Approved: September 16, 2004 (by letter)
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Stephen Morris at 11:15 a.m. on March 24, 2004, in Room 123-S of the Capitol.

All members were present.

Committee staff present:
J. G. Scott, Chief Fiscal Analyst, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Susan Kannarr, Kansas Legislative Research Department
Amy Van House, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes
Jill Wolters, Senior Assistant, Revisor of Statutes
Judy Bromich, Administrative Analyst
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Tom Bell, Executive Vice President, Kansas Hospital Authority
Jerry Marquette, CEO, Coffeyville Regional Medical Center
Steven Scheer, Principal, Health Management Associates
Dr. Robert Day, Director, Governor's Office of Health Planning and Finance
Laura Howard, Deputy Secretary, Division of Health Care Policy, Kansas Department of Social and Rehabilitation Services
Jerry Slaughter, Executive Director, Kansas Medical Society
Karla Finnell, Kansas Association for the Medically Underserved
Debra Zehr, R.N., Vice President, Kansas Association of Homes and Services for the Aging

Others attending:
See Attached List.

Chairman Morris opened a public hearing on:

Establishment of a Provider Assessment Program

The Chairman welcomed the following conferees in support of the establishment of a provider assessment program:

Tom Bell, Executive Vice President, Kansas Hospital Association (Attachment 1). Mr. Bell explained that the Kansas Hospital Association feels that a provider assessment program could help the state solve the difficult problem of chronic underpayment of Medicaid providers. It would be the establishment of 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.

Jerry Marquette, CEO, Coffeyville Regional Medical Center (Attachment 2). Mr. Marquette explained that Coffeyville Regional is a large Medicaid provider. In 2003 they billed Medicaid nearly $7.8 million in total charges and received only $2.8 million in payments for the services. Mr. Marquette noted that this is why additional funds to increase Medicaid payments for hospitals and doctors need to be found.

Steve Scheer, Principal, Health Management Associates, whose practice specializes in Medicaid financing (Attachment 3). Mr. Scheer described the proposed hospital provider assessment program in his written testimony. He explained as state revenues have shrunk, hospitals and state governments across the country have turned to provider assessment programs as a means to increase Medicaid assessment rates. In his written testimony, Mr. Scheer recommended specific provisions of the legislation for consideration that would make this approach both work better for everyone and would be more universally acceptable among the hospital community.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE at 11:15 a.m. on March 24, 2004, in Room 123-S of the Capitol.

Dr. Robert M. Day, Ph.D., Director, Governor's Office of Health Planning and Finance (Attachment 4). **HB 2938** referred to in the written testimony did not apply regarding the Senate hearing on the subject of the hospital provider assessment program. Dr. Day expressed concern that not including an assessment on HMOs, which contract with the state to provide Medicaid services, is a missed opportunity. He further noted that the estimate of an assessment on the net revenues of the current HMO places the amount that could be used to draw additional federal match dollars at $9.5 million. Dr. Day urged the committee to consider adding an HMO assessment to additional dollars.

Laura Howard, Deputy Secretary, Kansas Department of Social and Rehabilitation Services (SRS) (Attachment 5). SRS supports the passage of provider assessment legislation that would enable SRS to provide long-needed rate increases for critical health care services and supports managed care. In her written testimony, Ms. Howard explained that if the legislation is passed, SRS would need 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 within CMS.

Jerry Slaughter, Executive Director, Kansas Medical Society (Attachment 6). Mr. Slaughter explained that the 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. He also noted that this assessment program would allow the state to begin to address the fee schedule in a comprehensive way for the first time in 30 years and urged favorable consideration of the program.

Karla Finnell, J.D., M.P.H., Kansas Association for the Medically Underserved (Attachment 7). Ms. Finnell expressed the concern that 280,000 Kansans do not have health insurance coverage. Delaying treatment, not filling a prescription and rationing medications all results in worsening of the condition, rendering it more expensive to treat. Ms. Finnell requested committee passage of the provider assessment bill.

Written testimony was submitted by Debra Zehr, RN, Vice President, Kansas Association of Homes & Services for the Aging (Attachment 8).

Committee questions and discussion followed.

Senator Adkins moved, with a second by Senator Schodorf, to recommend **Senate Substitute for HB 2912** which contains the provider assessment language. Committee discussion followed.

Senator Helgerson moved, with a second by Senator Downey, to amend the provider assessment language to add health maintenance organizations and recommend a **Senate Substitute for HB 2912**. Motion carried on a voice vote.

Senator Helgerson moved, with a second by Senator Schodorf, to recommend **Senate Substitute for HB 2912** favorable for passage as amended. Motion carried on a roll call vote.

Senator Kerr moved, with a second by Senator Helgerson, to direct the Chairman of Senate Ways and Means to send a letter to the Secretary of the Department of Social and Rehabilitation Services (SRS) to direct SRS to file two clearly separate plans regarding provider assessment regarding the amended portion tied together for CMS to consider. Motion carried on a voice vote.

Chairman Morris called the committee's attention to discussion of:

SB 539--Authority of certain state agencies to issue bonds to finance capital improvements for water-related infrastructure projects

Ken Grotewiel, Kansas Water Office, explained a balloon amendment to **SB 539** (Attachment 9). Committee discussion followed.

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE at 11:15 a.m. on March 24, 2004, in Room 123-S of the Capitol.

Senator Adkins moved, with a second by Senator Downey, the balloon amendment for **SB 539** and recommend a **Senate Substitute for SB 539**. Motion carried on a voice vote.

Senator Adkins moved, with a second by Senator Jackson, to report **Senate Substitute for SB 539** without recommendation as amended and request to have the bill re-referred back to Senate Ways and Means for an interim study. Motion carried on a roll call vote.

Chairman Morris called the committee's attention to discussion of:

HB 2582--Creating the horsethief reservoir benefit district

Senator Adkins moved, with a second by Senator Jackson, to recommend **HB 2582** favorable for passage. Motion carried on a voice vote.

The meeting adjourned at 12:30 p.m. The next meeting is scheduled for March 31, 2004.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE March 24, 2004

NAME	REPRESENTING
Mark Welsh	KS Dept. on Aging
Joe HARKINS	KS WATER OFFICE
David Pope	KS Dept of Agric.
SCOTT CARLSON	SCC
Mark Heim	SCC
Ken Grotewiel	KS Water Office
Julie Thomas	DOB
Mike Hayden	KDWP
Dennis Kasselman	First Guard Health Plan
Joy Hirsch	" "
~~First Guard~~ Mike Hutfles	First Guard Health Plan

Donald A. Wilson
President

To: **Senate Ways and Means Committee**

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

Re: **Provider Assessment Program**

Date: **March 24, 2004**

The Kansas Hospital Association appreciates the opportunity to comment regarding the establishment of a provider assessment program. As many of you know, this is the result of much discussion from the end of last session into this legislative session. We think such a program 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, we are talking about establishing 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.

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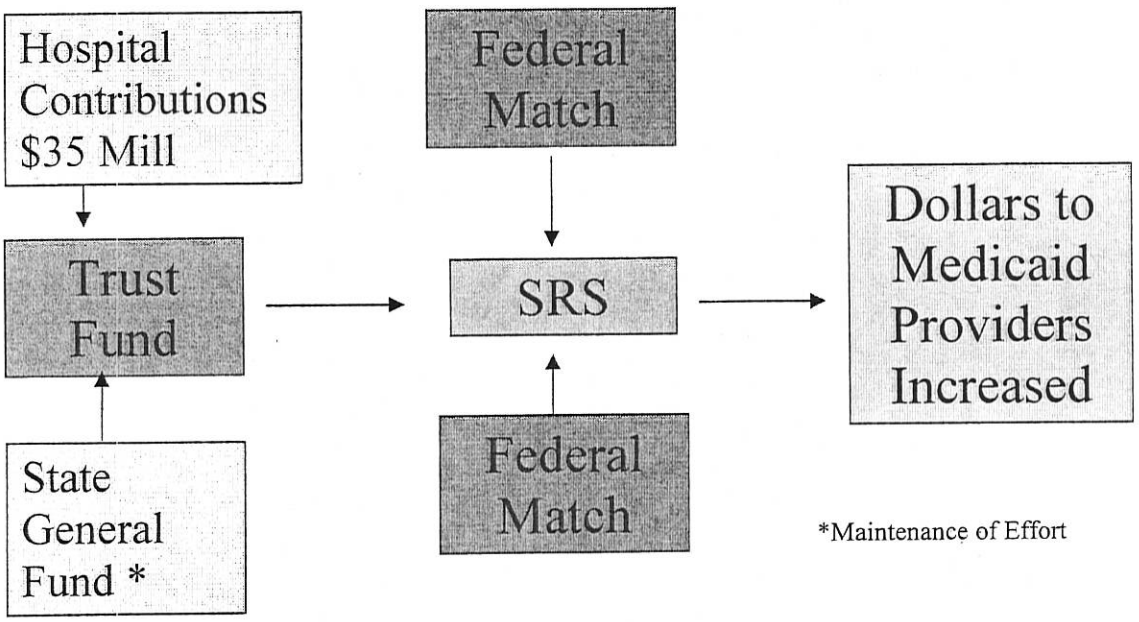
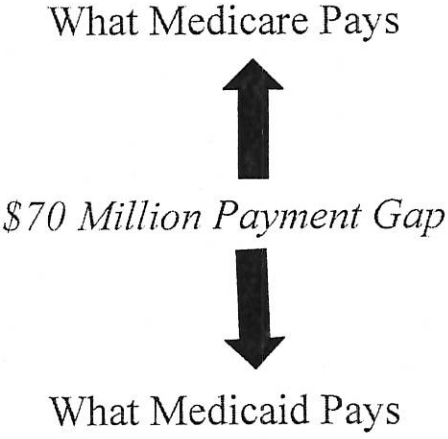
Senate Ways and Means
3-24-04
Attachment 1



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?



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: Senate Ways and Means Committee

FROM: Jerry Marquette
CEO, Coffeyville Regional Medical Center

RE: **MEDICAID HOSPITAL ASSESSMENT TESTIMONY**

As the Chief Executive Officer 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 the bill you are considering that would enhance Medicaid payments for hospitals and physicians. Let me begin by sharing my concerns over Medicaid reimbursement for Coffeyville Regional Medical Center and conclude by recapping the work the association has done 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 to augment the state's Medicaid payments. 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 and can work to 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 67337

Senate Ways and Means
3-24-04
Attachment 2

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Testimony
Senate Ways and Means Committee
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 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.

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 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

Senate Ways and Means
3-24-04
Attachment 3

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.

We 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.

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 Nursery, Burn, and Behavioral Medicine patients;
3. Increased Emergency Department payments; and
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. I have 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.

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 states 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 states 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.

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

Testimony
presented to
Senate Ways and Means

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

March 24, 2004
10:00AM

For additional information contact:
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Senate Ways and Means
3-24-04
Attachment 4

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

Senate Ways and Means
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 believe that not including an assessment on an HMO, which contracts with the state to provide Medicaid services, is a missed opportunity. Our estimate of an assessment on the net revenues of the current HMO places the amount that could be used to draw additional federal match dollars at $9.5 million. This money could be used to improve reimbursement to the HMO as well as improve reimbursement to pharmacists and provide needed additional funding to the safety net clinics. Kansas currently ranks at the bottom in Medicaid capitated rates. Over the last three years the Medicaid program has decreased payments to pharmacists in an attempt to control drug costs. Finally, there has been no State funding increase for

safety net clinics since the first $1.5 million was allocated to support these clinics. The total amount of additional funding from this assessment would be $14.25 million. We estimate the total amount raised by the hospital assessment would be $35 million based on a 1.83% assessment on net inpatient revenue of hospitals. These numbers were arrived at through consultation with Steve Scheer. The additional federal dollars made available from the hospital assessment is $52.5 million. Total all fund payments to hospitals would be $70 million leaving an additional $17.5 million to be used to improve physician reimbursement.

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 outpatient 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.

Finally, I would urge the committee to consider adding an HMO assessment to this amendment to capture additional dollars. Thank you for the opportunity to present to you today. I would be happy to answer any questions you may have.

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

Senate Ways and Means
March 24, 2004

Provider Assessments

Division of Health Care Policy
Laura Howard, Deputy Secretary
785.296.3271

For additional information contact:
Public and Governmental Services
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Senate Ways and Means
3-24-04
Attachment 5

Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

Senate Ways and Means
March 24, 2004

Provider Assessments

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

This proposed legislation 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.

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 this legislation 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 provider assessment legislation 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.

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

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To: Senate Ways and Means Committee

From: Jerry Slaughter
Executive Director

Date: March 24, 2004

Subject: Medicaid hospital assessment program

The Kansas Medical Society appreciates the opportunity to appear today to express our support of the proposed assessment program on Kansas hospitals 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

Senate Ways and Means
3-24-04
Attachment 6

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 program.

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

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Testimony of Karla Finnell, J.D., M.P.H
Kansas Association for the Medically Underserved
March 24, 2004
Senate Ways and Means Committee

KAMU, on behalf of the safety net primary care clinics and the many underserved Kansans, supports the provider assessment bill and expresses its most sincere appreciation of the work of Legislature, the Governor and the many providers who have collaborated to improve access to health care for the Medicaid population and other vulnerable populations. Increased Medicaid reimbursement to providers and hospitals is necessary to ensure access and the financially viability of the overall health care system.

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 is 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.

Today, 34 primary care safety net clinics reduce the burden of uncompensated care by providing access to basic primary health care services, including ancillary services such as lab and x-ray to 122,000 underserved Kansans, 92% of which are poor or nearly poor. All safety net clinics provide access to low cost or free pharmaceutical services through manufacturer's

Senate Ways and Means
3-24-04
Attachment 7

KAMU

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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 51% from AWP. 11 sites provide access to dental care. 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 the provider assessment bill, authorization to utilize funds to support the expansion of medical and dental services at primary care safety net clinics, and authority to appoint a member of the health care access improvement advisory panel established by that represents medically underserved community and the safety net primary care clinics.

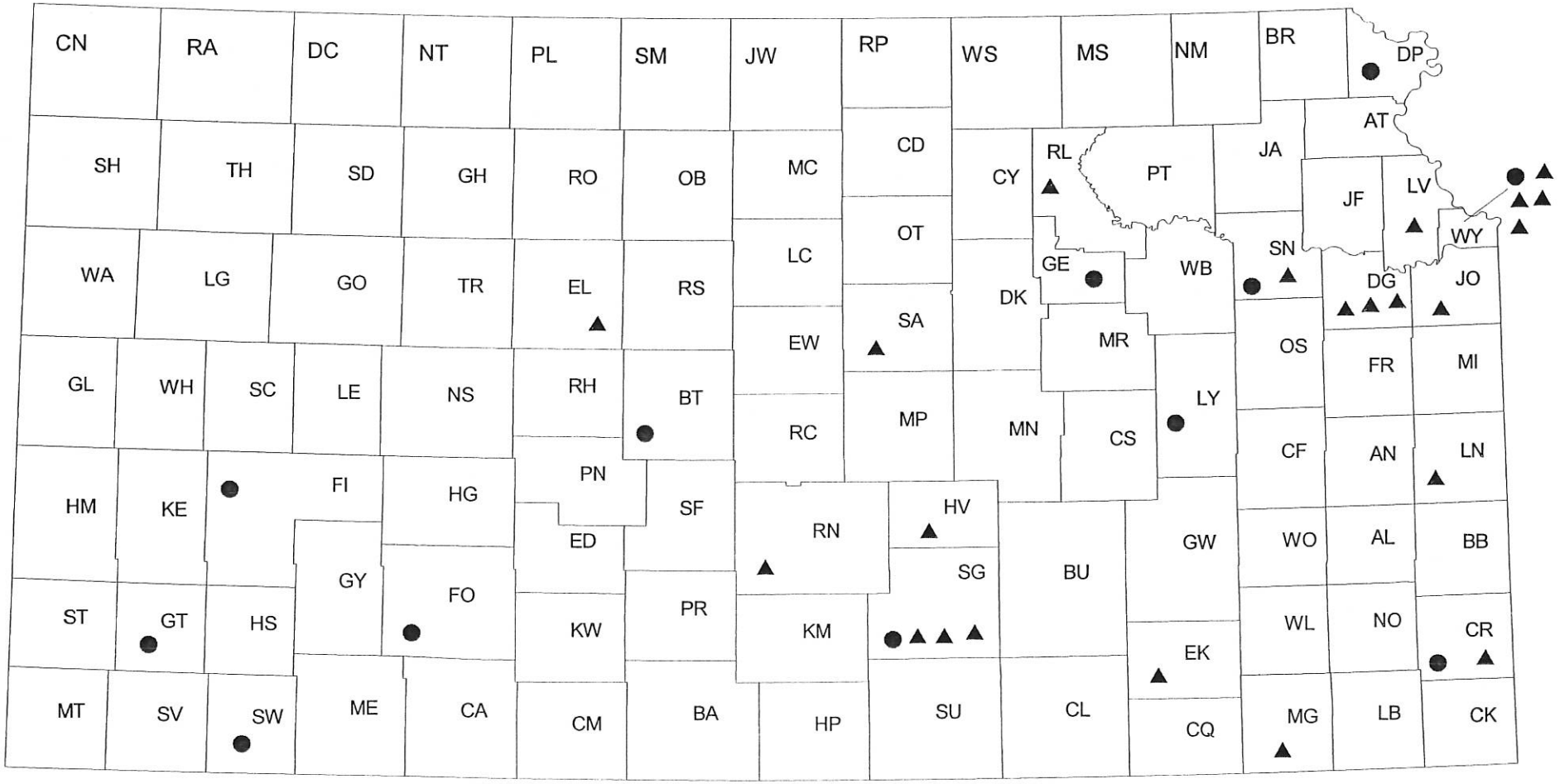
THANK YOU FOR YOUR CONSIDERATION!!

Karla Finnell

Kansas Health Centers - A Good Investment

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

Safety Net Clinics in Kansas



▲ Primary Care Clinics

● Community Health Centers or Satellite

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

HOSPITAL PROVIDER ASSESSMENT TESTIMONY

To: Steve Morris, Chair, and Members,
Senate Ways and Means Committee
Fr: Debra Zehr, RN, Vice President
Date: March 24, 2004

Thank you, Chairman Morris, 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 the concept of a hospital provider assessment for these reasons:

- It is the result of at least two years of careful consideration, analysis and consensus-building on the part of hospitals that will be directly impacted by the proposed legislation.
- 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 nursing homes to any legislation considered by this Legislature for these reasons:

- There is no consensus among concerned parties about the merits of a nursing home provider tax; in fact, there is sharp division among long-term care provider groups.
- 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.
- In the case of nursing homes, individual elderly citizens who pay for their own care would bear the direct brunt of such an assessment.
- 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.

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Senate Ways and Means
3-24-04
Attachment 8

SENATE BILL No. 539

By Committee on Ways and Means

2-20

AN ACT concerning issuance of bonds by certain state agencies to fund capital improvements for water-related infrastructure; amending K.S.A. 82a-1360, 82a-1361, 82a-1362, 82a-1363, 82a-1364, 82a-1367 and 82a-1368 and repealing the existing sections; also repealing K.S.A. 82a-1365.

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

Section 1. K.S.A. 82a-1360 is hereby amended to read as follows: 82a-1360. As used in K.S.A. 82a-1360 ~~to 82a-1368, inclusive~~ *through 82a-1364 and 82a-1366 through 82a-1368, and amendments thereto*, unless the context otherwise requires:

~~(a) "Director" means the director of the Kansas water office.~~

(a) "Agency head" means the director of the Kansas water office, the administrative officer ("executive director") of the state conservation commission, the secretary of agriculture or the secretary of wildlife and parks.

(b) "Capital improvements for water-related infrastructure projects" includes, but is not limited to:

(1) Purchase of reservoir storage in a structure which has been planned, authorized and constructed by the federal government or the state of Kansas and which contains waters for conservation storage water supply;

(2) purchase of federal or state reservoir storage for fish, wildlife and recreational purposes;

(3) purchase of ground water rights and overlying land rights from willing sellers for municipal, industrial, aquifer preservation and fish, wildlife and recreational purposes;

(4) construction of multipurpose small lake projects or addition of water supply capacity to proposed multipurpose small lake projects, including engineering services and land acquisition; and

(5) reservoir protection, restoration and enhancement for long-term water quality and quantity assurance.

(b) ~~(c)~~ "Revenue bonds" means bonds issued pursuant to this act and *the Kansas development finance authority act*, payable as to both principal and interest from: (1) The revenue derived from water supply contracts with water users who will derive benefits from the construction of a large

Senate Ways and Means
3-24-04
Attachment 9

reservoir project or from the purchase of space in existing reservoirs; (2) the revenue from participants in water assurance programs; (3) in the discretion of the ~~director~~ *head of a water-related agency*, the proceeds of any ~~grant-in-aid~~ *gift, loan or grant-in-aid which is made in furtherance of any of the authorized goals or purposes found in the state water planning act, K.S.A. 82a-901 et seq., and amendments thereto, and* which may be received from any source; ~~or~~ (4) *the state water plan fund created by K.S.A. 82a-951, and amendments thereto; or (5)* any one or more of the foregoing.

~~. (c) "Large reservoir project" means a structure that has been planned, authorized and constructed by the federal government or the state of Kansas which contains waters for conservation storage water supply.~~

~~(d)~~ *"Water-related agency" means the Kansas water office, the state conservation commission, the Kansas department of agriculture or the Kansas department of wildlife and parks.*

Sec. 2. K.S.A. 82a-1361 is hereby amended to read as follows: 82a-1361. ~~(a) The Kansas water office is~~ *Any water-related agency, or two or more water-related agencies jointly, are* hereby authorized *to request the Kansas development finance authority* to issue and sell revenue bonds for the purpose of paying all or part of the cost of ~~acquiring a site or sites, constructing, reconstructing, improving and expanding large reservoir projects or to finance the purchase of storage in existing reservoirs~~ *capital improvements for water-related infrastructure projects*. The revenue bonds may be issued from time to time and sold in amounts which the ~~director deems~~ *agency head or heads deem* necessary for such purposes. *No such bonds shall be issued unless the issuance is approved by the governor and specifically approved by appropriation or other act of the legislature, other than this act.*

~~(b)~~ Prior to the issuance of the revenue bonds~~, the director~~ *and pursuant to a request from agency head or heads, the Kansas development finance authority* shall adopt a resolution or resolutions in the name and on behalf of the ~~Kansas water office~~ *water-related agency or agencies*, which resolution or resolutions, unless otherwise provided therein, shall take effect immediately and:

(1) Determine an interest rate or rates to be paid on the principal of the revenue bonds not in excess of the maximum rate of interest prescribed by K.S.A. 10-1009, and amendments thereto;

(2) determine that the revenue bonds will be term or serial bonds or any combination thereof maturing not later than 40 years from the date of issuance;

(3) *(A)* make provision for charges in water supply contracts with water users who will derive benefits from the construction of a large

(a) Capital improvements for water-related infrastructure projects proposed to be funded by the issuance of revenue bonds may be recommended to the legislature and governor by one or more agency heads. Before any such revenue bonds shall be issued:

(1) the project shall have been reviewed under the water planning process and approved by the Kansas water authority as authorized in the state water resources planning act, K.S.A. 82a-901 et seq., and amendments thereto; and

(2) the issuance of such bonds shall have been approved by the governor and specifically approved by appropriation or other act of the legislature, other than this act.

9-2

reservoir project or from the purchase of space in existing reservoirs ~~and~~, *(B)* fix charges to participants in water assurance programs *and (C) make provision for charges to beneficiaries of other capital improvements for water-related infrastructure projects* in an amount necessary to assure the prompt payment of the principal of and interest on the revenue bonds as they become due, to maintain any required reserves and to provide for any deficits resulting from failure to receive sums payable to the ~~Kansas water office~~ *water-related agency or agencies* by such water users ~~or~~, participants in water assurance programs *or beneficiaries of capital improvements for water-related infrastructure projects,* or resulting from any other cause, and shall sell the revenue bonds in the manner provided by K.S.A. 10-106, and amendments thereto, at a price of not less than 90% of the par value thereof; and

(4) register the revenue bonds with the state treasurer.

~~(c)~~ *(d)* Prior to the issuance of the revenue bonds, the ~~director~~ *agency head or heads* may:

(1) Pledge to the payment of the principal and interest on the revenue bonds *for the purchase of large reservoir conservation storage capacity* the gross revenues derived from water supply contracts with water users from revenue from participants in water assurance programs or from any one or more or all of such sources;

(2) pledge to the payment of the principal of and interest on the revenue bonds the proceeds of any grant-in-aid, gift, donation, bequest or other such fund, or the income from any of such sources, obtained by the ~~Kansas water office~~ *water-related agency or agencies* directly or in trust;

(3) pledge to the payment of the principal of and interest on any revenue bonds issued ~~to acquire conservation water supply storage capacity in federal reservoirs~~ *for capital improvements for water-related infrastructure projects*, if moneys otherwise authorized to be pledged are insufficient, moneys appropriated from the following, in descending order of priority: The state water plan fund created by K.S.A. 82a-951, and amendments thereto, the state economic development initiatives fund created by K.S.A. 79-4804, and amendments thereto or the state general fund;

(4) create and maintain (A) revenue bond funds adequate to promptly pay both the principal of and interest on the revenue bonds when they become due and (B) a reasonable reserve fund; and

(5) covenant or contract with respect to any and all matters consistent with the authority granted herein necessary and convenient in the determination of the ~~director~~ *agency head or heads* to sell the revenue bonds and obtain the most favorable interest rate thereon, including, but not limited to, maturities, priority of liens, number of issuances, special funds

for security, redemption privileges, investments of the proceeds of the revenue bonds and any other funds pledged to the payment thereof or held as security therefor, security agreements, trust indentures, paying agencies, registration provisions and conversion privileges.

Sec. 3. K.S.A. 82a-1362 is hereby amended to read as follows: 82a-1362. (a) Revenue bonds issued hereunder, including refunding revenue bonds authorized hereunder, shall be special obligations of the Kansas ~~water office~~ *development finance authority* in accordance with their terms and shall not constitute an indebtedness of the state of Kansas or the ~~Kansas water office~~ *water-related agency or agencies*, nor shall they constitute indebtedness within the meaning of any constitutional or statutory provision limiting the incurring of indebtedness.

(b) All contracts, agreements and covenants contained in the resolution authorizing the issuance of revenue bonds shall be binding in all respects upon the ~~Kansas water office, its~~ *water-related agency or agencies and their* officials, agents, employees and successors. Such agreements, contracts and covenants shall be enforceable by appropriate legal action brought pursuant to the terms of the resolution authorizing the issuance of revenue bonds.

Sec. 4. K.S.A. 82a-1363 is hereby amended to read as follows: 82a-1363. The Kansas ~~water office~~ *development finance authority* may issue revenue bonds for the purpose of refunding revenue bonds issued hereunder pursuant to the terms and authority of K.S.A. ~~10-116a~~ *74-8912*, and amendments thereto.

Sec. 5. K.S.A. 82a-1364 is hereby amended to read as follows: 82a-1364. The proceeds derived from the sale of ~~all~~ *any* revenue bonds issued under this act shall be *divided, if necessary, according to the bond agreement and* deposited to the credit of the ~~Kansas water office~~ *appropriate water-related agency or agencies* in either an account administered pursuant to K.S.A. 75-4251 *et seq.*, and amendments thereto, or in an account arranged pursuant to K.S.A. 75-3799, and amendments thereto, and used solely for the purposes for which the revenue bonds are authorized. The ~~director is~~ *agency head or heads are* authorized to make all contracts and execute all instruments which, in the ~~director's~~ discretion *of the agency head or heads,* may be deemed necessary or advisable for the ~~purpose of~~ *either or both of the following purposes: (a)* Acquiring a site or sites, constructing, reconstructing, improving and expanding large reservoir projects or ~~to finance~~ *financing* the purchase of space in existing reservoirs and ~~to provide~~ *providing* for the manner of disbursement of the funds for such purposes*; or (b) funding capital improvements for other water-related infrastructure projects*. Other than contracts with federal, state or local governmental units, contracts authorized by this act shall be made pursuant to K.S.A. 75-3739 or 75-3799, and amendments thereto. Noth-

ing contained in this act shall be construed as placing in the state treasury any money collected under this act or requiring such action, and the legislature hereby declares that funds deposited under this section shall not be subject to the provisions of section 24 of article 2 of the Kansas constitution.

Sec. 6. K.S.A. 82a-1367 is hereby amended to read as follows: 82a-1367. (a) This act constitutes full and complete authority for the purposes set out in this act, and no procedure or proceedings other than those required by this act shall be necessary for the performance of the provisions thereof. The powers conferred by this act shall be in addition and supplemental to and not in substitution for, and the limitations imposed by this act shall not affect, the powers conferred on ~~the Kansas water office~~ *any water-related agency* by any other law.

(b) The provisions of this act are severable, and if any provision, section, subsection, sentence, clause or phrase of this act, including, but not limited to, the provisions relating to any of the sources of revenues for payment of bonds authorized pursuant to this act are for any reason held to be unconstitutional or otherwise invalid by any court of competent jurisdiction, such decision shall not affect the validity of the remaining portions of this act. The legislature hereby declares that it would have passed this act and each provision, section, subsection, sentence, clause or phrase thereof irrespective of the fact that any one or more of the same are declared invalid.

Sec. 7. K.S.A. 82a-1368 is hereby amended to read as follows: 82a-1368. Prior to the issuance of any revenue bonds under authority of this act and after the adoption of a resolution authorizing any revenue bonds under this act, the ~~director~~ *appropriate agency head or heads* shall cause to be published once in the Kansas register a notice to all persons interested that the Kansas ~~water office~~ *development finance authority* has determined to issue revenue bonds under authority of this act. The notice shall state the amount or maximum amount of revenue bonds to be issued pursuant to such resolution, together with a brief statement of the purposes for which the proceeds are to be used, and further, that unless an action to contest the legality of the proposed revenue bonds shall be filed in a court of law within 30 days from the date of such publication, the right to contest the legality of any revenue bonds issued in compliance with the proceedings taken by the ~~Kansas water office~~ *water-related agency or agencies* prior to the date of such publication and the right to contest the validity of the provisions of such proceedings shall cease to exist and no court shall thereafter have authority to inquire into such matters. After the expiration of the 30 days, no one shall have any right to commence an action contesting the validity of such revenue bonds or the provisions of such proceedings and all revenue bonds shall be conclusively presumed to be legal, and no court shall thereafter have authority to inquire into such matters.

Sec. 8. K.S.A. 82a-1360, 82a-1361, 82a-1362, 82a-1363, 82a-1364, 82a-1365, 82a-1367 and 82a-1368 are hereby repealed.

Sec. 9. This act shall take effect and be in force from and after its publication in the statute book.