recommend **SB 527** favorable for passage as amended. The motion was seconded by Representative Osborne. Motion carried.

Discussion and Action on HB 2688 - Kansas use law procedures, establishing the state use law committee.

Representative Pottorff, Chair of the General Government and Commerce Budget Committee, presented the Budget Committee report on **HB 2688** with balloon amendments and moved for the adoption of the Budget Committee recommendation with balloon amendments (Attachment 25). The motion was seconded by Representative Shriver. Motion carried.

Representative Pottorff moved to recommend **HB 2688** favorable for passage as amended and allow for technical corrections as necessary. The motion was seconded by Representative Shriver. Motion carried.

Discussion and Action on HR 6027 - Brachial Plexus Injury Awareness.

Representative Landwehr, Chair of the Social Services Budget Committee, presented the Budget Committee report on **HB 6027** stating that the brachial plexus injuries affect the network of nerves that control the muscles of the shoulder, arm, elbow, wrist, hand and fingers and can result in full to partial paralysis of one or both arms. The Awareness Week is the third week in October and is an opportunity to educate the public, inform parents and professions about the services available and to reach out to the general public making a difference in the lives of those with brachial plexus injuries. The Budget Committee provided no amendments to the resolution.

Representative Landwehr moved for the adoption of the Budget Committee report to recommend **HR 6027** favorable for passage. The motion was seconded by Representative Bethell.

Representative Klein moved to send ten copies of the enrolled resolution to the author of the bill. The motion was seconded by Representative Campbell. With permission of the second, the motion was withdrawn.

Representative Feuerborn moved for a substitute motion to strike line 7-11, Page 2, of **HR 6027.** The motion was seconded by Representative Gatewood. Division was requested. Motion failed.

Representative Landwehr renewed the motion to adopt the Budget Committee report to recommend **HR 6027** favorable for passage. Motion carried.

Representative Bethell moved to approve the minutes as written of March 3, March 4, March 5, March 8, March 9, March 10, March 11 and March 12, 2004. The motion was seconded by Representative Campbell. Motion carried.

The meeting was adjourned at 2:15 p.m. The next meeting is "on call of the Chair".

Melvin Neufeld, Chairman

HOUSE APPROPRIATIONS COMMITTEE

March 24, 2004
9:00 A.M.

NAME	REPRESENTING
Bob Harder	UMC - KS / BTC
Shannon Jones	SLCC / BTC
Chip Wheeler	Ass'n of Osteopathic Med.
Dan Murray	Federico Consulting
DEBORAH STERN	KHA
Vicki Lynn Hesse	Budget
Jeff Bottenberg	KU Hosp. Auth.
Madison Foster	Grant County
Debra Zehr	KAHSA
Ernie Pogge	AARP
Andre Hein	Hein Law Firm
BOB NYQUIST	KPHA
LINDA LUBENSKY	KS Home Care Assoc
Janie Nyquist	Wife of Bob Nyquist Owner Rose Hotel Pharmacy
PETER STERN	KANSAS PHARMACY SPEAKEASY
Tom Bruno	KPSC
JERRY SLAUGHTER	KMS
CHRIS COLLINS	"
Teresa Schwab	Oral Health Kansas
Jim Gregory	Kansas Chamber of Commerce
Joe Wheeler	Blue Cross Blue Shield
Scott Brunner	SRS

HOUSE APPROPRIATIONS COMMITTEE

March 24, 2004
9:00 A.M.

NAME	REPRESENTING
Laura Howard	SRS
Nancy Pierce	KHCA
Kimbra Caywood	Kearney & Assoc.
Robert Day	Gov. Office
Steve Scheer	Health Management Associates
Dodie Wellshear Johnson	Ks Acad. of Family Physicians
Adam Ogley	Gov. Office
[illegible]	Grant County
Karla Fennell	Kansas Ass to medically underserved
John Peterson	Ks Governmental Consultant

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

To: **House Appropriations Committee**

From: **Thomas L. Bell**
Executive Vice President

Re: **HB 2938**

Date: **March 24, 2004**

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of House Bill 2938. As many of you know, this bill is the result of much discussion from the end of last session into this legislative session. We think the bill before the Committee can help the state solve the difficult problem of chronic underpayment of Medicaid providers. We would also like to commend the leadership shown on this issue by legislative leadership and the Governor's office. Much effort has been put into this proposal by the legislative and executive branches and we appreciate the willingness to look at an alternative way to deal with one of Medicaid's biggest issues.

We could spend the entire committee meeting talking about the situation surrounding Medicaid payments to healthcare providers, but there is no need to do that. Committee members have heard time and again about how Medicaid reimburses providers at less than cost and about the ramifications of this policy. Our focus today is on a possible way to deal with this issue.

In its simplest terms, HB 2938 establishes a program whereby hospitals in Kansas will be assessed a certain amount of money for the purpose of generating additional federal matching funds to be used to increase Medicaid reimbursement rates for hospitals and physicians. We have our expert consultant, Steve Scheer, with us today to explain the mechanism in more detail, but the chart below demonstrates the design.

Kansas Hospital Association
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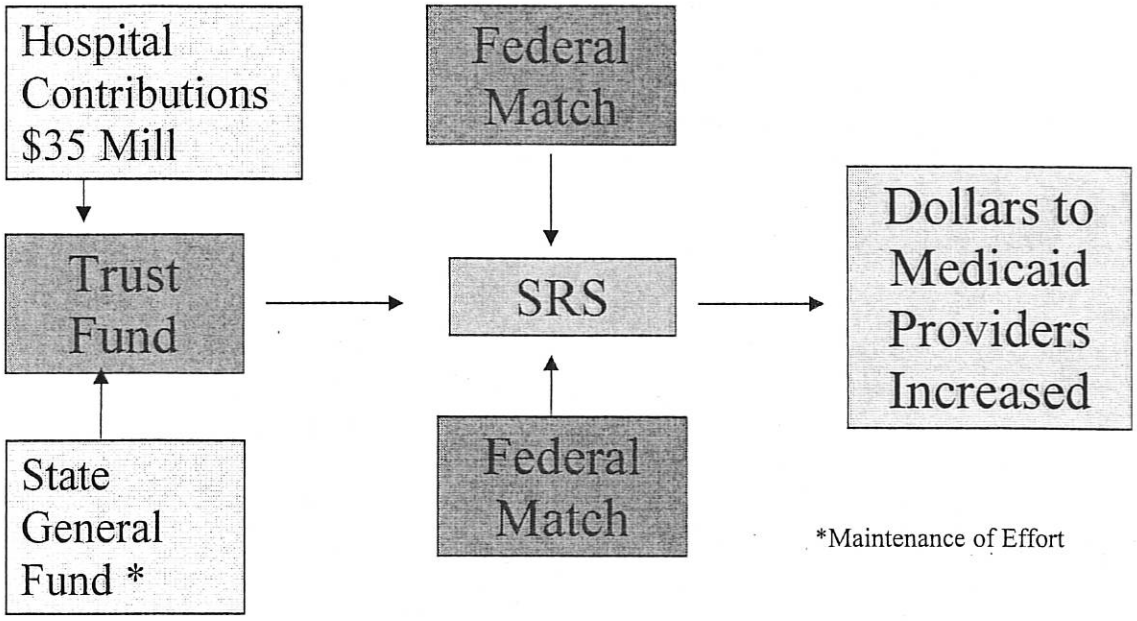

Perhaps a more important question to ask is why are we considering such a program? Last session, when legislative leaders asked us to examine a provider assessment program, we had our reservations. These programs are complicated and they require a high level of cooperation between the state and health care providers. In addition, we must go through an approval process with the federal government. Finally, we will have to be vigilant that the purpose of the program remains in focus. As we considered the situation, however, we realized there were really only two choices. First, we could do nothing and continue to watch Medicaid rates erode as a percentage of what it costs to deliver the care. Or, we could be more proactive and attempt to develop a program that holds some promise of helping the state to solve the Medicaid reimbursement dilemma. We had many discussions with our board and membership and ultimately determined to follow the latter course.

As we investigated this type of proposal, the extent of underpayment by Medicaid became clearer. The barometer for measuring the fairness of payments for any state Medicaid program is Medicare, and its ceiling is set in federal law by what is called the "upper payment limit." Medicare payment rates are established and adjusted each year to approximate what it "costs" providers to deliver care. In Kansas, for other than Critical Access Hospitals, Medicare payments fall short of costs for nearly two thirds of our hospitals, so that ceiling is fairly low. How then do Medicare payment rates compare to Medicaid payments for the same services provided in Kansas?

What Medicare Pays

$70 Million Payment Gap

What Medicaid Pays

The gap between what could and should be paid and what is paid for Medicaid services is nearly $70 million. This gap has become a very costly and stealthy tax on insurance premiums we more softly call the "cost shift." The double-digit health insurance premium increases caused in part by this cost shift are no longer sustainable by either businesses or individuals.

In addition to closing this gap, a program like that embodied in HB 2938 can help us to better prepare for the possibility of Medicaid block grants. If the federal government moves toward a block grant system, payments to states will probably be based on how close to the upper payment limit the state is. Obviously, Kansas can and should attempt to get closer to this level.

As we have worked with legislative and executive leadership to craft a proposal, it is apparent that there must be a true partnership between hospitals and the state to ensure that the resources of Kansas hospitals and the communities they serve will be used to improve the health care system in a fair and equitable manner. To help maintain such a partnership, the program must contain certain key provisions:

- The assessment rate and base need to be specified in the statute.
- The program must have a formal agreement between the State and any providers assessed.
- To the extent permitted by federal regulation, assessment funds need to be returned to hospitals in the most expeditious manner possible.
- The assessment and increased hospital payments must terminate if either is not eligible for federal matching funds.
- The increased provider payments financed by the hospital assessment must be required by the statute and an efficient and equitable mechanism to determine the specifics must be included.
- There must be a requirement for independent auditing of the program.
- The increased hospital payments should not be due and payable until approved by the federal government and the assessment becomes eligible for federal matching funds.
- There must be "maintenance of effort" by the state to prevent the diversion of new funds for other purposes or to supplant existing state funds.

Indeed, one of the guiding principles mentioned earlier this session by SRS Secretary Janet Schalansky is that we must "recognize the value of partnerships both within the agency and with community partners to stretch capacity and achieve extraordinary results." If such a true partnership among the provider community and the executive and legislative branches of government is maintained, this program can be successful.

Thank you for your consideration of our comments.

COFFEYVILLE REGIONAL MEDICAL CENTER, INC.

March 24, 2004

TO: House Appropriations Committee

FROM: Jerry Marquette
CEO, Coffeyville Regional Medical Center

RE: **HR 2938 TESTIMONY**

As the Chief Executive Office of Coffeyville Regional Medical Center and the Chairman of the Board of Directors of the Kansas Hospital Association, I am pleased to testify in favor of the passage of HR 2938. Let me begin by sharing my concerns over Medicaid reimbursement for Coffeyville Regional Medical Center and conclude by covering the work the association has conducted on behalf of the entire membership regarding this bill.

Coffeyville Regional is a large Medicaid provider in terms of the percentage of patients we treat. Nearly 14 percent of all of our patients are Medicaid. In 2003, we billed Medicaid nearly $7.8 million in total charges and received only $2.8 million in payments for those services. Receiving only 35 percent of our charges, which is far below our costs of providing those services, with no recourse to bill anyone else is not a practice we would expect from any other payer, yet that is the Medicaid reality. This is why additional funds to increase Medicaid payments for hospitals and doctors need to be found.

Early last summer, the Board of Directors of the Kansas Hospital Association authorized the association's staff to investigate the feasibility of a provider assessment as a part of the state's Medicaid program. This investigation included hiring expertise in the field, forming a task force to oversee the program, working cooperatively with the legislature and Governor's office and performing numerous financial models on Kansas hospitals. The end result is that the Board of Directors of the Kansas Hospital Association feels that this is a program we can endorse in concept. HR 2938, given some minor technical corrections, can work for Kansas hospitals and strengthen the state's Medicaid program.

I will be happy to answer any questions you might have.

(620) 251-1200
1400 West Fourth ♦ Coffeyville, Kansas 6733

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Testimony
House Appropriations Committee
HR 2938
Steven Scheer, Principal, Health Management Associates
March 24, 2004

Mr. Chairman, members of the Committee, my name is Steven Scheer. I am a principal with the firm of Health Management Associates, a health care consulting firm. My practice specializes in Medicaid financing.

I am here today to help describe the proposed hospital provider assessment program as described in HR 2938. As state revenues have shrunk, hospitals and state governments across the country have turned to provider assessment programs as a means to increase Medicaid payment rates. My role today is to describe a "best practice" approach to solving the annual budget problems in each state caused by growth in the Medicaid budget and inadequate state general funds to finance the growth. And, I'm happy to report that most, if not all, of those best practices are included in HR 2938.

I will first describe how the Medicaid program is financed and how providers, specifically hospitals, are paid. I will then cover the Upper Payment Limit as it applies to the Kansas Medicaid program. I will then discuss the proposed "Partnership Program" and the federal rules governing all provider contribution programs. Lastly, I will give an example of some of the characteristics, to help understanding of the approach.

Each state may finance its Medicaid program as it sees fit, with few regulatory controls. The state may use general tax revenues or it may use special funds, such as the Tobacco Fund to pay for Medicaid and draw down federal matching funds. The state may also use transfers from one governmental entity, such as a public hospital, or it can use an assessment on providers, such as hospitals, to raise the funds needed to finance Medicaid services. In any case, every time the state of Kansas spends $100 on Medicaid services it receives $60.82 from the federal government. So the state only spends $39.18 out of its own funds.

The "contract" between the state and federal governments that governs operations of the Medicaid program is called the "State Plan." The State Plan describes who is eligible for Medicaid, which services they qualify for, how

Donald A. Wilson
President

much the provider will be paid for each service and other information regarding everything from the scope of benefits to final to quality assurance. In addition to the State Plan, the state must describe and assure to the federal government that spending under the State Plan will be less than the ***Upper Payment Limit*** *(UPL)*, which is the most the federal government will pay.

Payments for Medicaid hospital services are grouped into two categories: Regular Payments and Disproportionate Share Hospital Payments. Regular payments must be less than the UPL that I spoke of earlier. Disproportionate Share Hospital payments, called DSH payments, must be less than each hospital's DSH limit and, in the aggregate, must be less than the state's DSH limit.

So what exactly is the *Upper Payment Limit*? In simplest terms, it is the amount that Medicare would have paid for the same services provided in the same facility. For purposes of determining the UPL all of the hospitals in a state are separated into three groups: state owned, non-state government owned and all others, called "private." When determining the UPL, inpatient services are separated from outpatient services.

I measured the upper payment limits for all Kansas hospitals, except the state-owned facilities. In total, and using a conservative technique, we determined that the UPL was in excess of $72 million.

In 1991, Congress passed and President Bush signed the "Provider Tax and Donation Amendments" Act which require that, to receive federal matching funds, a provider donation program must be:

1. Broad based;
2. Uniform;
3. Redistributive; and
4. Not hold providers harmless.

Each of these conditions also includes an exception. We have designed the Partnership Program so that it complies with these federal requirements and the rules promulgated under the statute.

KANSAS HOSPITAL ASSOCIATION
Donald A. Wilson
President

This bill proposes to assess *Inpatient Net Revenue*, which in hospital jargon is the actual revenue received from caring for patients, at a rate of 1.83%. The assessment will not be charged to any state-owned facility, the KU Medical Center or any Critical Access Hospital. This rate and base will generate total funds of $35.0 million annually.

As written, the bill would use 80% of the funds, including the corresponding federal matching funds, for hospital payments. Based upon my analysis, ultimately this should result in provider benefits such as:

1. Increased Inpatient and Outpatient payments;
2. Targeted increases for selected services such as, Neonatal Nursey, Burn, and Behavioral medicine patients;
3. Increased Emergency Department payments
4. Improved Access Payments for Inpatient and Outpatient Services

Additionally, 20% of the funds are available to increase physician reimbursement rates under Medicaid. The overall effect of these payment changes, coupled with the assessment, means that most non-exempt hospitals would receive a net benefit.

I have been asked, as part of the overall design, to recommend specific provisions of the legislation that would make this approach both work better for everyone and would be more universally acceptable among the hospital community. My thirty years experience in Medicaid finance, during which time I have worked on more than half of the provider assessment plans, either in the design phase or in fixing problems that evolved with the program. It is with these experiences in mind that I suggest the following for your consideration:

1. Establish a separate Trust Fund that would receive the assessment revenues and from which expenditures would be made to providers. Federal regulators believe that a separate fund permits better accounting. Providers prefer to know that their funds, which are designated to be used to draw federal match and be spent on patient care, are segregated too.

Donald A. Wilson
President

2. Assure that the State continues to fund regular Medicaid payments at historic levels. The great concern of providers is that the assessment will only substitute for regular Medicaid payments. If they are not given some assurance that this will not happen with the assessment funds, they will not willingly participate.

3. Most State's that I have worked with have established a "Sunset" clause to have the program end after a period of time, or they have inserted a "Poison Pill" so that if the rules governing the program change or the State does not maintain its effort, the assessment ends.

4. Most State's have also inserted many or all of the payment provisions in the statute in order to provide assurance to the provider community. In the bill before you today, this issue has been handled in a rather ingenious fashion by providing for a specific percentage split among the providers (e.g. Physicians and hospitals), and by establishing a committee, panel or authority to oversee the collection and allocation within each provider group.

One question I am often asked is: "Will the feds approve the plan?" I have three parts to my response:

1) The plan contained in the bill before you is legal and approvable – CMS (the Centers for Medicare and Medicaid Services) go over every assessment plan with a fine tooth comb, looking for flaws so that they can disapprove – then they will approve the plan.
2) The types of state plans that are currently getting the greatest scrutiny are those based on Intergovernmental Transfers – not assessment plans.
3) The bill calls for no payments until the plan is approved by CMS – so the state has no additional risk.

That concludes my formal remarks. I would be pleased to answer any questions. Thank you.

Testimony House Appropriations Committee
Wednesday, March 24, 2004
FirstGuard Health Plan
House Bill 2938

Chairman Neufeld and members of the committee, thank you for the opportunity to testify in support of House Bill 2938 regarding health care access improvement and provider assessments. I am Joy Wheeler, President of FirstGuard Health Plan.

FirstGuard Health Plan currently provides managed care services to 95,000 members in the blended HealthWave program; Title 19 has 62,815 members and Title 21 has 32,148 members. FirstGuard's membership in these programs continues to steadily increase, growing by 25% over the past two years.

One key to FirstGuard's business success in HealthWave has been the extremely positive relationship built and maintained with our network of physicians and hospitals that provide care to this population. FirstGuard has diligently worked to build a seamless accessible network for all HealthWave members. Today, in Title 19 we have 1420 Primary Care and 2979 Specialist Physicians and in Title 21 there are 1473 Primary Care Physicians and 2974 Specialist Physicians. Hospitals in both programs are currently at 152 total.

Over the past years our work with SRS to bring the Title 19 and Title 21 programs together under HealthWave has been very successful. Working collaboratively with SRS, Kansas hospitals and our physician provider network offered/sponsored to us by the Kansas Medical Society, we have improved the quality of service while implementing cost containment initiatives, benefiting our members and the State of Kansas.

As we recognize the importance of the physician and hospital providers serving the needs of medically underserved Kansans, we at FirstGuard support the provider and managed care assessment, which will facilitate an increase in the reimbursement levels for HealthWave providers. Clearly, these providers have been laboring for many years under low payment rates. The provisions of this bill will allow justified improvements in their reimbursement. FirstGuard Health Plan strives to offer access to comprehensive health care services. Improvement to provider payments is necessary to assure the long-term integrity of the current and hopefully expanded network of both primary care and specialist physicians. Increasing Medicaid rates for physicians and hospitals will clearly enhance continued provider involvement in HealthWave.

Finally, I would like to state how much we appreciate the support provided by the Governor, Legislators, this Committee and its Leadership, the SRS and the Department of Insurance as we have established a positive business relationship aimed at improving the health of the citizens of Kansas.

Thank you. I am happy to respond to any questions.

KANSAS MEDICAL SOCIETY
KMS

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kmsonline.org

To: House Appropriations Committee

From: Jerry Slaughter
Executive Director

Date: March 24, 2004

Subject: HB 2938; concerning the Medicaid hospital assessment program

The Kansas Medical Society appreciates the opportunity to appear today in support of HB 2938, which establishes an assessment on Kansas hospitals and the Medicaid-contracted managed care plan for the purpose of improving access to care for the Medicaid population. This assessment program is modeled after similar programs that have been used successfully by a number of states over the years to increase federal funds available to the Medicaid program without creating a drain on the state general fund.

We are well aware of the difficult budget challenges facing our state at the present time. Although the economic picture is improving somewhat, it is apparent that for the next several years, the state will have difficulty just meeting funding obligations for caseload increases, let alone funding needed increases in reimbursement to providers. Likewise, it is probable that the factors driving Medicaid costs upwards - increasing caseloads, pharmacy costs, utilization of services by the chronically ill, and new, expensive technology - will continue to absorb a larger part of the overall budget. This assessment program provides the state with an opportunity to address a much needed adjustment of both hospital and physician reimbursement rates. Both provider groups have participated in Medicaid in spite of very low reimbursement for years.

Physician participation in Kansas Medicaid programs has been very good historically. A high percentage of physicians in all specialties participate as part of the Medicaid provider network. For example, a 2000 study by the American Academy of Pediatrics showed that 9 out of 10 Kansas pediatricians participated in Medicaid. It is widely accepted that a high degree of physician participation improves access to care, thereby enhancing prevention and early intervention of problems, reducing utilization of costly hospital emergency departments, and improving patient outcomes. It follows that in addition to being good for the individual patient, a strong physician network is also cost effective for the state. In recent years, many areas of the state, both rural and urban, have begun to experience problems associated with physicians being less willing to keep their practices open to new or even existing Medicaid patients. The reason physicians cite most often for limiting the number of Medicaid patients they will see in their practice is low reimbursement. A number of studies show that physicians' decisions to provide care to Medicaid populations are related to both Medicaid fee levels and to such fee levels

HOUSE APPROPRIATIONS

DATE 3-24-2004
ATTACHMENT 5

compared to other payors. These studies show that, as Medicaid fee levels increase, physicians are more likely to participate in the program, and those participating may treat more Medicaid patients as a result (The Urban Institute, *Recent Trends in Medicaid Physician Fees, 1993-1998,* September 1999).

The Kansas Medicaid physician fee schedule is substantially below that of most state Medicaid programs, Medicare, and private insurance programs (Mathematica Policy Research, Inc., January 1998). A representative sample of payment codes across several medical specialties shows that Medicaid fees are often only 20% to 45% of the corresponding fees paid by one large, statewide Kansas private insurer. In the aggregate, the Kansas Medicaid physician fee schedule is 71% of the Medicare fee schedule (*Comparison of Medicaid and Medicare Physician Fee Schedules*, DeFrain Mayer Actuaries, November 2001). However, wide variation among categories of service exist, with some services substantially below Medicare. For example, a 2001 study by the American Academy of Pediatrics found that numerous preventive medicine codes in Kansas Medicaid ranged from 25% to 39% of the comparable Medicare codes. Almost 7 out of 10 pediatricians reported that Medicaid reimbursement did not cover their overhead costs. The DeFrain Mayer study showed across most specialties that the majority of office visit codes were reimbursed in the range of 50% to 61% of corresponding Medicare fees. Likewise, several common surgical procedures are reimbursed by Medicaid at 55% to 65% of the Medicare fee schedule, again well below private insurers rates.

The last time the Kansas physician fee schedule went through an overall revision and update was 1975. Since then a few limited, specialty-specific modifications and enhancements have been made, but overall the fee schedule has fallen further and further out of date. State budget constraints and the rapid growth in pharmacy, long term care and other program costs have been significant impediments to a comprehensive update in the fee schedule.

However, we have reached a point that without a comprehensive improvement in the physician fee schedule, it is quite likely that substantial erosion of the physician network will occur. If the network starts to unravel the consequences to the Medicaid program are considerable. From a budgetary standpoint, costs will increase due to more care being provided in emergency departments, not in the less expensive setting of a physician office. As care becomes more episodic, preventive services will decline and patients will present sicker with more complicated conditions to treat. That will drive outpatient and inpatient hospital costs, and pharmacy costs even higher. Illnesses such as asthma and diabetes, very treatable and manageable if diagnosed early, will become significantly more expensive for the state.

It is well documented by studies in recent years that the Kansas Medicaid fee schedule for physician reimbursement is out of date, inadequate, well below national norms, and unfair to a group of health care providers that has historically participated in the Medicaid program in very high numbers in spite of very low reimbursement. This assessment program will allow the state to begin to address the fee schedule in a comprehensive way for the first time in 30 years. We urge your favorable consideration of this legislation.

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

House Appropriations Committee
March 24, 2004

House Bill 2938

Division of Health Care Policy
Laura Howard, Deputy Secretary
785.296.3271

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Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Appropriations Committee
March 24, 2004

House Bill 2938

Good morning, Mr. Chairman, and members of the Committee. I am Laura Howard, Deputy Secretary for Health Care Policy at the Kansas Department Social and Rehabilitation Services. I am pleased to appear before you today to talk about H.B. 2938 and health care-related assessments.

This bill would authorize the levying of assessments on certain health care providers. Hospitals, excluding those that are state agencies, state educational institutions, or state mental health or developmental disabilities hospitals, would be assessed a percentage of their net inpatient revenue for FY 01. Health maintenance organizations contracting with the State for Medicaid managed care would be assessed a percentage of their non-Medicare premiums.

According to the latest Kaiser Commission on Medicaid and the Uninsured survey of state Medicaid programs, at the beginning of FY 2003 twenty-one states had an approved provider tax in place. Eighteen states added an additional provider tax in FY 2004. These additions may not be approved yet; I have no information on CMS approval of these additions.

I would like to provide an overview of how a health care-related assessment works and review what is allowable under Federal regulations.

Health care-related assessments
Health care-related assessments are fees levied on health care items or services. They are only considered health care-related, by the Centers for Medicare and Medicaid Services (CMS), if at least 85 percent of the assessment revenue falls on health care providers or if health care providers are treated differently than other entities in the levying and collection of a broader assessment fee.

A wide range of health care-related items and services are eligible for assessment fees. The way in which such assessments work follows: A group of providers is assessed a fee, which must be imposed on a permissible class of items or services on all providers in that class (e.g., inpatient hospital services, etc.), which is then collected by the state. The money acquired in this way is used by the state to match Federal funds for payments to a variety of Medicaid providers, as long as those payments are not limited solely to the group of providers on whom the fee is assessed.

Federal regulations

In order for revenue from a health care-related assessment to be acceptable to CMS as legitimate potential State match, it must be broad-based, applied uniformly, and the assessed entity cannot be held harmless for the assessment fee.

The fee is **broad-based** if it is assessed on all health-care related items or services in the class or on all providers of the items or services. If the fee is levied by a local unit of government, it must extend to all items, services, or providers in the class within that governmental unit's jurisdiction. This legislation would assess all providers in each of the two classes, so the assessment meets the criterion for being broad-based.

CMS considers the assessment to be **uniformly imposed** as long as it meets one of the following tests:

- Every provider in the class is assessed the same amount;
- If it is an assessment imposed on beds in health-care facilities, the fee is the same for each bed; or,
- If the fee is assessed on revenues, it is imposed at a uniform rate for all items, services, or providers in the class.

If a fee is assessed on any basis other than the three criteria listed above, the State must demonstrate that the amount of the assessment is the same for each provider. If the fee is assessed on revenues, Medicaid or Medicare payments can be excluded in the calculation of the assessment as long as that exclusion is applied to all providers who are being assessed.

A provider assessment is not uniformly imposed if it permits credits, deductions, or exclusions that result in returning all or part of the fee paid to the providers assessed. Under this legislation, each provider in the two classes is assessed at the same rate, so the assessment is uniformly imposed.

A provider assessment violates **hold harmless** provisions if funds collected via provider fees are used to artificially inflate expenditures reported to CMS in order to draw even more Federal funds. It is not allowable for a state to reimburse the assessed providers in such a way as to compensate them for the assessed fee. Since the money collected from these assessments would be used to increase a variety of service rates, to pay for graduate medical education, and to enhance access to services, the proposed assessments do not violate the hold harmless provisions of the Federal regulations.

If H.B. 2938 is passed SRS would have to submit a State Plan Amendment to CMS detailing how the assessments would be levied and how the funds would be used. This amendment would be reviewed by the Medicaid National Institutional Reimbursement Team (NIRT) within CMS.

The passage of this bill would enable SRS to provide long-needed rate increases for critical health care services. We are willing to perform the administrative work necessary to implement the provisions of this legislation.

SRS would suggest two technical amendments to the bill. Section 12 (e) of the bill lists the source of monies deposited in the Health Care Access Improvement Fund. We would recommend deleting Section 12 (e)(2) that would direct federal matching funds into the Health Care Access Improvement Fund. The reimbursement mechanism for providers created in HB 2938 uses enhanced Medicaid rates or other existing payment mechanisms that combine state and federal dollars. Moving the federal funds into a separate fund is unnecessary to achieve the desired effect of the bill. Section 4 (a)(2) and Section 8 (a)(2) would delay when hospitals or health maintenance organizations begin making the assessment payments until after the enhanced rates are paid through Medicaid. The reimbursement mechanism in the bill is enhancing the rates paid to hospitals and health maintenance organizations and reflect an increase in the ongoing revenue stream for these providers. The plan amendment creating the provider assessment and increasing the rates would probably go into affect at the same time, therefore we do not see the advantage of a statutory requirement to pay the providers more before the assessment is applied. We also believe that making the assessment and the changes in reimbursement effective simultaneously would be more acceptable to the Centers for Medicare and Medicaid Services. SRS would suggest deleting Section 4 (a)(2) and Section 8 (a)(2) of HB 2938.

Thank you for the opportunity to testify in support of H.B. 2938. I ask the Committee for your support, and stand ready for any questions from the Committee

KANSAS
GOVERNOR'S OFFICE OF HEALTH PLANNING AND FINANCE
ROBERT M. DAY, DIRECTOR
KATHLEEN SEBELIUS, GOVERNOR

Testimony on House Bill 2938
presented to
The House Appropriations Committee

by Robert M. Day, Ph.D.
Director
Governor's Office of Health Planning and Finance

March 24, 2004
9:00AM

For additional information contact:
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Governor's Office of Health Planning and Finance
Robert M. Day, Ph.D., Director

House Appropriations Committee
March 24, 2004

House Bill 2938

Mr. Chairman, members of the committee I am Bob Day, Director of the Governor's Office of Health Planning and Finance. I am here to support House Bill 2938, the health care access improvement program. As you know the current rules and regulations governing the Title XIX program allows the state to use funds from provider assessments to serve as state match for Medicaid. The two criteria that the assessment must meet are that it be broad based and that providers may not be held harmless. Numerous states have been using provider assessments for years. The Governor's Office has worked with the Kansas Hospital Association and the Kansas Medical Society as well as FirstGuard and the Kansas Pharmacist's Association to support a provider assessment of both hospitals and health maintenance organizations that contract for Medicaid.

We estimate the total amount raised by this assessment would be over forty four million dollars, of which thirty five million would come from the net inpatient revenues of hospitals and nine and half million would come from the HMO. A consultant hired by both the Hospital Association and our office generated these estimates. The estimates are based on 2001 hospital revenues and 2003 revenues from FirstGuard, the only HMO contracting for Medicaid in Kansas. The assessments paid to the state will then be used by the state to match federal funds for payments to Medicaid providers; it is estimated that $66.75 million in new federal funding will be made available through this process.

We have for some time been concerned with Kansas' low rate of Medicaid reimbursement for physicians as well as low hospital reimbursement for certain hospital services for both inpatient and out patient care. This assessment provides us the opportunity to improve those rates and in turn help maintain sufficient provider participation to assure Medicaid beneficiaries access to needed care. In addition we know that low public reimbursement for care leads to cost shifting on the part of providers. This cost shifting impacts private payers and the commercially insured since their payments help offset the loss incurred from low Medicaid rates.

While we support the bill before you, we do have some minor reservations about some of the language surrounding the disbursement of the funds. We believe the language in Sec.13 (b) (2) is too prescriptive. Since any allocation of funds in this section would be subject to legislative approval we think the language should allow for greater flexibility. This is not to suggest that the safety net clinics or the issues surrounding dental care are not important but only that the language is perhaps too restrictive in specifying that the funds could only be used for the purposes specified. Increasing GME payments would actually increase the payment to specific hospitals that are already benefiting from the increased hospital rates through the hospital portion of this assessment program.

Thank you for the opportunity to present to you today. I would be happy to answer any questions you may have.

50th Anniversary
KAHSA
Kansas Association of
Homes & Services for the Aging

TESTIMONY IN SUPPORT OF HB 2983 AS WRITTEN

To: Melvin Neufeld, Chair, and Members,
House Appropriations Committee
Fr: Debra Zehr, RN, Vice President
Date: March 24, 2004

Thank you, Chairman Neufeld, and Members of the Committee. The Kansas Association of Homes and Services for the Aging represents 160 not-for-profit long-term care provider organizations throughout the state. Our members serve over 15,300 older people in nursing homes, retirement communities, assisted living and housing units, and community-based service programs.

We are here to lend our support to House Bill 2983 as it is currently written. The bill is the result of at least two years of careful consideration, analysis and consensus-building on the part of hospitals and HMO's that will be directly impacted by the proposed legislation. The assessment will be based on a percentage of net revenue and as such, individual patients will not be assessed a per day tax. The bill is constructed in such a way that certain provider groups, such as critical care access hospitals, are not subject to an assessment.

We adamantly oppose the addition of any other provider groups, specifically nursing homes. Why? There is no consensus; in fact, there is sharp division among long-term care provider groups about the merits of a tax on nursing facilities. KAHSA's analysis has not been able to demonstrate to our satisfaction that a provider tax would not harm some providers and as a result, some nursing home residents. Unlike the provider group under consideration in House Bill 2983, in the case of nursing homes, individual elderly citizens who pay for their own care would bear the direct brunt. The Centers for Medicare and Medicaid Services (CMS) has rejected all applications in the past year and is investigating nursing home provider taxes in thirteen states because they appear to be in noncompliance with federal law.

Thank you. I would be happy to answer questions.

HOUSE APPROPRIATIONS
DATE 3-24-04
ATTACHMENT 8

785.233.7443 fax 785.233.9471 217 SE 8th Avenue Topeka, KS 66603-39

MARIAN CLINIC

March 24, 2004

Representative Neufeld and Members of the House Appropriations Committee:

Marian Clinic provides health care for people who have limited resources and who have no health insurance. In its 16 years of existence, Marian Clinic has grown to now having approximately 14,000 patient visits annually.

We have a tremendous volunteer physician and volunteer nurse support in the Topeka community with 35 doctors who come on site to see patients during the month, 180 doctors see Marian Clinic pts in their offices without charging them, 25 volunteer nurses assist staff nurses during clinics and numerous clerical volunteers. St. Francis Health Center donates labs, x-rays and hospitalizations for Marian Clinic patients. We provide samples to patients, one-half a million dollars in medicines through applications to the pharmaceutical companies and help with medicines through the Shawnee County Medical Society's HealthAccess program.

The Clinic has three major programs: medical care, women's health and dental care. In our medical program the most common complaints are orthopedic problems, hypertension and diabetes. More and more people have chronic health conditions and often need intensive attention. The Clinic endeavors to change the reality for the uninsured, that they tend to live sicker and die younger than other Americans.

A major objective of the Clinic is to provide the opportunity to every woman who visits the Clinic with basic women's health screenings and follow-up care appropriate for age, symptoms, family and health history, and to provide basic preventative and proactive education in the area of women's health. Some of these services are reimbursed by the state through the Early Detection Works program.

Medical Plaza Building 1001 SW Garfield Avenue Topeka, KS 66604 785-233-9780

HOUSE APPROPRIATIONS
DATE 3-24-2004
ATTACHMENT 9

Our third program is dental care. Two full time staff dentists with four dental assistants and office personnel see more than 500 patient visits a month. Our dental clinic provided 1/3 of all the dental services in Kansas clinics this past year.

Marian Clinic has a staff of 25 persons to coordinate and assist the volunteer effort. By increased funding a dental hygienist could be added to the dental staff, thus freeing up the two dentists and increasing patient visits. A full-time interpreter and an eighth staff nurse could be added to the present number of 7 staff nurses.

State funding has remained the same for the past six years and demand has continued to increase. In that time, Marian Clinic patient visits has doubled from 6993 visits to 12, 763 visits.

As you can see by the Marian Clinic Annual Revenue Sources for fiscal year ending May 31, 2003, our funding sources are diverse. Patient charges provide 28% of the operating costs. Of that, nearly all are patient out-of-pocket. Medicaid accounts for just 5% and HealthWave is 2%. Our sponsors, the Sisters of Charity of Leavenworth, contributed 22%. The rest of the budget comes from grants, contributions and fundraisers.

I appreciate the 9% of our total revenue received from the State. I would like to see it increased to 15% so I can carry out those plans. Thank you for including funding of Kansas clinics for underserved Americans in HB 2938.

Marilyn Page
Executive Director

MARIAN CLINIC

healthier lives for the uninsured

INTERESTING FACTS

- The Sisters of Charity of Leavenworth founded Marian Clinic in 1988 as a unique response to documented need. The Clinic has long been a community endeavor with widespread support from 35 faith groups, 70 organizations, 160 businesses and over 1800 individual donors.

- The annual patient census grows steadily. Today the Clinic ministers to men, women and children of every faith and background, providing them with medical and dental appointments, care and treatment. To be eligible, individuals must be without health insurance and meet income guidelines based on national poverty levels. A single person may earn up to $15,715 a year, a family of three up to $26,705.

- The Clinic expects to provide 14,500 patient visits in 2004-05. Over 250 health care professionals volunteer their services.

- A strong core of nurses offers a team response that gives patients prompt access to health care. The nurses encourage regular appointments and self-care, provide phone and face-to-face consultations and triage urgent walk-ins. This effort helps reduce unnecessary emergency room visits.

- The Clinic values a holistic approach to patient care and offers mental health counseling and social support as needed.

- This past year Marian Clinic Dental appointments accounted for one-third of all dental visits at clinics for the uninsured in Kansas.

- Based on the Clinic's current activity, staff members are helping medical patients obtain nearly $1/2 million of free pharmaceuticals each year.

- The women's health program enables over 200 women a year to receive breast exams and to schedule mammograms for breast cancer detection, making Marian Clinic the leading agency for those screenings in North Central Kansas.

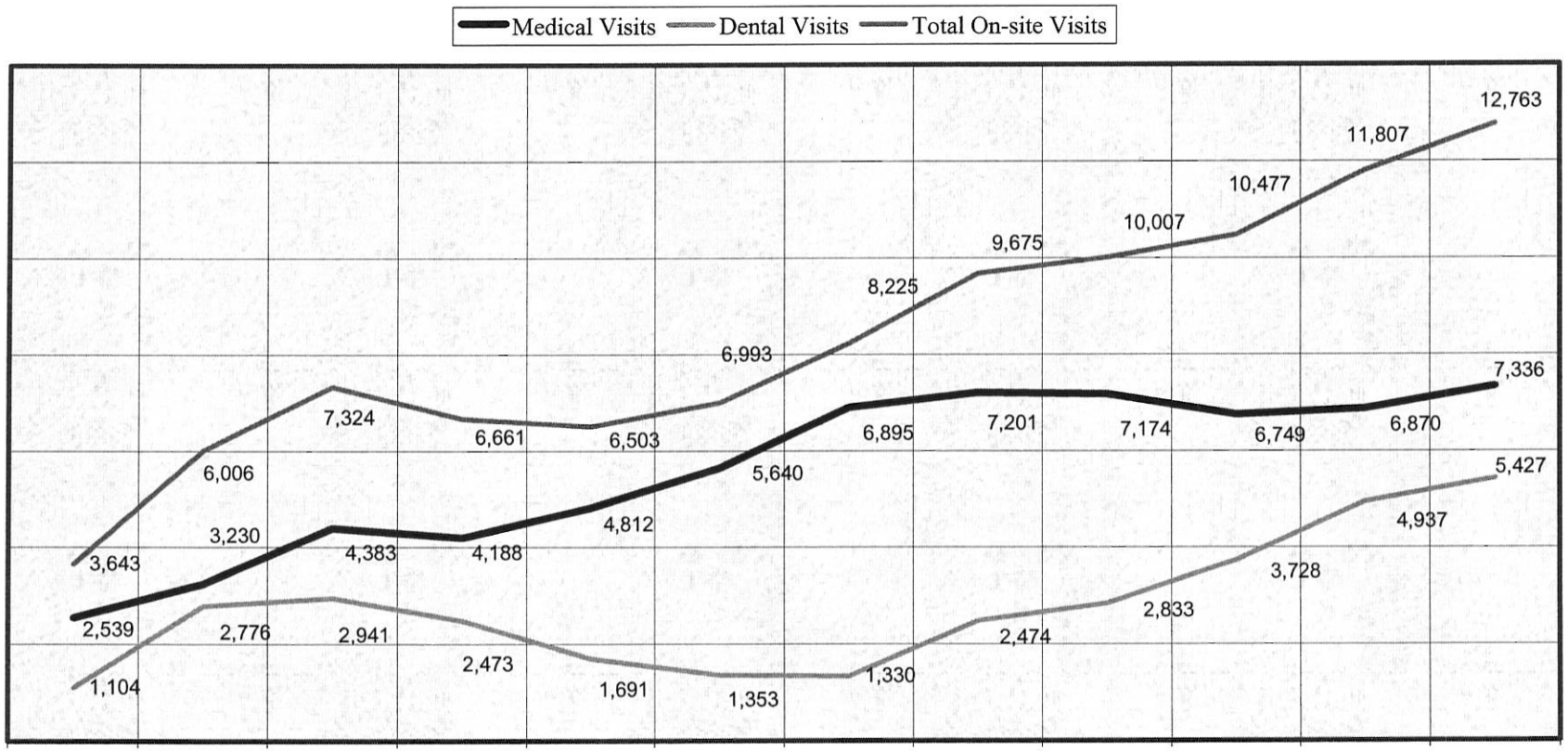
- The Clinic's emphasis on health screenings, wellness education and self-care helps bring about healthier lives for the uninsured.

- Patients and reimbursement for service provides 30% of the operating budget. The Sisters of Charity provide another 22%. The Clinic relies on gifts and grants for the remainder.

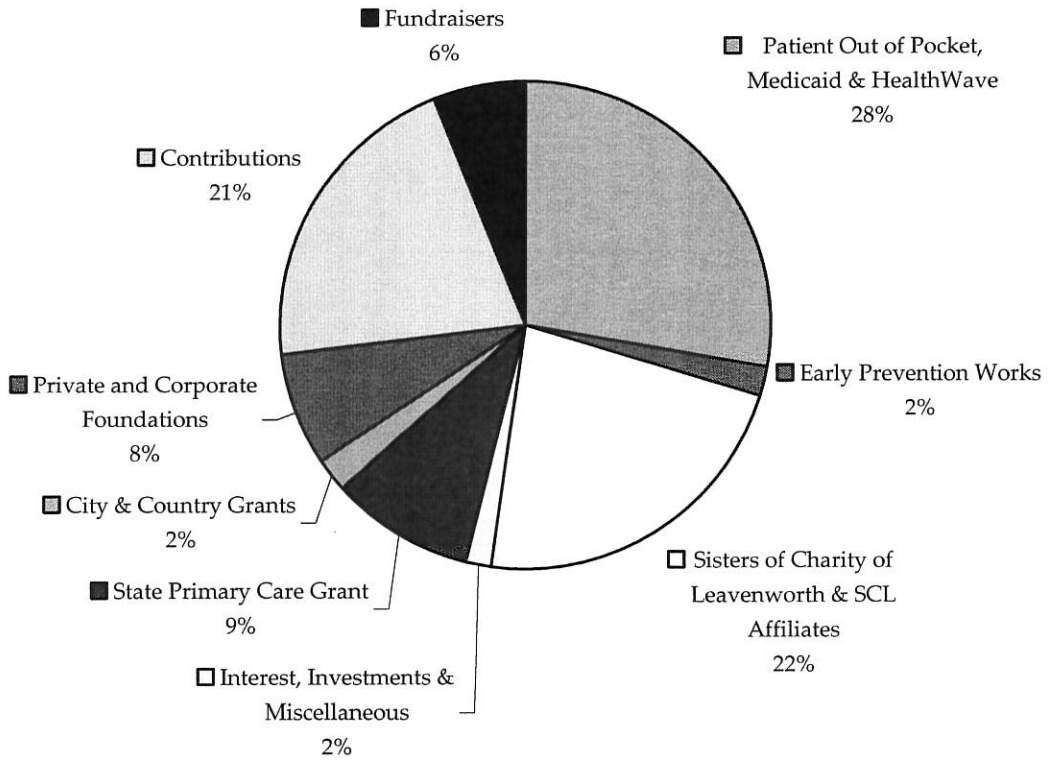
- For every $1 donated the Clinic provides $4 in health care services to the community.

Administrative offices and medical services—Medical Plaza Building
1001 SW Garfield Ave. Topeka KS 66604 Phone 785-233-8081 Fax 785-233-8952
Dental services—Marian Clinic Dental
3164 East Sixth Ave. Topeka, KS 66607 Phone 785-233-2800 Fax 785-2335116
www.marianclinic.org

Marian Clinic Service History



Marian Clinic Annual Revenue Sources FY Ending May 2003



Testimony
House Appropriations
Lee Eaton, Kansas Health Care Association
March 24, 2004

Honorable Representatives,

Thank you for the opportunity to be here today. I am taking the place of Dennis Bush who was unable to attend today. I think Mr. Bush's testimony speaks for itself. What I am prepared to testify to and take questions on is similar.

Our current Medicaid reimbursement is about $108 dollars a day. That is currently about $20 a day less than our costs. This obviously places an extreme burden on our ability to provide quality care. The provider tax is a mechanism to bring additional funding to the Medicaid program without an additional outlay from the State. Clearly we are similarly situated to the Kansas Hospital Association and our asking this committee for support on both the Kansas Hospital Association Provider Assessment and the Nursing Facility Provider Assessment.

HOUSE APPROPRIATIONS

DATE 3-24-2004
ATTACHMENT 10

phone: 785-749-2000 fax: 785-344-1199 4851 Harvard, Lawrence, KS 66049 www.pioneer

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403
www.kspca.org

Testimony of Karla Finnell, J.D., M.P.H
Kansas Association for the Medically Underserved
March 24, 2004
House Appropriations Committee

KAMU, on behalf of the safety net primary care clinics and the many underserved Kansans, supports HB 2938 and expresses its most sincere appreciation to the committee for its inclusion of funding to support expansion of medical and dental care for the medically undeserved. Today more than 280,000 Kansans do not have health insurance coverage. The uninsured may be our relatives, our neighbors or even the support staff key that play an integral role in the operations of this Legislature. Of the uninsured, 72% or more than 200,000 uninsured Kansans are poor or nearly poor, and are frequently called the working poor. The majority are employed.

Numerous studies confirm those without health insurance coverage are unable to access care due to the cost and have serious problems paying medical bills. The Kansas Health Insurance Study, identified the following characteristics of people who are without health insurance coverage:

- Uninsured are less likely to have a usual source of health care (67.4% vs. 87%)
- Uninsured have a higher utilization of the emergency room (17.7% vs. 12.5%)
- Uninsured are less likely to have had a doctor visit within the last six months (29.1% vs. 53.3%).

Delaying treatment, not filling a prescription and rationing medications all results in worsening of the condition, rendering it more expensive to treat. The General Accounting Office found that the uninsured are hospitalized 50% more often than the insured for avoidable hospital conditions like pneumonia and uncontrolled diabetes. The same study also found that the uninsured are four times more likely to utilize the emergency room. As one would anticipate, uninsured individuals diagnosed with cancer are more likely to be diagnosed in the later stages of cancer. While the human tragedy associated with lack of access to health insurance is staggering, the lack of insurance impacts all of us. Private providers with thin profit margins absorb the cost of uncompensated care. Costs are also passed on to the insured and other third party-payors in increased fees.

We are very proud of the work done by the primary care safety net clinics. Primary Care Clinics are not the total solution but today 34 organizations provide basic health care services to 122,000 underserved Kansans, 92% of which are poor or nearly poor, including primary medical care, ancillary services such as laboratory and x-ray. 11 sites provide dental care. All safety net clinics provide access to low cost or free pharmaceutical services through manufacturer's indigent drug programs, drug rooms stocked with samples, and the federal 340B drug program which allows clinics to purchase prescriptions at the federal government cost rate, a savings of

KAMU

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for the
Medically Underserved
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51% from AWP. Health care at the clinics is not free. Patients contribute to the cost of their care by paying a co-payment on a sliding fee scale.

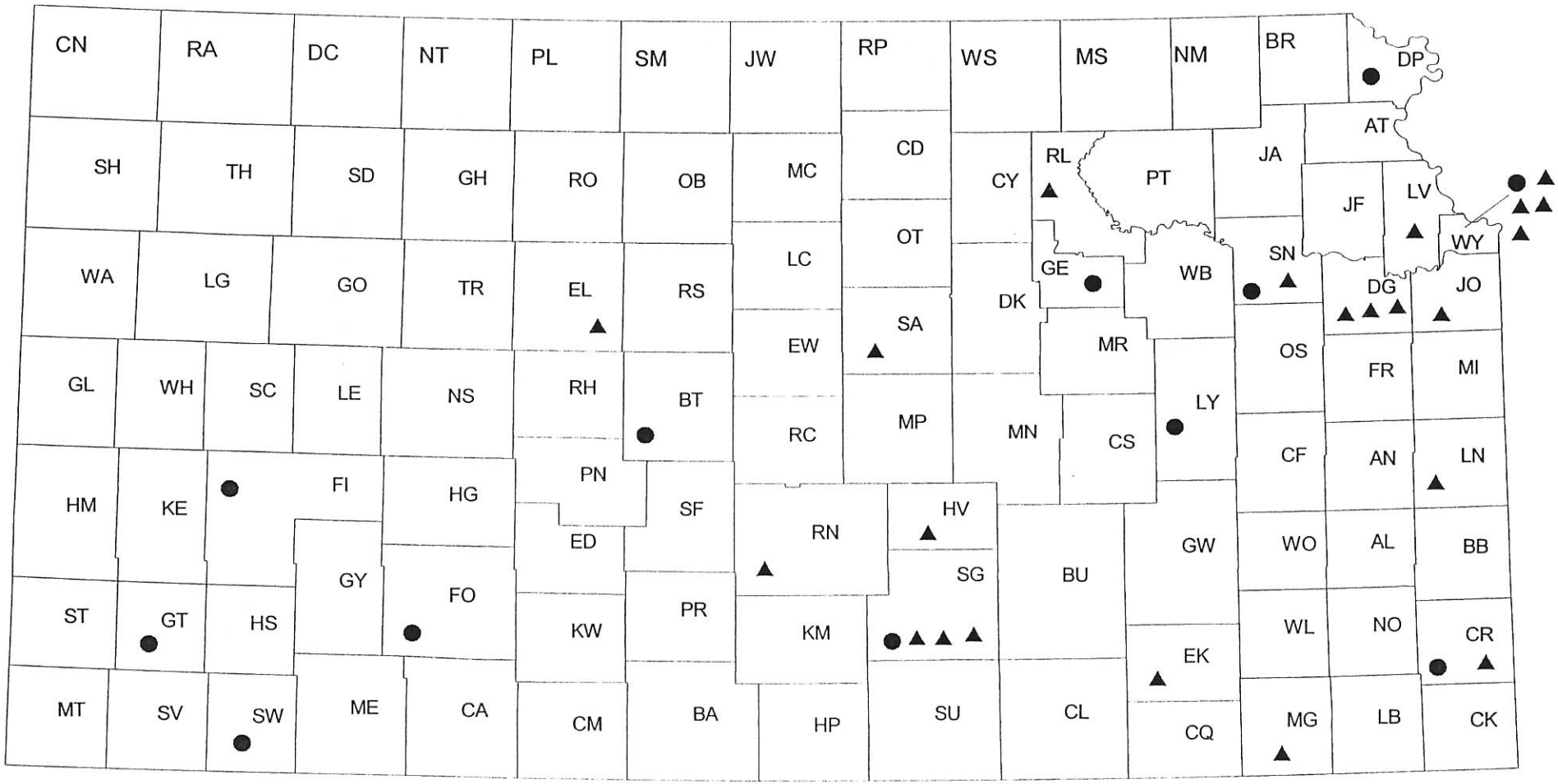
The safety net primary health care system is a good investment for the State. The state of Kansas provides $1.52 million dollars that contributes to the support of operations of 15 of the 34 safety net clinics. State funding for primary care must be matched by local funds at a ration of 1:1, mandating community support for the project. In reality, the State receives a much greater yield on its investment. Usually, other sources contribute at least four dollars for every dollar invested by the State in supporting health care provided by primary care clinics. Federally funded Community Health Centers in Kansas receive more than $5.8 Million in federal 330 funding, compared to a state investment of $400,000.00, providing a leveraging of state resources of $10 for every $1 invested by the State. Primary health care is the least expensive level of care and yields substantial savings by reducing avoidable hospitalizations and emergency room visits.

Now is an excellent time to increase the support for safety net. Funding has remained flat while the demand for care continues to increase. Safety net clinics are willing to expand primary health care, dental and pharmaceutical services as appropriate to the communities being served but need the support of the State of Kansas. An unprecedented amount of new federal dollars are available now, whereas President Bush has committed to double the capacity of community health centers by 2006. This growth initiative, announced in 2001, has proceeded on track with strong bipartisan support in Congress. An additional $219 million in new funding is proposed in the President's FY05 budget. Your support will be efficiently used, will leverage resources valued far beyond the investment of the State. Clinics would provide health care services to the uninsured primarily through a network of referrals need support as well. These clinics are not Medicaid eligible but provide vital health care to the most vulnerable citizens, the uninsured.

KAMU request committee passage of HB 2938, as well as authorization of funds to support expansion of medical services at primary care clinics who do not accept Medicaid as well as appointment of a member of the health care access improvement advisory panel established by HB 2983 that represents medically underserved community.

THANK YOU!!

Safety Net Clinics in Kansas



▲ Primary Care Clinics

● Community Health Centers or Satellite

Agency Name	County
Community Health Council	Riley
Project Access	Sedgwick
Community Health Council of Wyandotte County	Wyandotte
We Care Project, Inc.	Barton
Community Health Center of Southeast Kansas	Crawford
Wathena Medical Center	Doniphan
United Methodist Mexican-American Ministries	Finney
Konza Prairie Community Health Center	Geary
Flint Hills Community Health Center	Lyon
Hunter Health Clinic	Sedgwick
Shawnee County Health Agency	Shawnee
Kansas Statewide Farmworker Health Program	Statewide
Swope Health Services	Wyandotte
GraceMed Health Clinic	Sedgwick
Medical Plaza of Arma	Crawford
Douglas County Dental Clinic	Douglas
Health Care Access, Inc	Douglas
Heartland Medical Clinic	Douglas
Elk County Rural Health Clinic	Elk
First Care Clinic of Hays	Ellis
Health Ministries Clinic	Harvey
Health Partnership Clinic of Johnson County	Johnson
Saint Vincent Clinic	Leavenworth
Pleasanton Family Practice	Linn
Cherryvale Rural Health Clinic	Montgomery
Pottawatomie Co Health Dept	Pottawatomie
Community Health Center of Hutchinson	Reno
Riley County Community Health Clinic	Riley
Salina Cares Health Clinic, Inc	Saline
Good Samaritan Clinic	Sedgwick
Guadalupe Clinic	Sedgwick
Sedgwick County Health Department	Sedgwick
Marian Clinic	Shawnee
Duchesne Clinic	Wyandotte
Silver City Health Center	Wyandotte
Southwest Boulevard Family Health Care	Wyandotte
Turner House Clinic for Children	Wyandotte

Statewide Independent Living Council of Kansas

SILCK

700 S.W. Jackson, Suite 212, Topeka, KS 66603 ☎ (785) 234-6990 voice / tdd ☎ (785) 234-6651 fax

Testimony Presented to
House Appropriations Committee
Representative Melvin Neufeld, Chair
In Support of HB 2938

I am Shannon Jones, executive director of SILCK and spokesperson for the Big Tent Coalition (BTC). The BTC is a coalition of over 85 organizations representing over 645,000 Kansans. The concern of the BTC is adequate funding for health and social services for frail elderly, disabled, needy persons and mothers and children dependent upon state services. I hope most of you have seen our budget request, which is attached to this testimony.

With the cooperation of the Governor and the members of the legislature, we have made some headway in bringing down the number of persons on the waiting lists. We thank you for that support.

We are here this morning to support HB2938. As we understand this proposed legislation, it provides for a provider tax to be applied to hospitals and HMO's. This provider tax would then generate money, which would be used to provide additional reimbursement to critical health care providers such as the hospitals, physicians, and dental services. These are all items in our basic budget request. The restoration of inpatient acute care reimbursement, $4.9M; physician reimbursement, $7.5M and as we understand the proposal there may be some money allocated to improving the dental program, pharmaceutical and perhaps some other health care areas.

The title of this bill is properly stated, it provides for "establishing the health care access improvement program". As an advocacy organization, this is what we are about. As a coalition we want to improve access to medical services for the persons we represent. We recognize that the persons we represent, in many instances, cannot have a good quality of life apart from medical services. We also recognize that the providers who provide services to our constituents should be paid for those services.

Persons who are elderly and frail, disabled, poor and needy are in critical need of the services, which can be provided through the passage of HB 2938. We hope you will give this bill your immediate and positive attention. The people we represent are counting on your care and concern.

HOUSE APPROPRIATIONS

DATE 3-24-2004
ATTACHMENT 12

BIG TENT COALITION
Proposed BTC Budget Update FY 2005

Background: The Big Tent Coalition started in January, 2003. The Coalition now has a membership of 87 organizations representing over 600,000 Kansans. Our concern is the health and well-being of the physically and mentally disabled, the frail elderly, mothers and children on welfare, the poor and the needy.

While not reflected below, the BTC remains critically concerned about ALL underserved populations. In particular, seniors on the FE waiver with limitations imposed on their plans of care, and the 1,436 children and adults with MR/DD who are in need of additional support services but are not included in our official listing.

We have been encouraged by the reception we had last year and continuing to the current time.

The Governor has responded to several of our concerns and requests. Our budget request is a work in progress with more information forthcoming. The following is a status report as we understand the Governor's Message and Budget presentation January 12, 2004.

The listing of our budgetary concerns is not a priority listing. **The following list is our number one priority.**

State General Fund Request FY'05	**Need**
Needs related to Home and Community Based Services as of 1-1-04	
Physically Disabled - $6,355 per person 1,097 persons = $ 7.0M	
Governor's recommendation increase of $3M;	$4.0M
Developmental Disability - $13,656 per person x 995 persons = $ 13.6M	
Governor's recommendation increase of $3M;	$10.6M
Head Injury - $15,816 per person x 73 persons =	$1.1M
Governor's recommendation is no increase	
Frail Elderly - $4,718 per person x 559 =	$2.6M
Sub Total	$ 18.3M

Restores Senior Care Act	$ .9M	Reduced in '05 to $6M from $6.9M in '04
Restores AWP from minus 13 to minus 11	$1.2M	
Restores in patient acute care reimbursement rate	$4.9M	
Restores medical transportation reimbursement rate	$1.2M	
Restores a number of brand prescription drugs	$5.3M	
Preserves General Assistance & Medikan, as is	$2.7M	
Restores Developmental Disability Grant	$ .6M	
Restores Medikan rate at CMHC	$1.4M	
Restores CDDO state aid	$ .8M	
Restores Health Wave premiums before allotment	$ .4M	
Restores eligibility for transitional medical assistance	$ .9M	
Provides physician reimbursement	$7.5M	
Provides for childhood vaccine	$ .4M	
Provides for adult dental	$6.4M	
Restores Family Support services for DD waiver	$1.6M	
Sub Total	$36.2M	
Total new State General Funds requested	**$54.5M**	

12-2

1/21/04
Shannon Jones
BTC Spokesperson
785-234-6990
(02)
12-2

Kansas Pharmacists Association
Kansas Society of Health-System Pharmacists
Kansas Employee Pharmacists Council
1020 SW Fairlawn Rd.
Topeka KS 66604
Phone 785-228-2327 ✦ Fax 785-228-9147 ✦ www.kansaspharmacy.org

TESTIMONY re: HB 2938

House Appropriations Committee

Presented by Robert Nyquist
on behalf of
Kansas Pharmacists Association

March 24, 2004

Chairman Neufeld, and members of the Appropriations Committee. Thank you for allowing me to testify today.

I am Bob Nyquist, President of the Kansas Pharmacists Association. I am a pharmacist as well as a pharmacy owner. The recent past has not been a good time for pharmacy, either in Kansas or nationally. We have had to endure initially mail order pharmacy along with restricted pharmacy networks taking our patients unwillingly from us. As with mail order, Internet pharmacy and Canadian or other foreign pharmacy delivery systems not only hurt Kansas pharmacists but also the State of Kansas. This generates millions of dollars going out of state, which we could certainly use at the present time.

We have had our Medicaid fees cut, even though they have remained constant as opposed to the increase in drug prices, when the Medicaid drug budget has increased. We have saved the State about 10 million dollars through our efforts to control drug costs by implementing the Preferred Drug Lists, but our fees are only about $22.5 million out of a Medicaid budget of about $290 million. A Medicaid patient is not required to pay the $3 co-pay on a prescription if they say they don't have the money to pay, which obviously affects the pharmacist's bottom line. More recently, we have been dealing with discount cards, which do nothing more than take a cut out of our already limited margins.

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Contracts with PBMs representing insurance companies and other entities which give us take-it-or-leave-it contracts are the standard, of which many pharmacies are beginning to refuse. These are not negotiated contracts, as we are told what the reimbursement fee is going to be and we can't call even one other pharmacist to see of they are going to accept it or not. Therefore, we have no power to negotiate and that is why some of the contracts have been signed. Another reason is that we feel, particularly in rural Kansas, a responsibility to our community to provide pharmacy services even though it is not financially sound business for us to do so. We are called out at all times if the day and night, holidays and weekends to serve our patients.

I believe there are only 3 counties in Kansas that do not have a pharmacy, and those people are not that far from one in another county. So we have in place now the infrastructure to serve the pharmaceutical needs of Kansas. Without an increase in pharmacy fees this will not be the case in the near future, as around 50% of the pharmacy owners are 50 years of age or older. Some of these pharmacists feel that they may never be able to sell their pharmacies and consequently when they are gone so does the pharmacy service to many rural areas of Kansas.

We now have the Medicare Discount cards as well the Medicare Bill itself, which will even take more of our bottom line. It has been estimated that each pharmacy will lose approximately $125 per day when the Medicare Bill takes effect in 2006. The discount cards will also hurt, but there has been no estimate as to what extent. We have heard recently that there is the possibility of a State of Kansas discount card, which only means another hit to our bottom line.

We in pharmacy are very similar to where the State of Kansas is today in a monetary sense. Kansas has as many, if not more, expenses as it has ever had, but with less income to pay these increasing expenses. We in pharmacy have exactly the same problem and that is why we have been and are continuing to search for better business practices and efficiencies. We certainly appreciate the support for increasing the Medicaid pharmacy reimbursement rates. We believe this will strengthen the partnership that pharmacy has with the State of Kansas in providing better access to pharmacy, which provides a critical part of health care services to the citizens of Kansas.

Thank you very much for permitting me to testify. I will be happy to yield to any questions.

United Methodist Western Kansas Mexican-American Ministries
Community Health Center and Community Centers

March 22, 2004

To: Committee on Appropriations
Re: HB 2938
From: Penney Schwab, Executive Director
United Methodist Mexican-American Ministries, Inc.

Thank you for your commitment to improve access to health care for underserved people across Kansas. As part of that commitment, the Board of Directors and staff of United Methodist Mexican-American Ministries (MAM) urge you to support HB 2938, Establishing the Health Care Access Improvement Program, State Medicaid Plan, Hospital and Health Maintenance Organization.

The use of funds from the health maintenance organization assessment to support medical and dental care expansion is crucial to the health of underserved people across Kansas. According to the Kansas Insurance Commission survey in 2001, 16.5% of Southwest Kansans were without health insurance. Today, we believe that figure is significantly higher due to beef industry lay-offs and the generally slow economy. Primary care clinics around the state are reporting the same things we observe here: fewer families with insurance, more families delaying care until the situation is serious (and more expensive), and more families unable to pay even minimum fees of $10.00 or less.

MAM is completing a clinic addition to our Dodge City facility that will allow us to expand from 708 unduplicated users to 2,675 unduplicated users and bring us closer to meeting the needs of low-income residents of Ford and surrounding counties. The building was bought with private funds, and we are currently raising private funds to pay for the addition.

But it is increasingly difficult to secure operating costs to cover costs of care for those with no source of third-party pay—71% of all clients in 2003. Our current basement site in Dodge City doesn't have room to provide prenatal care—a service we hope to add once we're in the new building. Currently about 45 women drive to our Garden City clinic for prenatal care---and other women go without care---because they lack private access due to lack of insurance or ability to pay full fees. Securing a full-time physician for that site will cost approximately $ 150,000 per year. About 97% of our clients have household incomes below 200% of the federal poverty level, so we simply cannot "pass on" our costs to our clients.

There is indeed a "health care crisis" for the increasing number of people unable to afford basic dental and health care. HB 2938 offers a way to help more of those people. Thank you for including the primary care safety net clinics as part of HB 2938. We are grateful for your support for people who are uninsured, underinsured, or for other reasons have *no* access to health services except the safety net clinics.

Sincerely,
Penney Schwab
Penney Schwab

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Executive Director Penney Schwab
Medical Director Karen Nonhof
712 St. John
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Community Developers
Donna Sanchez-Jennings
311 N. Grant
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Jose Olivas
321 W. Grant
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Isela L
224 N.
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Dodge City, KS 67801
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KHCA

Member of ahca

Kansas Health Care Association
(785) 267-6003 www.khca.org
Fax: (785) 267-0833 Email: khca@khca.org

Testimony
House Appropriations
Dennis Bush, Kansas Health Care Association
March 24, 2004

The Kansas Health Care Association appreciates the opportunity to comment in support of HB 2938, the Hospital Provider Assessment bill. You have previously heard from the Kansas Hospital Association's February 17, 2004 testimony, that they "recognize the value of partnerships with state agencies and community partners to provide access to needed health care services for the frail, the poor and the elderly citizens of Kansas." Likewise, the Kansas Health Care Association (KHCA) also believes that by partnering with the state Medicaid agency we can bring in additional Federal dollars to Kansas to help rural facilities and homes that are struggling to cover their costs.

The Kansas Hospital Association goes on to report that they are experiencing increased costs and decreased reimbursement for their providers due to current budgetary constraints. As you all know, the Kansas Nursing Facility reimbursement rates for July 1, 2004 also falls far below the cost of delivering care for our elderly residents. Similar to the Kansas Hospital Association, KHCA also recognizes Kansas' fiscal crisis and that additional revenue is non-existent. That is why we support The Kansas Hospital Association Provider Assessment as well as the Nursing Facility Provider Assessment, HB 2470. We ask this committee for support on both Provider Assessments so that we both are allowed to partner with the state Medicaid agency to bring in Federal dollars that otherwise would not come to Kansas.

The Kansas Hospital Association has already testified that these additional dollars would decrease the "gap" between the services that they must provide to Medicaid clients and the resources necessary in order to provide these services. We likewise would be able to decrease the "gap" between nursing facility costs incurred and nursing facility reimbursement rates. According to a December 2003 BDO Seidman report, nationally the average shortfall in Medicaid reimbursement is now $11.55 per Medicaid patient day. (This report is based on 37 states reporting, including Kansas, with these states representing 88% of the Medicaid days in the country.)

Kansas ranks amongst the 10 worst Medicaid rates with a shortfall of $10.10 per day, the difference in allowable costs versus reimbursed costs.

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You know that no business can survive losing $10 a day on every $100 of costs. That is a sure way to go into bankruptcy and many of the nursing homes in this state are doing just that. Some are shutting their doors and some are restructuring their debt to stay open a bit longer. Some facilities that have been in a family for 2 or 3 generations are now jeopardized. Providers are struggling to maintain quality of care levels. In order to deliver quality of care, nursing home providers have had to implement cost-saving measures, operate with reduced margins and also pass on some of these costs to the private pay residents. But this can not go on forever, and serves only to address the budget constraints and funding reductions as a short-term problem. For example, last year the Frail Elderly budget had no inflationary growth for one year even though we know that nursing facility staffing and food expenses grew while liability insurance expenses skyrocketed (34.5%).

We must look to alternative forms of financing long term care for our poorest and most needy. Now that all other resources are exhausted, we owe it to our elders to evaluate and consider bringing hundreds of millions of federal dollars into Kansas. The Legislature and this committee are crucial elements in our profession's ability to overcome increasing Medicaid shortfalls in the upcoming fiscal years. We ask this committee to support HB 2938 as well as HB 2470.

The Homestead
Assisted Living Residence
2414 N. Henderson Drive • Garden City, KS 67846
316-272-9800

Testimony
House Appropriations
Gilbert Cruz, Kansas Health Care Association
March 24, 2004

Chairman Neufeld and Committee:

My name is Gilbert Cruz and I write today to testify on behalf of the Kansas Hospital Association's HB 2938. KHCA member facilities are supportive of a Provider Assessment for hospitals as well as nursing facilities in order to bring in additional federal Medicaid matching dollars to help adequately fund care and services to Kansas elders. A Provider Assessment is needed to close the gap between Medicaid reimbursement for services and the actual cost to provide those services. We support HB 2938 and HB 2470. The Provider Assessment proposed by HB 2470 would benefit over 90% of Kansas' nursing facilities. KHCA has taken great care to ensure that the assessment laid out in the bill is legal, allowable and meets all federal requirements.

With a Provider Assessment, both Hospitals and nursing facility providers will be able to decrease the "gap" between allowable costs and reimbursed costs and to provide services to all of Kansas' poor elders and Medicaid clients. HB 2470 would allow for the state of Kansas to bring in $32.9 million in federal dollars for long-term care services that can also benefit those on HCBS/FE waiting lists.

From my standpoint, barriers to successful use of a Provider Assessment have been carefully contemplated and solutions crafted. I hope the Appropriations Committee will take the time to examine the facts and figures and then pass both bills favorably, HB 2470 and HB 2938.

Respectfully submitted for consideration,

Gilbert Cruz RRT, MPA

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KHCA

Member of ahca

Kansas Health Care Association

(785) 267-6003 www.khca.org
Fax: (785) 267-0833 Email: khca@khca.org

March 23, 2004

Dear House Appropriations Committee Member:

I ask you today to discuss a crisis that affects you and all nursing facility providers in the long term care profession.

I am increasingly alarmed that more and more nursing homes, particularly in rural Kansas, are either shutting their doors or are telling their legislator that they are struggling to keep their doors open.

According to a December 2003 BDO Seidman report, nationally, the average shortfall in Medicaid reimbursement is now $11.55 per Medicaid patient day. (This report is based on 37 states reporting, including Kansas, with these states representing 88 % of the Medicaid days in the country.)

Kansas ranks amongst the 10 worst Medicaid rates with a shortfall of $10.10 per day, the difference in allowable (actual) costs versus reimbursed costs.

Whether you are a legislator, a business owner or an administrator of a nursing home, you know that no business can survive losing $10 a day on every $100 of costs. That is a sure way to go into bankruptcy and many nursing homes in this state are doing just that. Some are shutting their doors; some are restructuring their debt to stay open a bit longer. Some facilities that have been in a family for 2 or 3 generations are now jeopardized.

Providers are struggling to maintain quality of care levels. We achieve this by cost saving measures, by reduced margins and by passing on some of those costs to private pay residents. These are excellent ways to address short-term problems but budget constraints and funding reductions do not appear to be short-term. This underfunding cannot go on forever.

I believe we have done a great job managing our costs. For example, last year the Frail Elderly budget had no inflationary growth for one year even though we all know that costs grew including staffing and food costs, while liability insurance expenses skyrocketed by 34.5%.

Because of Kansas' fiscal crisis, additional revenue is non-existent. However, there is a way to begin to address this problem. You are likely aware of the Centers for Medicare and Medicaid Services approval of a Medicaid federal match program through provider assessments. In Kansas we must look to alternative forms of financing long term care for our poorest and our most needy. Now that all other resources are exhausted, we owe it to our elders to evaluate and consider bringing federal dollars back to Kansas.

Today you will hear about the Hospitals' creative ideas to address shortfalls in their funding in HB 2938. Nursing homes have a similar bill, HB 2470. If you support a provider assessment for hospitals to increase rates for physicians, you should also consider the same for nursing facilities to address quality of care and the economic survival of facilities in the state. Your attention to this issue for physicians and nursing facilities is a crucial element in our profession's ability to overcome increasing Medicaid shortfalls in the upcoming fiscal years. I ask for your thoughts and suggestions

Linda Berndt
Executive Vice President
lberndt@khca.org
785 220-2084

Note: For your information, attached is data regarding the economic impact nursing facilities have ir is a listing of all your nursing facilities, statewide economic expenditures and employee salaries and your district's facilities. You will note that the impact is significant in property taxes from for-profit fac

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Legislative Testimony

HB 2938

March 24, 2004

Testimony before the Kansas House Appropriations Committee
By Lew Ebert, President and CEO
Written Testimony

THE KANSAS CHAMBER

The Force for Business

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Topeka, KS 66612-1671
785-357-6321
Fax: 785-357-4732
E-mail: info@kansaschamber.org
www.kansaschamber.org

Thank you for the opportunity to comment on HB 2938, establishing the health care access improvement program; state Medicaid plan; hospitals and health maintenance organizations.

Skyrocketing health care costs are draining millions of dollars from Kansas businesses, forcing employers to cut from other aspects of their operations, including employee benefits, raises and jobs. Additionally, escalating health care expenses compound rising workers compensation costs for both private sector and public sector employers.

The Chamber encourages policy makers to improve the business climate by lowering the costs of doing business in the state and improving our competitive position. Kansas must create a business climate that permits Kansas employers to grow their businesses and that enables the state to attract potential new employers. To do that, health care costs in Kansas must be reduced.

A recent poll of the state's business owners and executives commissioned by The Kansas Chamber of Commerce identified managing the costs of health care as **the** most important factor in improving the state's business climate. Another current survey by the independent, non-profit health policy and research institution, the Kansas Health Institute, showed that nearly 80% of Kansans said they support public funding for state programs that help small business find affordable health insurance.

There are a number of measures worthy of consideration that would assist small businesses provide affordable health care insurance to their employees, ranging from small business tax credits, to working around costly insurance mandates, providing for enhanced public education, and additional funding for low-wage earners to help them afford health care insurance.

An assessment program for hospitals and Medicaid managed care could provide a mechanism for Kansas to maximize federal funds available for improving health care access in the Medicaid program and contribute to stabilization in the health care system. Revenue generated by the assessment program could assist the provider system in Kansas, increase physician reimbursement, shore up safety net clinics, and subsidize health insurance for low-wage earners employed by small business, increase funding to the health care data government board, add support for the Office of Health Planning and Finance, and increase reimbursement to Medicaid managed care

Kansas Academy Of Family Physicians

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1-800-658-1749 Fax 316-721-9044 kafp@kafponline.org
http://www.kafponline.org

To: House Appropriations Committee

From: Carolyn Gaughan, Executive Director

Date: March 24, 2004

RE: **House Bill 2938**

The Kansas Academy of Family Physicians (KAFP)[1] appreciates the opportunity to provide written testimony in support of HB 2938, creating the *Health Care Access Improvement Program,* which will receive funds from a new assessment on hospitals and health maintenance organizations that have a Medicaid contract with the State of Kansas. This assessment program has been successfully established in a number of other states and represents a much-needed opportunity to increase health care access for Medicaid service consumers.

Today, we especially want to address two elements of HB 2938: increasing Medicaid reimbursement rates to physicians and funding for graduate medical education, which we understand will include the Medical Student Loan Program at the Kansas University Medical Center.

Increasing Medicaid Reimbursement Rates to Physicians

It has been nearly 30 years since Kansas' Medicaid fee schedule experienced a comprehensive update and Kansas falls well below most other states in its physician reimbursement rates. Our members continually report that they want to continue serving Medicaid patients. However, as the fee schedule becomes more outdated and actual costs of service outweigh reimbursement rates, it becomes increasingly difficult to continue serving this population.

Dedicating revenues from the provider assessment program to a comprehensive updating of the physician fee schedule will encourage physicians' continued participation in the State Medicaid Program and, thereby, will better ensure health care access for all Kansans.

Funding for the Medical Student Loan Program

One of the highest priorities of KAFP has always been to secure full funding of all four years of the Medical Student Loan Program in the KU Medical Center's budget. This year, the Governor provided full funding for the second-, third-, and

[1] KAFP represents more than 1,430 members statewide.

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fourth-year students, but was only able to add only $250,000 from the State General Fund for first-year students.

It is our understanding that some of the revenues dedicated to "graduate medical education" in this bill would be used for the Medical Student Loan Program, as well as other medical education programming. As funding for the Medical Student Loan Program has been very tenuous from year-to-year, we strongly support this effort to better ensure full funding of this vital program.

We appreciate this opportunity to express the support of the Kansas Academy of Family Physicians for passage of HB 2938 and the utilization of some of the revenues for the Medical Student Loan Program.

AGRICULTURAL AND NATURAL RESOURCES BUDGET COMMITTEE REPORT ON SB 487

Brief

SB 487 would provide for a partial diversion of gas severance tax receipts from the State General Fund (SGF) beginning in FY 2007 relative to collections in 14 counties. For the counties with at least $0.5 million in FY 2003 severance tax receipts (Barber, Comanche, Finney, Grant, Hamilton, Haskell, Kearny, Kingman, Kiowa, Meade, Morton, Seward, Stanton, and Stevens), an increasing portion of receipts would be diverted from the SGF beginning in FY 2007 into a new fund, the Gas Valuation Depletion Trust Fund (GVDTF). Each participating county would have a separate trust account established on its behalf within the GVDTF.

The portion of gas severance tax receipts from the 14 counties earmarked for deposit in the GVDTF would be 4.96 percent in FY 2007; 7.44 percent in FY 2008; 9.93 percent in FY 2009; and 12.41 percent in FY 2010 and thereafter. Under current law, the SGF receives 93 percent of severance tax receipts, while the County Mineral Production Tax Fund (CMPTF) receives the other 7 percent. Under the provisions of the bill, the CMPTF would continue to receive 7 percent of gas severance tax receipts, while the SGF's 93 percent share would be reduced relative to the new earmarking of receipts for the GVDTF.

Beginning in 2007, counties would be entitled to receive distributions from their accounts within the GVDTF by January 15 when the previous tax year's gas leasehold property valuation was less than 50 percent of such valuation in tax year 2005. Each distribution would be exactly 20 percent of all moneys credited to a county's trust account.

Background

The bill was requested for introduction and supported by Senator Morris.

A fiscal note indicated that based on current gas production declines and the assumption that the price of gas remains relatively constant, the amount of revenues diverted from the SGF to the GVDTF would be as follows:

($ in millions)

	SGF	GVDTF
FY 2007	($2.7)	$2.7
FY 2008	($3.9)	$3.9
FY 2009	($4.9)	$4.9
FY 2010	($5.7)	$5.7

Counties with at least $0.5 million in gas severance tax receipts in FY 2003 (14). (Barber, Comanche, Finney, Grant, Hamilton, Haskell, Kearny, Kingman, Kiowa, Meade, Morton, Seward, Stanton, Stevens)

All Other (91) Counties

Account established on behalf of each such county with new fund, Gas Valuation Depletion Trust Fund (GVDTF).

New Gas Sev Tax Disposition of Revenue

(No Change in Current Disposition of Revenue

(7%) (93%)

(7%) (93%)

CMPTF SGF

	CMPTF	SGF	GVDTF
FY 2007	7.00%	88.04%	4.96%
FY 2008	7.00%	85.56%	7.44%
FY 2009	7.00%	83.07%	9.93%
FY 2010	7.00%	80.59%	12.41%

CMPTF SGF

All Counties with Accounts in GVDTF Use Gas Leasehold Valuation for TY 05 as Baseline

GVDTF Counties with gas values less than 50% of TY 2005 for a Given Future Tax Year

All Other GVDTF Counties

20% of Trust Account Distributed to Each County by Jan 15 of Next Tax Year

GVDTF Counties with gas val REMAINING < 50% of TY 2005 for a Next Future Tax Year

GVDTF Counties with gas val returning to 50% or more of TY 2005 value -- No Distribution

20% of Trust Account Distributed to Each County by Jan 15 of Next Tax Year

nated diagnostic-related groupings, procedures or codes;

(2) not more than 20% of hospital provider assessment revenues shall be disbursed to providers who are persons licensed to practice medicine and surgery or dentistry through increased medicaid rates on designated procedures and codes; and

(3) not more than 3.2% of hospital provider assessment revenues shall be used to fund graduate medical education.

(b) Of the proceeds of the health maintenance organization assessment credited to the fund:

(1) Not less than 53% of health maintenance organization assessment revenues shall be disbursed to health maintenance organizations that have a contract with the department through increased medicaid rates;

(2) not more than 30% of health maintenance organization assessment revenues shall be disbursed to fund medicaid eligible health care clinics, dental care expansion for indigent health care clinics or graduate medical education;

(3) not more than 17% of health maintenance organization assessment revenues shall be disbursed to pharmacy providers through increased medicaid rates.

Sec. 14. There is hereby established the health care access improvement advisory panel for the purposes of administering and selecting the disbursements described in section 13, and amendments thereto. The panel shall be appointed as follows: Three members appointed by the Kansas hospital association, two members appointed by the secretary of social and rehabilitation services, two members appointed by the Kansas medical society, one member appointed by each health maintenance organization that has a medicaid managed care contract with the department of social and rehabilitation services, one member appointed by the Kansas pharmacy association, and one member appointed by the governor. The panel shall make an annual report to the legislature regarding the collection and distribution of all funds received and distributed by this act.

Sec. 15. The department of social and rehabilitation services shall not agree to any federal medicaid waiver where the federal government, as a condition of granting the waiver, requires the state of Kansas to agree to any limit on the normal federal cost share in the medicaid program where the state expenditures are not comparably restricted.

Sec. 16. The secretary of social and rehabilitation services may adopt rules and regulations necessary to implement this act.

Sec. 17. This act shall take effect and be in force from and after its publication in the Kansas register.

PROPOSED AMENDMENTS TO HB 2938
For Consideration by Committee on Approp

,

, increased medicaid rates on designated procedures and codes for providers who are persons licensed to practice dentistry, or home and community-based services

one member appointed by the Kansas association for the medically underserved,

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HOUSE BILL No. 2938

By Committee on Appropriations

3-16

AN ACT concerning social welfare; establishing the health care access improvement program; state medicaid plan; hospitals and health maintenance organizations.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act, the following have the meanings respectively ascribed thereto, unless the context requires otherwise:

(a) "Department" means the department of social and rehabilitation services.

(b) "Fund" means the health care access improvement fund.

(c) "Health maintenance organization" has the meaning provided in K.S.A. 40-3202, and amendments thereto.

(d) "Hospital" has the meaning provided in K.S.A. 65-425, and amendments thereto.

(e) "Hospital provider" means a person licensed by the department of health and environment to operate, conduct or maintain a hospital, regardless of whether the person is a federal medicaid provider.

(f) "Pharmacy provider" means an area, premises or other site where drugs are offered for sale, where there are pharmacists, as defined in K.S.A. 65-1626, and amendments thereto, and where prescriptions, as defined in K.S.A. 65-1626, and amendments thereto, are compounded and dispensed.

Sec. 2. Subject to the provisions of section 3, and amendments thereto, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to 1.83% of each hospital's net inpatient operating revenue for ~~state~~ fiscal year 2001.

Replace the hospital's

In the event a hospital does not have a complete 12 month 2001 fiscal year, the assessment for that hospital shall be $200,000.

Sec. 3. (a) A hospital provider that is a state agency, a state educational institution, as defined in K.S.A. 76-711, and amendments thereto, or a critical access hospital, as defined in K.S.A. 65-468, and amendments thereto, is exempt from the assessment imposed by section 2, and amendments thereto.

(b) A hospital operated by the department in the course of performing its mental health or developmental disabilities functions is exempt from the assessment imposed by section 2, and amendments thereto.

(c) Nothing in this act shall be construed to authorize any home rule

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unit or other unit of local government to license for revenue or impose a tax or assessment upon hospital providers or a tax or assessment measured by the income or earnings of a hospital provider.

Sec. 4. (a) The assessment imposed by section 2, and amendments thereto, for any state fiscal year to which this statute applies shall be due and payable in equal ~~quarterly~~ installments on, or on the state business day nearest to, July 19, ~~October 19~~, January 18 ~~and April 19~~. No installment payment of an assessment under this act shall be due and payable, however, until after:

and

(1) The hospital provider receives written notice from the department that the payment methodologies to hospitals required under this act have been approved by the centers for medicare and medicaid services of the United States department of health and human services and the state plan amendment for the assessment imposed by section 2, and amendments thereto, has been granted by the centers for medicare and medicaid services of the United States department of health and human services; and

(2) ~~the hospital has received the payments required to be paid to it under this act.~~

Replace

the hospital has received payments for two quarters after the effective date of the payment methodology approved by the centers for medicare and medicaid services.

(b) The department is authorized to establish delayed payment schedules for hospital providers that are unable to make installment payments when due under this section due to financial difficulties, as determined by the department.

(c) If a hospital provider fails to pay the full amount of an installment when due, including any extensions of time for delayed payment granted under this section, there shall be added to the assessment imposed by section 2, and amendments thereto, unless waived by the department for reasonable cause, a penalty assessment equal to the lesser of:

(1) An amount equal to 5% of the installment amount not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter; or

(2) an amount equal to 100% of the installment amount not paid on or before the due date.

For purposes of this subsection (c), payments shall be credited first to unpaid installment amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

Sec. 5. (a) After December 31 of each year, except as otherwise provided in this subsection, and on or before March 31 of the succeeding year, the department shall send a notice of assessment to every hospital provider subject to assessment under this act.

(b) The hospital provider notice of assessment shall notify the hospital provider of its assessment for the state fiscal year commencing on the next July 1.

(c) If a hospital provider operates, conducts or maintains more than one licensed hospital in the state, the hospital provider shall pay the assessment for each hospital separately.

(d) Notwithstanding any other provision in this act, in the case of a person who ceases to operate, conduct or maintain a hospital in respect of which the person is subject to assessment in section 2, and amendments thereto, as a hospital provider, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under section 2, and amendments thereto, by a fraction, the numerator of which is the number of the days during the year during which the provider operates, conducts or maintains a hospital and the denominator of which is 365. Immediately upon ceasing to operate, conduct or maintain a hospital, the person shall pay the adjusted assessment for that state fiscal year, to the extent not previously paid.

(e) Notwithstanding any other provision in this act, a person who commences operating, conducting or maintaining a hospital shall pay the assessment computed under section 2, and amendments thereto, in installments on the due dates stated in the notice and on the regular installment due dates for the state fiscal year occurring after the due dates of the initial notice.

Sec. 6. (a) The assessment imposed by section 2, and amendments thereto, shall not take effect or shall cease to be imposed and any moneys remaining in the fund shall be refunded to hospital providers in proportion to the amounts paid by such hospital providers if the payments to hospitals required under section 13, and amendments thereto, are changed or are not eligible for federal matching funds under title XIX or XXI of the federal social security act.

(b) The assessment imposed by section 2, and amendments thereto, shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under title XIX of the federal social security act. Moneys in the health care access improvement fund derived from assessments imposed prior to such determination shall be disbursed in accordance with section 13, and amendments thereto, to the extent that federal matching is not reduced due to the impermissibility of the assessments and any remaining moneys shall be refunded to hospital providers and health maintenance organizations in proportion to the amounts paid by them.

Sec. 7. The department shall assess each health maintenance organization that has a medicaid managed care contract awarded by the state and administered by the department an assessment fee that equals 5.9% of non-medicare premiums collected by that health maintenance organization. The assessment shall be collected on a quarterly basis and calculated by reference to information contained in the health maintenance

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organization's statement filings for the previous state fiscal year.

Sec. 8. (a) The assessment imposed by section 7, and amendments thereto, for any state fiscal year to which this statute applies shall be due and payable in equal ~~quarterly~~ installments on, or on the state business day nearest to, July 19, ~~October 19~~, January 18 ~~and April 19~~. No installment payment of an assessment under this act shall be due and payable, however, until after:

(1) The health maintenance organization receives written notice from the department that the payment methodologies to ~~hospitals~~ required under this act have been approved by the centers for medicare and medicaid services of the United States department of health and human services and the state plan amendment for the assessment imposed by section 7, and amendments thereto, has been granted by the centers for medicare and medicaid services of the United States department of health and human services; and

(2) ~~the health maintenance organization has received the payments required to be paid to it under this act.~~

(b) The department is authorized to establish delayed payment schedules for health maintenance organizations that are unable to make installment payments when due under this section due to financial difficulties, as determined by the department.

(c) If a health maintenance organization fails to pay the full amount of an installment when due, including any extensions of time for delayed payment granted under this section, there shall be added to the assessment imposed by section 7, and amendments thereto, unless waived by the department for reasonable cause, a penalty assessment equal to the lesser of:

(1) An amount equal to 5% of the installment amount not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter; or

(2) an amount equal to 100% of the installment amount not paid on or before the due date.

For purposes of this subsection (c), payments shall be credited first to unpaid installment amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

Sec. 9. (a) After December 31 of each year, except as otherwise provided in this subsection, and on or before March 31 of the succeeding year, the department shall send a notice of assessment to every health maintenance organization subject to assessment under this act.

(b) The health maintenance organization notice of assessment shall notify the health maintenance organization of its assessment for the state fiscal year commencing on the next July 1.

(c) If a health maintenance organization operates, conducts or main-

and

health maintenance organizations

Replace

the health maintenance organization has received payments for two quarters after the effective date of the payment methodology approved by the centers for medicare and medicaid services.

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tains more than one health maintenance organization in the state, the health maintenance organization shall pay the assessment for each health maintenance organization separately.

(d) Notwithstanding any other provision in this act, in the case of a person who ceases to operate, conduct or maintain a health maintenance organization in respect of which the person is subject to assessment in section 7, and amendments thereto, as a health maintenance organization, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under section 7, and amendments thereto, by a fraction, the numerator of which is the number of days during the year during which the health maintenance organization operates, conducts or maintains a health maintenance organization and the denominator of which is 365. Immediately upon ceasing to operate, conduct or maintain a health maintenance organization, the person shall pay the adjusted assessment for the state fiscal year, to the extent not previously paid.

(e) Notwithstanding any other provision in this act, a person who commences operating, conducting or maintaining a health maintenance organization shall pay the assessment computed under section 7, and amendments thereto, in installments on the due dates stated in the notice and on the regular installment due dates for the state fiscal year occurring after the due dates of the initial notice.

Sec. 10. (a) The assessment imposed by section 7, and amendments thereto, shall not take effect or shall cease to be imposed and any moneys remaining in the fund shall be refunded to health maintenance organizations in proportion to the amounts paid by such health maintenance organizations if the payments to health maintenance organizations required under section 9, and amendments thereto, are changed or are not eligible for federal matching funds under title XIX or XXI of the federal social security act.

(b) The assessment imposed by section 7, and amendments thereto, shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under title XIX of the federal social security act. Moneys in the health care access improvement fund derived from assessments imposed prior thereto shall be disbursed in accordance with section 13, and amendments thereto, to the extent that federal matching is not reduced due to the impermissibility of the assessments and any remaining moneys shall be refunded to health maintenance organizations in proportion to the amounts paid by such health maintenance organizations.

Sec. 11. To the extent practicable, the department shall administer and enforce this act and collect the assessments, interest and penalty assessments imposed under this act using procedures generally employed

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the administration of the department's other powers, duties and ctions.

Sec. 12. (a) There is hereby created in the state treasury the health care access improvement fund, which shall be administered by the secretary of social and rehabilitation services. All expenditures from the health care access improvement fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of social and rehabilitation services or the secretary's designee.

(b) The fund shall not be used to replace any moneys appropriated by the legislature for the department's medicaid program.

(c) The fund is created for the purpose of receiving moneys in accordance with this act and disbursing moneys only for the purposes of improving health care delivery and related health activities as specified and provided by section 13, and amendments thereto, notwithstanding any other provision of law.

(d) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the health care access improvement fund interest earnings based on:

(1) The average daily balance of moneys in the health care access improvement fund for the preceding month; and

(2) the net earnings rate of the pooled money investment portfolio for the preceding month.

(e) The fund shall consist of the following:

(1) All moneys collected or received by the department from the hospital provider assessment and the health maintenance organization assessment imposed by this act;

~~(2) all federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;~~ strike

(3) any interest or penalty levied in conjunction with the administration of this act; and

(4) all other moneys received for the fund from any other source.

Sec. 13. The proceeds of the hospital provider assessment imposed by section 2, and amendments thereto, and the proceeds of the health maintenance organization assessment imposed by section 7, and amendments thereto, shall be disbursed for the following purposes and in accordance with and subject to the following:

(a) Of the proceeds of the hospital provider assessment credited to the fund:

(1) Not less than 80% of hospital provider assessment revenues shall be disbursed to hospital providers through a combination of medicaid access improvement payments and increased medicaid rates on desig-

renumber accordingly

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nated diagnostic-related groupings, procedures or codes;

(2) not more than 20% of hospital provider assessment revenues shall be disbursed to providers who are persons licensed to practice medicine and surgery or dentistry through increased medicaid rates on designated procedures and codes; and

(3) not more than 3.2% of hospital provider assessment revenues shall be used to fund graduate medical education.

(b) Of the proceeds of the health maintenance organization assessment credited to the fund:

(1) Not less than 53% of health maintenance organization assessment revenues shall be disbursed to health maintenance organizations that have a contract with the department through increased medicaid rates;

(2) not more than 30% of health maintenance organization assessment revenues shall be disbursed to fund medicaid eligible ~~health care clinics, dental care expansion for indigent health care clinics or graduate medical education;~~ services, activities to increase access to dental care, and primary care safety net clinics;

(3) not more than 17% of health maintenance organization assessment revenues shall be disbursed to pharmacy providers through increased medicaid rates.

Sec. 14. There is hereby established the health care access improvement advisory panel for the purposes of administering and selecting the disbursements described in section 13, and amendments thereto. The panel shall be appointed as follows: Three members appointed by the Kansas hospital association, two members appointed by the secretary of social and rehabilitation services, two members appointed by the Kansas medical society, one member appointed by each health maintenance organization that has a medicaid managed care contract with the department of social and rehabilitation services, one member appointed by the Kansas pharmacy association, and one member appointed by the governor. The panel shall make an annual report to the legislature regarding the collection and distribution of all funds received and distributed by this act.

Sec. 15. The department of social and rehabilitation services shall not agree to any federal medicaid waiver where the federal government, as a condition of granting the waiver, requires the state of Kansas to agree to any limit on the normal federal cost share in the medicaid program where the state expenditures are not comparably restricted.

Sec. 16. The secretary of social and rehabilitation services may adopt rules and regulations necessary to implement this act.

Sec. 17. This act shall take effect and be in force from and after its publication in the Kansas register.

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AGRICULTURAL AND NATURAL RESOURCES BUDGET COMMITTEE REPORT ON SB 527

Brief

SB 527 would create the Water Supply Storage Assurance Fund and the Local Water Project Match Fund administered by the Kansas Water Office. The bill also specifies the uses of each fund.

Background

The Assistant Director of the Kansas Water Office testified in support of the bill. The two funds have been authorized by appropriations provisos for several years. The Water Supply Storage Assurance Fund was statutory until its inadvertent abolishment in 1998.

The fiscal note states that the bill would have a negligible fiscal effect on the Kansas Water Office.

Proposed Amendment to Senate Bill No. 527

The Committee on **Appropriations** recommends **SB 527** be amended on page 2, following line 35, by inserting the following:

"Sec. 3. K.S.A. 2003 Supp. 74-2622 is hereby amended to read as follows: 74-2622. (a) There is hereby established within and as a part of the Kansas water office the Kansas water authority. The authority shall be composed of 23 members of whom 13 shall be appointed as follows: (1) One member shall be appointed by the governor, subject to confirmation by the senate as provided in K.S.A. 75-4315b, and amendments thereto. Except as provided by K.S.A. 46-2601, and amendments thereto, such person shall not exercise any power, duty or function as a member or chairperson of the water authority until confirmed by the senate. Such member shall serve at the pleasure of the governor and shall be the chairperson of the authority; (2) except as provided by subsection (b), 10 members shall be appointed by the governor for terms of four years. Of the members appointed under this provision one shall be a representative of large municipal water users, one shall be representative of small municipal water users, one shall be a board member of a western Kansas groundwater management district, one shall be a board member of a central Kansas groundwater management district, one shall be a member of the Kansas association of conservation districts, one shall be representative of industrial water users, one shall be a member of the state association of watershed districts, one shall have a demonstrated background and interest in water use conservation and environmental issues, and two shall be representative of the general public. The member who is representative of large municipal water users shall be appointed from three nominations submitted by the league of Kansas municipalities. The member who is representative of small municipal water users shall be appointed from three nominations submitted by the Kansas rural water district's association. The member who is representative of a western Kansas groundwater

management district shall be appointed from three nominations submitted by the presidents of the groundwater management district boards No. 1, 3 and 4. The member who is representative of a central Kansas groundwater management district shall be appointed from three nominations submitted by the presidents of the groundwater management district boards No. 2 and 5. The member who is representative of industrial water users shall be appointed from three nominations submitted by the Kansas association of commerce and industry. The member who is representative of the state association of watershed districts shall be appointed from three nominations submitted by the state association of watershed districts. The member who is representative of the Kansas association of conservation districts shall be appointed from three nominations submitted by the state association of conservation districts. If the governor cannot make an appointment from the original nominations, the nominating authority shall be so advised and, within 30 days thereafter, shall submit three new nominations. Members appointed by the governor shall be selected with special reference to training and experience with respect to the functions of the Kansas water authority, and no more than six of such members shall belong to the same political party; (3) one member shall be appointed by the president of the senate for a term of two years; and (4) one member shall be appointed by the speaker of the house of representatives for a term of two years. The state geologist, the chief engineer of the division of water resources of the state board of agriculture, the director of the division of environment of the department of health and environment, the chairperson of the state corporation commission, the secretary of commerce, the director of the Kansas water office, the secretary of wildlife and parks, the administrative officer of the state conservation commission, the secretary of the state board of agriculture and the director of the agricultural experiment stations of Kansas state university of agriculture and applied science shall be nonvoting members ex officio of the authority.

Nonvoting members ex officio of the Kansas water authority shall not make motions, second motions or cast votes on any motion at any meeting of the authority, at any meeting of any subcommittee of the authority or at any meeting of any select, advisory or other committee appointed or otherwise established by the authority. The director of the Kansas water office shall serve as the secretary of the authority.

(b) A member appointed pursuant to subsection (a)(2) shall be appointed for a term expiring on January 15 of the fourth calendar year following appointment and until a successor is appointed and qualified.

(c) In the case of a vacancy in the appointed membership of the Kansas water authority, the vacancy shall be filled for the unexpired term by appointment in the same manner that the original appointment was made. Appointed members of the authority attending regular or special meetings thereof shall be paid compensation, subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223, and amendments thereto.

(d) The Kansas water authority shall:

(1) Consult with and be advisory to the governor, the legislature and the director of the Kansas water office.

(2) Review plans for the development, management and use of the water resources of the state by any state or local agency.

(3) Make a study of the laws of this state, other states and the federal government relating to conservation and development of water resources, appropriation of water for beneficial use, flood control, construction of levees, drainage, irrigation, soil conservation, watershed development, stream control, gauging of stream and stream pollution for the purpose of determining the necessity or advisability of the enactment of new or amendatory legislation in this state on such subjects.

(4) Make recommendations to other state agencies and political subdivisions of the state for the coordination of their activities relating to flood control, construction of levees, drainage, irrigation, soil conservation, watershed development,

stream control, gauging of stream, stream pollution and groundwater studies.

(5) Make recommendations to each regular session of the legislature and to the governor at such times as the authority considers advisable concerning necessary or advisable legislation relating to any of the matters or subjects which it is required by this act to study for the purpose of making recommendations to the legislature. All such recommendations to the legislature shall be in drafted bill form together with such explanatory information and data as the authority considers advisable.

(6) Approve, prior to submission to the legislature by the Kansas water office or its director, (A) any contract entered into pursuant to the state water plan storage act, (B) any amendments to the state water plan or the state water planning act and (C) any other legislation concerning water resources of the state.

(7) Approve, before they become effective, any policy changes proposed by the Kansas water office concerning the pricing of water for sale pursuant to the state water plan storage act.

(8) Approve, before it becomes effective, any agreement entered into with the federal government by the Kansas water office.

(9) Request any agency of the state, which shall have the duty upon that request, to submit its budget estimate pertaining to the state's water resources and any plans or programs related thereto and, upon the authority's receipt of such budget estimate, review and evaluate it and furnish recommendations relating thereto to the governor and the legislature.

(10) Approve, prior to adoption by the director of the Kansas water office, rules and regulations authorized by law to be adopted.

(11) Approve, prior to adoption by the director of the Kansas water office, guidelines for conservation plans and practices developed pursuant to subsection (c) of K.S.A. 74-2608,

and amendments thereto.

(e) The Kansas water authority may appoint citizens' advisory committees to study and advise on any subjects upon which the authority is required or authorized by this act to study or make recommendations.

(f) The provisions of the Kansas governmental operations accountability law apply to the Kansas water authority, and the authority is subject to audit, review and evaluation under such law.

Sec. 4. K.S.A. 2003 Supp. 74-2622 is hereby repealed.";

And by renumbering the remaining section accordingly;

In the title, in line 11, before the period, by inserting "; prescribing guidelines for the functions and authority of ex officio members of the Kansas water authority; amending K.S.A. 2003 Supp. 74-2622 and repealing the existing section."; and the bill be passed as amended.

_____Chairperson

Ch s in State Use Law agreed upon by the vendors, Universities, Dept. of Administration and USDs. Comments are using HB 2688 as introduced as basis, unless otherwise noted.

- Criteria for eligibility same as in original HB 2688. ("Qualified Vendors")
- Remove "offered for sale" language in current law and in bill.
- Mechanism for products and pricing remains with the Director of Purchasing.
- Shorten definition of "Unified School District" so as not to include PTAs etc., but clarify purchasing coops are part of the law.
- Products and services approved after the publication of the catalog are eligible for the State Use Law. It is the responsibility of the vendor producing the product or service to notify the state agency and USDs of the new product.
- It is the responsibility of the vendors to distribute the catalog.
- Eliminate language about foundations, affiliated organizations etc.
- Waivers can be granted when it is shown that the qualified vendor can't furnish the product or service and that it is available from another commercial provider (as in HB 2688.)
- Waivers can be granted directly by the Vendor. If the vendor does not grant the waiver, agencies can appeal to the Dir. Of Purchasing. If vendors do not agree with the decision of the Dir. Of Purchasing, they can appeal to the new "State Use Law Committee" ('SULC')
- The SULC shall be comprised of six members:
  - Member to be appointed by the Director of Purchasing
  - Member to be appointed by the Regents/Universities
  - Member to be appointed by the USDs
  - Three members to be appointed by the Governor. Two of whom are knowledgeable of the training and employment needs of the blind and disabled and one who is a qualified vendor.
- SULC responsibilities
  - Deal with agency and USD non-compliance
  - Deal with waiver disputes
  - Review the State Use Law Program and issue a report addressing the following issues:
    - The pricing process used by the Dir. Of Purchasing for eligible products and services.
    - Product and service eligibility process used by the Dir. Of Purchasing for state use law products and services.
    - Enforcement for non-compliance.
    - Review of waivers granted by vendors and State Purchasing Director.
    - Application of the State Use law to purchasing cards.
    - Threshold dollar amount of purchase by state agency or Unified School District for State Use Law to apply.
    - Development of an electronic procurement system for the State Use Law system.
    - Any other issue identified by interested parties.
- The Director of Purchasing shall convene quarterly meetings with qualified ve Committee and agencies to discuss the State Use Law.

HOUSE APPROPRIATIONS

DATE 3-24-2004

ATTACHMENT 25

Balloon v. 5
March 23, 2004

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Session of 2004

HOUSE BILL No. 2688

By Committee on Appropriations

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AN ACT concerning state procurement; relating to state purchase of products by certain qualified vendors; amending K.S.A. 75-3317, 75-3319, 75-3321 and 75-3322 and K.S.A. 2003 Supp. 75-3320 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 75-3317 is hereby amended to read as follows: 75-3317. As used in K.S.A. 75-3317 through 75-3322, and amendments thereto, unless the context requires otherwise:

(a) "Director of purchases" means the director of purchases of the department of administration;

(b) ~~"Kansas industries for the blind division and rehabilitation services" means workshops and home industry projects for blind or other handicapped persons which are located in Kansas and which are supported, operated or supervised by the division of services for the blind or rehabilitation services of the department of social and rehabilitation services~~ *"qualified vendor" means a not-for-profit entity incorporated in the state of Kansas that:*

(1) Primarily employs the blind or disabled;

(2) is operated in the interest of and for the benefit of the blind or persons with other severe disabilities, or both;

(3) the net income of such entity shall not, in whole or any part, financially benefit any shareholder or other individual; and

(4) such qualified vendor's primary purpose shall be to provide employment for persons who are blind or have other severe disabilities;

(c) "state agency" means any state office or officer, department, board, commission, institution, bureau or any agency, division or any unit within an office, department, board, commission or other state authority;

(d) ~~"rehabilitation facility" means any community mental health center or community facility for the mentally retarded operating under K.S.A. 19-4001 *et seq.* and amendments thereto or nonprofit corporation contracting with a mental retardation governing board to provide services under K.S.A. 19-4001 *et seq.* and amendments thereto, which has registered with the secretary of social and rehabilitation services for the purposes of K.S.A. 75-3317 through 75-3322, and amendments thereto, and~~

~~shall also mean the Kansas foundation for the blind, Wichita, Kansas; center industries, inc., Wichita, Kansas, and, upon registration hereunder, any workshop or other facility for blind or other handicapped persons which is located in Kansas and which is certified to the United States department of labor and licensed by the secretary of social and rehabilitation services as a sheltered workshop under K.S.A. 75-3307b and amendments thereto.~~ *"Unified school district" means ~~any unified school district, board of education or any unit within a unified school district or board of education, including, but not limited to, school buildings, athletic facilities, maintenance facilities and administrative facilities, and any purchasing cooperative which includes one or more unified school districts, one or more board of education, or any affiliated not-for-profit support entity including, but not limited to, a parent teacher association or parent teacher organization;~~*

(e) "committee" means the state use law committee authorized pursuant to section 6, and amendments thereto.

Sec. 2. K.S.A. 75-3319 is ~~hereby amended~~ to read as follows: 75-3319. (a) The ~~director of purchases~~ *committee* shall determine fair market prices of products manufactured, processed and offered for sale and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, by ~~the Kansas industries for the blind division and rehabilitation services and by each rehabilitation facility~~ *qualified vendors*. All of the products and services shall be standard conforming. Those products and services offered for purchase by or for a state agency shall meet specifications required by the director of purchases. Those products *and services* offered for purchase by or for a unified school district shall meet specifications required by the board of education of the unified school district. The director of purchases shall revise the prices determined under this section from time to time in accordance with changing market conditions.

(b) Each ~~rehabilitation facility~~ *qualified vendor* shall cooperate with and shall provide the ~~director of purchases and the secretary of social and rehabilitation services~~ *committee* with all information necessary for the administration of K.S.A. 75-3317 through 75-3322, and amendments thereto.

(c) The provisions of K.S.A. 75-3317 through 75-3322, and amendments thereto, shall apply only to products manufactured or processed in Kansas or services provided ~~in Kansas by blind or other handicapped persons~~ *by a qualified vendor*.

(d) ~~The provisions of K.S.A. 75-3317 through 75-3322, and amendments thereto, shall not be construed to require a unified school district to purchase services offered by blind or other handicapped persons under this act.~~ *The committee shall maintain a registry of entities which meet the definition of qualified vendor, as defined by K.S.A. 75-3317, and*

Or any purchasing cooperative formed by one or more Unified school district.

Reinstate "director of purchases" – delete "*committee*"

"offered for sale" language deleted

The Director of Purchasing shall convene quarterly meetings with qualified vendors, the State Use Law Committee and agencies to discuss the State Use Law.

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amendments thereto.

Sec. 3. K.S.A. 2003 Supp. 75-3320 is hereby ~~amended~~ to read as follows: 75-3320. (a) The ~~secretary of social and rehabilitation services~~ *committee* shall furnish to the department of administration, and to each person or officer authorized to purchase materials, services and supplies for any state agency or unified school district, a list of products manufactured, processed and ~~offered for sale~~ and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, by ~~the Kansas industries for the blind division and rehabilitation services and by rehabilitation facilities~~ *qualified vendors*.

(b) ~~The list of products and services shall be certified by the director of purchases. The secretary of social and rehabilitation services shall amend such list from time to time in accordance with the recommendations of the director of purchases.~~

~~(c) The secretary of social and rehabilitation services may charge a reasonable publication fee to those rehabilitation facilities which advertise their products or services on such lists. The secretary of social and rehabilitation services shall remit all moneys received pursuant to this section to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the social welfare fund.~~ *Each qualified vendor shall submit to the committee a list of the products manufactured, processed and offered for sale and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto.*

(c) Each qualified vendor shall publish or cause to be published, a catalog of products manufactured, processed and offered for sale and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, by each such vendor. Such catalog shall be submitted to the committee and to the director of purchases who shall distribute such catalog to each state agency and unified school district.

(d) The products manufactured, processed and offered for sale and services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, by a qualified vendor shall not be required to be published in the catalog in order to be subject to the provisions of K.S.A. 75-3317 through 75-3322, and amendments thereto.

Sec. 4. K.S.A. 75-3321 is hereby ~~amended~~ to read as follows: 75-3321. *(a)* The director of purchases and any person or officer authorized to purchase materials and supplies for any state agency or unified school district or to purchase services for any state agency shall purchase, except as otherwise provided in this section, the products and services on the list certified by the director of purchases from ~~the Kansas industries for the blind division and rehabilitation services or from a rehabilitation facility~~

"qualified vendors"

"offered for sale" language deleted

The list of products and services shall be certified by the director of purchases.
(reinstating that language)

... to the Committee, the State Purchasing Director, State agencies and Unified School Districts . . .

"offered for sale" language deleted

Language deleted (catalog to be distributed by the qualified vendors)

(e) It shall be the responsibility of the qualified vendors to provide appropriate notice to State Agencies and Unified School Districts of the addition of any product or service provided by a qualified vendor after the publication of the catalog, provided the additional product or service has been approved by the State Use Law Committee.

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qualified vendors, when those products are to be procured by or for the state or unified school district or when those services are to be procured by or for the state. ~~Services offered for purchase are not required to be purchased by a unified school district.~~

~~*(b) Purchases made for a state agency by an affiliated organization, including, but not limited to, an endowment association, are subject to the provisions of this act and shall be deemed to be direct purchases by such state agency or unified school district.*~~

Sec. 5. K.S.A. 75-3322 is hereby amended to read as follows: 75-3322. *(a)* Whenever ~~the Kansas industries for the blind division and rehabilitation services and rehabilitation facilities~~ *qualified vendors* are unable to supply the products or services needed or are unable to meet delivery requirements on any order or requisition, *the state agency or unified school district may request* a written waiver ~~shall immediately be forwarded to the director of purchases or purchasing officer of the unified school district by the secretary of social and rehabilitation services or the secretary's designee and that~~ *Such* waiver shall relieve and exempt the state or unified school district purchasing authority from the mandatory provisions of K.S.A. 75-3317 to 75-3322, inclusive, and amendments thereto, in the case of the specific order, request or requisition.

(b) The committee may grant a waiver only when both of the following conditions are met:

(1) The qualified vendor cannot furnish the product or service within the period specified; and

(2) the product or service is available from commercial sources in the quantities needed and delivery will be significantly sooner than it will be available from the qualified vendor.

(c) The state agency or unified school district must provide the state use law committee sufficient evidence to indicate such conditions are met.

(d) The committee shall submit the written waiver to the appropriate qualified vendor.

(e) A waiver must be applied for each time a qualified vendor cannot meet delivery requirements for any individual purchase by a state agency, as prescribed by subsection (a) of this section.

New Sec. 6. (a) There is hereby established within the department of administration, the state use law committee, hereafter referred to as the committee, to facilitate the purchase of products and services provided by blind or disabled persons, which shall consist of 14 members.

(b) The state use law committee shall be composed of the following members:

(1) ~~One member~~ shall be the director of purchases ~~or the director's~~ designee.

(2) ~~One member~~ shall be the secretary of administration or the sec-

Language deleted

(f) Waivers may be granted directly by the qualified vendor

(g) If the qualified vendor does not grant the waiver, the State agency or Unified School District can appeal this decision to the State Purchasing Director. The qualified vendor may appeal the decision of the State Purchasing Director to the State Use Law Committee.

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retary's designee.

(3) Three members shall be representatives from private businesses who are knowledgeable of the needs and concerns of the blind and disabled in the state appointed by the governor.

(4) Three members shall be representatives from private businesses who are knowledgeable of the needs and concerns of the blind and disabled in the state appointed by the governor.

(5) One member shall be a person appointed by the speaker of the house of representatives.

(6) One member shall be a person appointed by the majority leader of the house of representatives.

(7) One member shall be a person appointed by the minority leader of the house of representatives.

(8) One member shall be a person appointed by the president of the senate.

(9) One member shall be a person appointed by the majority leader of the senate.

(10) One member shall be a person appointed by the minority leader of the senate.

(c) Such members shall serve for terms of two years, except that of the members first appointed, two members appointed pursuant to paragraph (3) of subsection (b) of this section, and two members appointed pursuant to paragraph (4) of subsection (b) of this section, as designated by the governor, shall serve terms of one year. Members appointed pursuant to paragraph (3) and (4) of subsection (b) of this section shall be eligible for reappointment. On July 1, of each year, the governor shall designate one of the gubernatorially appointed members to serve as a chairperson of the committee. Subsequent appointments shall be made as provided for original appointments for the unexpired terms.

(d) Members of the committee shall serve without compensation. Members of the committee attending meetings of the committee, or attending a subcommittee thereof authorized by such committee, shall be paid amounts provided in subsection (e) of K.S.A. 75-3223, and amendments thereto.

(e) The committee shall be responsible for carrying out the following functions in support of its mission to provide employment opportunities for persons who are blind or have other severe disabilities:

~~(1) To request from any state agency information as to product specification and service requirements in order to carry out its purpose.~~

(2) To meet as necessary to carry out its purposes.

~~(3) To request an annual report from each participating qualified vendor describing the volume of sales for each product or service sold under~~ the provisions of K.S.A. 75-3317 through 75-3322, and amendments

1. One member shall be appointed by the United School Superintendents
2. One member shall be appointed by the State Board of Regents.
3. One member shall be appointed by the State Director of Purchasing.
4. Two members shall be appointed by the Governor who are knowledgeable of the employment and training needs and concerns of the blind and disabled in Kansas.
5. One member shall be appointed by the Governor who is a qualified vendor.

Language deleted

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thereto.

(4) To prepare a report for the legislature and the governor annually.

(5) To distribute a publication that lists all supplies and services currently available from any qualified vendor. This list and any revisions shall be distributed to all purchasing agencies.

(6) To develop guidelines to be followed by qualifying agencies and unified school districts for participation under the provisions of K.S.A. 75-3317 through 75-3322, and amendments thereto. The guidelines shall be developed on or before six months after the effective date of this act and made available on a nondiscriminatory basis to all qualifying agencies.

(7) To review all bids submitted under the provisions of K.S.A. 75-3317 through 75-3322, and amendments thereto, and reject any bid for any purchase that is determined to be a substantially higher cost than the purchase would have cost had it been competitively bid.

(8) Establish rules, regulations and policies to assure effective implementation of this act, including appropriate rules and regulations relating to violations of K.S.A. 75-3317 through 75-3322, and amendments thereto.

(9) Publish, or cause to be published, a procurement list of products manufactured, processed and offered for sale and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, by qualified vendors and distribute this list to the department of administration, and to each person or officer authorized to purchase materials, services or supplies for any state agency or unified school district. Publish, or cause to be published, notice of of additions to the procurement list in the Kansas Register. Delete such products manufactured, processed and offered for sale and services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, which are no longer furnished by a qualified vendor or vendors.

(10) Approve fair market prices for items added to the procurement list and revise such prices in accordance with changing market conditions to assure that the prices established are reflective of the market. It shall be the responsibility of the qualified vendor to provide to the committee price comparisons and price data for products manufactured, processed and offered for sale and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto.

(11) Inform state agencies and unified school districts about the products manufactured, processed and offered for sale and services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, and the statutory mandate that items on the procurement list be purchased form qualified vendors, and encourage and assist state agencies and unified school districts to identify additional commodities and services that may be purchased from qualified nonprofit agencies. To the extent pos-

Duties of the Committee

(3) If anyone, including qualified vendors, becomes aware that State Agencies or Unified School Districts are not complying with this law, they may forward to the State Use Law Committee a report of such non-compliance.

(4) The State Use Law committee shall perform an evaluation of the report and make its own findings.

(5) These findings shall be forwarded to the Secretary of Administration for administrative action including enforcement of the State Use Law.

(6) The State Use Law Committee shall address the following issues and shall issue a report on these issues to qualified vendors, the Director of Purchasing, the Sec. Of Administration and the Board of Regents by January 1, 2005.

(a) The pricing process used by the Dir. Of Purchasing for eligible products and services.
(b) Product and service eligibility process used by the Dir. Of Purchasing for state use law products and services.
(c) Enforcement for non-compliance.
(d) Review of waivers granted by vendors and State Purchasing Director.
(e) Application of the State Use law to purchasing cards.
(f) Threshold dollar amount of purchase by state agency or Unified School District for State Use Law to apply.
(g) Development of an electronic procurement system for the State Use Law system.
(h) Any other issue identified by interested parties.

New section 6

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sible, monitor state agencies and unified school districts compliance with such requirements.

(12) Conduct a continuing study and evaluation of activities under K.S.A. 75-3317 through 75-3322, and amendments thereto, and section 6 through 9, and amendments thereto, for the purpose of assuring effective and efficient administration of K.S.A. 75-3317 through 75-3322, and amendments thereto and section 6 through 9, and amendments thereto. The committee may study, independently or in cooperation with other public or nonprofit private agencies, problems relating to:

(A) The employment of the blind or individuals with other severe disabilities, or both.

(B) The development and adaptation of production methods, which would enable a greater utilization of such individuals.

New Sec. 7. (a) The committee shall be responsible for approving fair market prices, and changes thereto, for products manufactured, processed and offered for sale and of services offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, on the procurement list. The committee shall approve an initial fair market price at the time a product manufactured, processed and offered for sale and a service offered under K.S.A. 75-3317 through 75-3322, and amendments thereto, is added to the procurement list. Such initial price shall be based on committee procedures, which shall permit negotiations between the contracting activity and the qualified vendor, which shall produce or provide the commodity or service to the state, assisted by the appropriate qualified vendor. If agreed to by the negotiating parties, such initial price may be developed using other methodologies specified in committee pricing procedures.

(b) Prices shall be revised in accordance with changing market conditions under committee procedures, which shall include negotiations between state agencies or unified school districts and producing qualified vendors, or the use of economic indices, changes in qualified vendors costs, or other methodologies permitted under these procedures.

(c) Recommendations for initial fair market prices, or changes thereto, shall be submitted jointly by state agencies or unified school districts and the qualified vendors. After review and analysis, the qualified vendors shall submit the recommended prices and methods by which prices shall be changed to the committee, along with the information required by committee pricing procedures to support each recommendation. The committee shall review the recommendations,revise the recommended prices where appropriate, and establish a fair market price, or change thereto, for each commodity or service, which is the subject of a recommendation.

New Sec. 8. (a) The committee shall maintain a procurement list which shall include the commodities and services which shall be procured

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by state departments and agencies under the provisions of K.S.A 75-3317 through 75-3322, and amendments thereto, and section 6 through 9, and amendments thereto, from the qualified vendors. Copies of the procurement list, together with information on procurement requirements and procedures, shall be available to state agencies or unified school districts upon request.

(b) Additions to and deletions from the procurement list shall be published in the Kansas Register after such addition or deletion, or both is approved by the committee.

Sec. 9. K.S.A. 75-3317, 75-3319, 75-3321 and 75-3322 and K.S.A. 2003 Supp. 75-3320 are hereby repealed.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

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