Approved: April 29, 2005
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:30 P.M. on March 29, 2005 in Room 231-N of the Capitol.

Committee members absent: Senator David Haley- excused

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Ms. Terri Weber, Kansas Legislative Research Department
Mr. Jim Wilson, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Senator Jim Barnett
Dr. Robert St. Peter, President & CEO, Kansas Health Institute
Ms. Sandy Praeger, Insurance Commissioner
Mr. Jerry Slaughter, Executive Director, Kansas Medical Society
Mr. Thomas Bell, President, Kansas Hospital Association
Mr. Gary Daniels, Acting Secretary, Kansas Department of Social and Rehabilitation Services
Dr. Ira Stamm, Psychologist, Marriage & Family Therapy

Bookkeeping

Chairperson Wagle announced that she does not have vouchers here for the legislatures today, but Ms. Sue Krische has them in her office and is asking everyone who is working today to go to her office and sign the vouchers. Also, the Select Committee on Health Care appointed by the Speaker, not the full House Appropriations Committee, asked her to announce that they are having a hearing on similar legislation, which would be **HB2531**, tomorrow morning at 7 a. m. in Room 514-N.

Hearing on SB 306 - Kansas Health Policy Authority

The Chair announced the next order of business was the hearing on **SB306** and mentioned that she was having Research pass around the same information they received at the informational hearing on March 24, 2005.

Chairperson Wagle then called upon the first proponent to testify, Senator Jim Barnett, who indicated he had enclosed some attachments and comparisons between the state of Kansas and Oklahoma, explaining each and noting that the figures do not represent an in depth study of eligibility between the two states' Medicaid programs, but it does prove helpful to review this information and provide a comparison. A copy of his testimony and attachments are (Attachment 1) attached hereto and incorporated into the Minutes by reference.

The next conferee was Dr. Robert St. Peter, President and CEO, Kansas Health Institute (KHI) who stated that KHI had prepared a series of memos on the organization of Medicaid functions within state governments, based on specific requests from the legislature, with particular emphasis on those states utilizing a commission structure.. A copy of his testimony and KHI's memos are (Attachment 2) attached hereto and incorporated into the Minutes by reference.

The third proponent to testify was Ms. Sandy Praeger, Commissioner of Insurance, who stated that their department believes that through the efficiencies brought about by this coordination we can help to control health care expenditures and can promote improved quality of the services delivered. A copy of her testimony is (Attachment 3) attached hereto and incorporated into the Minutes by reference.

Mr. Jerry Slaughter, Executive Director, Kansas Medical Society (KMS), who stated that as KMS reads the bill the new authority will have two principal functions:

1) to reorganize and consolidate responsibility for the state's health care purchasing, particularly Medicaid, into a single agency, and thereby improve efficiency, reduce duplication, and enhance the responsiveness of the state as a business partner, and

2) to establish a process for developing and advancing a coordinated statewide health policy agenda that includes health promotion, improved quality, efficiency, and effectiveness of health care deliver.

Mr. Slaughter also mentioned that the committee may want to give some consideration to whether to structure and membership of the Authority are appropriate for its primary function, reorganizing Medicaid, as well as its health policy development function. A copy of his testimony is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

The sixth and last proponent conferee was Mr. Thomas Bell, President Kansas Hospital Association (KHA), who stated that KHA's focus has been the movement of the state's medical assistance program to this new office and this bill would allow more focus on the Medicaid program specifically. A copy of his testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Acting Secretary Gary Daniels, Social and rehabilitation Services (SRS), offered neutral testimony. He offered history of when he was invited by the Governor to participate in some healthcare reform initiative in Kansas and urged the Committee's passage of Sections 7 - 21 of the legislation because of the questions and concerns discussed earlier, he does not support the remainder of the legislation. A copy of his testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

Dr. Ira Stamm, Psychologist, marriage & Family therapy, also offered neutral testimony stating:

- all health care insurance in Kansas, including the commercial side, also needs to come under the jurisdiction of the Kansas health policy authority created by this bill;

- a truly integrated system would put all the functions of public and private health care insurance under the umbrella of the Kansas health policy authority.;

- a question for the bill to consider is whether or not the Kansas health policy authority should have the authority to set prices in the marketplace for health care services and products; and finally,

- he respectfully requested that two paragraphs, provided in his testimony, be included in this bill.

A copy of his testimony is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

Written testimony was provided by Mr. Lew Ebert, President and CEO, the Kansas Chamber who stated that measure the Kansas chamber advocates for will allow cost and quality information to be published in a useable format so that consumers become better consumers of their health care dollar. A copy of his testimony is (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

As there was no further testimony offered, Chairperson Wagle asked for questions or comments from the Committee. Senators Barnett, Schmidt, Brungardt, Journey and Wagle and Ms. Correll had questions for Acting Secretary Daniels, Mr. Wilson, Dr. Stamm, Mr. Slaughter , Ms. Correll and Senator Barnett including: Dr. Stamm's figures and do they have the same parameters, regarding Acting Secretary Daniels' figures analyzed between Kansas and Oklahoma cannot see in testimony and can he provide in writing CMS approval and deferrals; is this going to create a newer bureaucracy, personnel hiring; clarification - are we seeing a decrease of "FTE's" and a the way the bill is structured - are they transferring twice;; is Medicare Part D being delayed; talk of where ERO would be housed - where and how will these be and will it be handled; can you have someone out of state service on this board and what is the thought process on this; Mr. Slaughter's

response vs. expertise needed to reassemble, redesign and reform a state agency- how do we envision this happening; and , in broadest terms are you creating a whole new authority outside the Executive branch.

Chairperson Wagle asked Mr. Wilson if he had some technical changes.. Mr. Wilson stated he had passed out proposed technical amendments to **SB306** and **HB2531** printed on a **SB306** balloon and the additional sheet was a change that had come to his attention later. He went on to say, for the most part, the balloon makes changes to reference statutes, makes some parallel language changes so that it reads the same way in a couple of areas, makes specific exceptions of classified service language in current law that employees be required to be in a merit based performance system, corrects technical "goofs" and omissions. A copy of the balloon is (Attachment 9) attached hereto and incorporated into the Minutes as referenced.

Action on SB306

The Chair then asked if there was a move on the technical amendment? Senator Palmer made a motion to move the technical amendment and the additional technical amendment on page 9. It was seconded by Senator Jordan and the motion carried.

Regarding the technical cleanup, Senator Schmidt asked, when it says that the Kansas Health Policy would start this July, seven voting members appointments required by August1 subject to Senate confirmation, are we going to confirm when the Committee comes back in January? Mr. Wilson stated that generally there is a standing committee on confirmations and most likely will meet after appointments are made, and it is anticipated that sometime in August that this action be taken. Senator Schmidt asked how often the policy authority meet and are they paid positions is a requirement that they meet once a month for the first 12 months they are appointed and then, at least, quarterly thereafter and they are given expenses comparable to Board members.

A discussion with Senators Barnett and Wagle, Mr. Wilson and Ms. Correl regarding rules and regulations as shown on pages 24 and 25.

The Chair then asked the Committee their will on this technical cleanup? Senator Barnett make a motion to move the proposed amendment outlined by the Revisor, striking the words on page 25, line 15, "approved by the board." It was seconded by Senator Palmer and the motion carried.

Senator Barnett stated he would recommend for the consideration of the Committee that we move favorable and develop a substitute bill with the amendments adopted. Seconded by Senator Palmer and the motion carried.

Adjournment

As it was going on Senate time, the Chair adjourned the meeting. The time is 2:30 p.m.

The next meeting is on call of the Chair.

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SENATE HEALTH CARE STRATEGIES COMMITTEE

GUEST LIST

DATE: Tuesday, March 29, 2005

NAME	REPRESENTING
Tom Bruno	EB
Ron Hein	Hein Law Firm, Chartered
Shannon Jones	SILCK
Carol Foreman	DOA
Susan Kang	KDHE
Patrick Hurley	HRC
Andy Allison	KHI
Robert St. Peter	KHI
Jim McLean	KHI
Pat Hubbell	Pharma
Cheryl Dillard	Coventry Health Care
Rebecca Bailey	KMS
Jerry Slaughter	KMS
Jason Otto	Lt. Gov Ofc
Cynthia Smith	SCL Health System
Linda Lubensky	KS Home Care Assoc
Eva Stamm	SRS
John Peterson	Ks Govt Consulting
Barbara Belcher	Merck

SENATE HEALTH CARE STRATEGIES COMMITTEE

GUEST LIST

DATE: March 29, 2005

NAME	REPRESENTING
Sprd Kent	DOA
Sheli Sweeney	Assoc. of CMHCs
Laura Howard	SRS
Larry Pitman	KFMC
Chip Wheelen	Asn of Osteopathic Med.
Amy Campbell	Kansas Mental Health Coalition
Mary Ellen Conlee	Via Christi Health System
Paul Johnson	PACK
Kelly Lenz	Kansas Insurance Dept.
Sandy Praeger	Kansas Insurance Commissioner
Fred Lucky	Kansas Hospital Assn
Faith Loretto	Ks. Dept. of Administration
Elisa Rawls	intern KNASW
GARY DANIELS	SRS
Tom Bell	KHA
Dennis Kasselman	First Guard Health Plan
Doug Smith	Ks. Medical Center LLC

STATE OF KANSAS

JIM BARNETT
SENATOR, 17TH DISTRICT
CHASE, COFFEY, GREENWOOD
LYON, MARION, MORRIS, AND OSAGE
COUNTIES

COMMITTEE ASSIGNMENTS
CHAIR: PUBIC HEALTH AND WELFARE
MEMBER: FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND INSURANCE
GOVERNOR'S HEALTH CARE COST CONTAINMENT COMMISSION
HEALTH CARE STABILIZATION FUND

TOPEKA

SENATE CHAMBER

Senate Health Care Strategies Committee
Testimony : Re SB 306

March 29, 2005

Dear Madam Chairman and other distinguished members of the Senate Health Care Strategies Committee, thank you for the opportunity to speak in support of SB 306. Today, I will be speaking from my heart regarding the issue of healthcare in our state. As well, I will be enclosing some attachments and comparisons between the state of Kansas and Oklahoma.

When I studied to become a doctor, the United States spent 6.0% of its gross domestic product on healthcare. Today, our nation spends over15% with continued growth expected to a level of 16% by the year 2006 (Attachment A). This is not sustainable. Healthcare care has become unaffordable and unaccessible to too many Kansans and too many Americans. This is not acceptable.

With the assistance of the Kansas Health Institute, we have worked over the past two months to craft SB 306, developing the Kansas Health Policy Authority. A number of states were studied, including Oklahoma. Attachment B lists the total enrollment of Oklahoma Medicaid and Kansas Medicaid. You will note that there are 531,191 Oklahomans enrolled in Medicaid and 302,594 Kansans enrolled.

Attachment C represents the Oklahoma Healthcare Authority's 2004 annual report. You will note administration costs of $64,030,651 for a total budget of $2,717,791,984. Attachment D reflects the total budget for the Health Care Policy Division of Kansas SRS. This demonstrates an actual operations cost of $73,102,046 for fiscal year 2004 for a total budget of $2,052,801,984. This rivals the Oklahoma Health Care Authority, demonstrating that the Kansas SRS Divisions administrative costs exceed those of the Oklahoma Health Care Authority. Governor Sebelius has recommend an increase to $77 million in fiscal year 2006 for Kansas SRS operations expenses. Furthermore, Attachment E demonstrates the organizational chart distributed to the Senate Health Care Strategies Committee by Dr. Robert Day. This reflects the Governor's ERO recommendation and indicates that $62.2 million would be required within the Department of Administration excluding salaries, which would require another $8.2 million. Thus, the total for the ERO created division within the Department of Administration would be $70.4 million.

Senate Health Care Strategies Committee
Date: March 29, 2005
attachment 1

I would also like to reference the Kaiser's statehealthfacts.org Web site as noted below:

- Kansas: Total Medicaid enrollment, FY 2000: 263,400.
- Kansas: Total Medicaid spending per enrollee, FY 2000: $4,580.

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TOPEKA

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GOVERNOR'S HEALTH CARE COST CONTAINMENT COMMISSION
HEALTH CARE STABILIZATION FUND

- Oklahoma: Total Medicaid enrollment, FY 2000: 584,600.
- Oklahoma: Total Medicaid spending per enrollee, FY 2000: $2,540.
- U.S.: Total Medicaid spending per enrollee, FY 2000: $3,762.

Lastly, the Oklahoma Health Care Authority's Website estimates the average cost per Medicaid beneficiary will be $3,995 in FY 2005. Governor Sebelius's FY 2006 budget proposal lists an average cost per Medicaid beneficiary of $443.57 per month or an annual cost of $5,322 per recipient.

These figures do not represent an in depth study of eligibility between Oklahoma and Kansas Medicaid programs. However, it does prove helpful to review this information and provide a comparison.

SB 306 provides a bold and visionary opportunity for the people of Kansas to control costs and improve the quality of healthcare.

Senator Jim Barnett

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EXHIBIT 1
National Health Expenditures (NHE), Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1993–2014

Spending category	1993	1998	2002	2003	2004[a]	2005[a]	2006[a]	2014[a]
NHE (billions)	$888.1	$1,150.9	$1,559.0	$1,678.9	$1,804.7	$1,936.5	$2,077.5	$3,585.7
Health services and supplies	856.3	1,112.6	1,499.8	1,614.2	1,735.5	1,862.5	1,997.8	3,451.3
Personal health care	775.8	1,009.8	1,342.9	1,440.8	1,549.0	1,663.6	1,781.3	3,067.0
Hospital care	320.0	378.5	484.2	515.9	551.8	588.6	623.5	1,007.2
Professional services	280.7	375.7	503.0	542.0	581.2	623.6	667.4	1,161.3
Physician and clinical services	201.2	256.8	340.8	369.7	397.2	425.7	453.8	782.5
Other professional services	24.5	35.5	46.1	48.5	52.2	55.6	59.6	102.3
Dental services	38.9	53.2	70.9	74.3	79.1	84.1	90.0	146.9
Other personal health care	16.1	30.2	45.3	49.5	52.8	58.2	63.9	129.7
Nursing home and home health	87.6	123.1	143.1	150.8	160.6	170.9	181.9	290.5
Home health care[b]	21.9	33.6	36.5	40.0	45.2	50.0	54.8	95.9
Nursing home care[b]	65.7	89.5	106.6	110.8	115.4	121.0	127.1	194.6
Retail outlet sales of medical products	87.5	132.5	212.6	232.1	255.4	280.5	308.5	608.0
Prescription drugs	51.3	87.3	161.8	179.2	200.5	223.5	249.3	521.3
Durable medical equipment	12.8	16.9	19.6	20.4	21.2	21.7	22.4	31.6
Nondurable medical products	23.4	28.4	31.1	32.5	33.7	35.3	36.8	55.1
Government administration and net cost of private health insurance	53.3	64.9	105.7	119.7	128.2	135.4	147.3	252.9
Government public health activities	27.2	37.9	51.2	53.8	58.3	63.6	69.2	131.4
Investment	31.8	38.3	59.2	64.6	69.2	74.0	79.7	134.4
Research[c]	15.6	20.5	36.5	40.2	43.1	46.4	50.5	90.7
Construction	16.2	17.7	22.7	24.5	26.1	27.6	29.1	43.6
NHE per capita	$3,353.9	$4,097.9	$5,317.4	$5,670.5	$6,039.8	$6,423.1	$6,830.2	$11,045.8
Population (millions)	264.8	280.8	293.2	296.1	298.8	301.5	304.2	324.6
GDP, billions of dollars	$6,642.3	$8,747.0	$10,487.0	$11,004.0	$11,719.3	$12,375.5	$13,019.1	$19,179.9
Real NHE[d]	$1,009.4	$1,192.9	$1,497.6	$1,583.8	$1,665.8	$1,752.5	$1,843.2	$2,623.8
Chain-weighted GDP index	0.88	0.96	1.04	1.06	1.08	1.11	1.13	1.37
Personal health care deflator[e]	0.82	0.94	1.08	1.12	1.16	1.20	1.25	1.68
NHE as percent of GDP	13.4%	13.2%	14.9%	15.3%	15.4%	15.6%	16.0%	18.7%

SOURCES: Centers for Medicare and Medicaid Services, Office of the Actuary; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

NOTES: Numbers may not add to totals because of rounding. 1993 marks the beginning of the shift to managed care.

[a] Projected.

[b] Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and counted as hospital care.

[c] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

[d] Deflated using GDP chain-type price index (2000 = 100.0).

[e] Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indices specific to each of the remaining PHC components (2000 = 100.0).

B

MEDICAID AND SCHIP ENROLLMENT- –JANUARY 2005

OKLAHOMA MEDICAID		**KANSAS MEDICAID**	
Total Enrollment *	531,191	Total Enrollment*	302,594
SCHIP	54,739**	SCHIP	34,903
No state only funded program		MediKan	

*All regular Medicaid, including Home and Community Based waiver programs, SCHIP, and TB patients.

**Oklahoma expanded Medicaid eligibility to 185 percent of the poverty guidelines for all persons 18 and under. Title XXI funds are used to make up the difference between the mandated eligibility level for regular Medicaid and 185 percent of the federal poverty guidelines for those children and youth who are Title XXI eligible. The number shown is the number of children covered by Oklahoma Medicaid who are eligible for Title XXI funding.

Where are the Medicaid Dollars Going? (continued)

Figure 13 **Condensed Summary of OHCA Expenditures SFY2004**

As of June 2004 EXPENDITURES	SFY04 Budget YTD	SFY04 Actual YTD	% (Over)/ Under
ADMINISTRATION	**$ 64,030,651**	**$ 57,822,935**	**9.7%**
OHCA MEDICAID PROGRAMS			
Managed Care:			
***SoonerCare* Plus**	236,937,729	232,911,364	1.7%
SoonerCare* Choice	44,395,013	42,034,718	5.3%
Acute Fee-for-Service Payments:			
Hospital Services	374,779,840	384,210,619	(2.5)%
Behavioral Health	124,255,512	118,318,453	4.8%
Physicians & Other Providers	229,655,497	229,856,738	(0.1)%
Prescription Drugs	362,315,182	355,209,786	2.0%
Miscellaneous Medical Payments	6,485,356	6,731,296	(3.8)%
Other Payments:			
Nursing Facilities	286,460,702	287,584,888	(0.4)%
ICF/MR Private	33,258,964	31,751,308	4.5%
Medicare Buy-In	66,485,747	69,240,600	(4.1)%
Graduate Medical Education	3,514,861	3,938,044	(12.0)%
DMHSAS/OHCA State Share		6,123,022	0.0%
OTHER OHCA MEDICAL PROGRAMS	**$12,109,664**	**$12,164,872**	**(0.5)%**
TOTAL OHCA	**$1,844,684,718**	**$1,837,898,643**	**0.4%**
QUALITY OF CARE PAYMENTS: State funds are from the collected Quality of Care Fee.			
ADMINISTRATION - QUALITY OF CARE	**$ 664,383**	**$ 664,383**	**0.0%**
Nursing Home Rate Adjustment	160,789,516	160,789,516	0.0%
NET - ***SoonerRide***	467,520	467,520	0.0%
Personal Allowance Increase	3,893,460	3,893,460	0.0%
Coverage for DME and supplies	2,708,208	2,708,208	0.0%
Coverage of Qualified Medicare Beneficiaries	14,005,748	14,005,748	0.0%
ICF/MR Rate Adjustment	19,199,633	19,199,633	0.0%
Contract Services	14,800	14,800	0.0%
Total Quality of Care	**$ 201,743,268**	**$ 201,743,268**	**0.0%**
OTHER STATE AGENCY PROGRAMS: State funds are reimbursed from the receiving agency or entity.			
Miscellaneous and Non-Medicaid Programs	$ 20,280,885	$ 20,280,885	0.0%
Dept. of Human Services Medicaid (OKDHS)	461,290,425	461,290,425	0.0%
Office of Juvenile Affairs Medicaid (OJA)	8,514,055	8,514,055	0.0%
Dept. of Mental Health Medicaid (DMHSAS)‡	21,476,577	21,476,577	0.0%
Oklahoma State Dept. of Health (OSDH)‡	2,197,429	2,197,429	0.0%
Department of Education Medicaid (DOE)‡	5,798,048	5,798,048	0.0%
Hospital Upper Payment Limit	22,507,007	22,507,007	0.0%
Medical Education Payments	129,299,572	129,299,572	0.0%
Total Other State Agency Programs	**$ 671,363,998**	**$ 671,363,998**	**0.0%**
TOTAL ALL EXPENDITURES	**$2,717,791,984**	**$ 2,711,005,909**	**0.2%**

Source: OHCA Financial Service Division, August 2004. Unless stated otherwise expenditures are state and federal dollars combined.

* *SoonerCare Choice figures represent capitated payments only. Noncapitated services are not included in this amount.*

‡ *Figures shown for DMHSAS, OSDH and DOE represent the federal share only of Medicaid expenditures.*

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OHCA and Medicaid

From 1988 to 1992, the number of Oklahomans receiving Medicaid assistance increased by 47 percent, from 245,000 to 360,000. This escalating growth came with an associated cost increase from $580 million to a slightly more than $1 billion. At the same time, the defeat of the proposed Health Care Provider Tax effectively capped the amount of money available to the state for entitlement programs – thus placing unavoidable and serious pressures on the state's budget. These financial realities, accompanied by ever-increasing eligible populations, would have led to the financial collapse of the state Medicaid system if left unchecked.

An immediate attempt to curb the growth in 1992 resulted in reductions in rates and specific services available to Oklahoma's Medicaid population. Physicians and other practitioners saw a 5 percent reduction in their rates and adult beneficiaries saw limits placed on office visits and hospitalization. Further, the state was also forced to completely eliminate adult dental services.

House Bill 1573, the Oklahoma Health Care Authority Act of 1994, created the Authority as an executive agency with the mandate to:

- Purchase Medicaid benefits and state and education employees' health care benefits.
- Study all state-purchased and state-subsidized health care systems.
- Make recommendations and changes aimed at minimizing the financial burden on the state, while allowing the state to provide the most comprehensive health care possible.
- Become the designated single state Medicaid agency effective January 1, 1995.

As a result of recommendations from broad-based citizens committees, the Oklahoma Health Care Authority was established by the Legislature in 1993 through House Bill 1573. The Health Care Authority Act can be found in Oklahoma Statutes Title 63, Sec. 5004.

As we complete our ninth year managing the now $2.7 billion program, it is a long way from 1993 when the task force projected Medicaid would, if left unchecked, approach $4 billion by the year 2000. One-third of the $2.7 billion pays for nursing home quality initiatives, medical education and medical-related programs administered by other state agencies.

The Oklahoma Health Care Authority has also led the effort to supplement state dollars with available and appropriate federal dollars. OHCA's revenue maximization initiatives have supported programs at the Oklahoma Department of Human Services, Department of Mental Health and Substance Abuse Services, Oklahoma State Department of Health, Office of Juvenile Affairs, and the Department of Education, as well as Oklahoma University and Oklahoma State University medical schools and teaching hospitals.

OHCA does not want to miss an opportunity to maximize federal revenues, however, we must be cautious. OHCA has an obligation, as a sound fiscal manager, to ensure that all plans to maximize federal revenues are compliant with applicable laws and regulations and will not put the state in jeopardy of a future disallowance.

OHCA staff perform an array of critical functions necessary for program administration, such as providing funds to Medicaid contractors; developing Medicaid payment policies; managing programs to fight waste, fraud and abuse; maintaining the operating systems that support Medicaid payments; developing cost-effective health care purchasing approaches; monitoring contractor and provider performance; promoting and preserving beneficiary rights and protections; and disseminating information to the Oklahoma Legislature, congressional delegation, beneficiaries and the general public.

- Since its inception OHCA has increased federal revenue by more than $790 million, a 97 percent increase.
- OHCA interacts with federal and tribal governments, other state agencies, hundreds of contractors and providers of care in addition to beneficiaries and their families.
- OHCA employs more than 300 persons directly and provides funding for more than 750 eligibility workers employed by the Oklahoma Department of Human Services.

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	FY 2004 Actual	FY 2005 Gov. Estimate	FY 2006 Base Budget	FY 2006 Enhanc. Pkg.	FY 2006 Gov. Rec.
Expenditures by Object					
Salaries and Wages	9,202,287	9,114,349	9,363,772	--	9,833,632
Contractual Services	63,732,916	70,086,590	68,205,284	328,300	67,005,284
Commodities	129,281	162,619	162,619	--	162,619
Capital Outlay	37,562	--	--	--	--
Debt Service	--	--	--	--	--
Subtotal: State Operations	**$73,102,046**	**$79,363,558**	**$77,731,675**	**$328,300**	**$77,001,535**
Aid to Local Governments	10,072,649	8,326,850	8,326,850	--	8,326,850
Other Assistance	1,469,920,030	1,824,835,250	1,808,110,882	83,991,644	1,967,473,599
Subtotal: Operating Expenditures	**$1,553,094,725**	**$1,912,525,658**	**$1,894,169,407**	**$84,319,944**	**$2,052,801,984**
Capital Improvements	--	--	--	--	--
Total Reportable Expenditures	**$1,553,094,725**	**$1,912,525,658**	**$1,894,169,407**	**$84,319,944**	**$2,052,801,984**
Non-expense Items	239,797,448	--	--	--	--
Total Expenditures by Object	**$1,792,892,173**	**$1,912,525,658**	**$1,894,169,407**	**$84,319,944**	**$2,052,801,984**
Expenditures by Fund					
State General Fund	510,384,109	621,662,836	611,889,483	33,878,874	664,332,038
Water Plan	--	--	--	--	--
EDIF	--	--	--	--	--
Children's Initiatives Fund	11,991,748	15,578,000	15,578,000	--	15,578,000
Building Funds	--	--	--	--	--
Other Funds	1,270,516,316	1,275,284,822	1,266,701,924	50,441,070	1,372,891,946
Total Expenditures by Fund	**$1,792,892,173**	**$1,912,525,658**	**$1,894,169,407**	**$84,319,944**	**$2,052,801,984**
FTE Positions	184.43	184.43	184.43	--	184.43
Non-FTE Unclassified Permanent	16.97	16.97	16.97	--	16.97
Total Positions	**201.40**	**201.40**	**201.40**	--	**201.40**

Performance Measures

There are no performance measures for this program.

Health Care Policy

Operations. The Health Care Policy Program includes five subprograms: Medical Policy/Medicaid, Mental Health, Addiction and Prevention, Community Support Services, and the Developmental Disability Council. The Medical Policy/Medicaid Subprogram purchases medical services for adults and children eligible for Medicaid, MediKan, and HealthWave benefits. Medicaid and HealthWave are regulated and partially funded by the federal government. The MediKan Program is wholly administered and funded by the state. Services are delivered through a mix of managed health care and fee for services.

The Mental Health subprogram contracts with community agencies to provide services to individuals and families who experience mental illness. The program emphasizes informed consumer choice and provides services in the least restrictive environment. Mental Health awards state and federal funds to nonprofit programs and evaluates the effectiveness of services. It oversees the three state psychiatric hospitals as well as the licensure and contract funding of community mental health centers. The Addiction and Prevention Services (AAPS) Subprogram contracts with community agencies to provide services to individuals and families for the prevention and treatment of addictions. AAPS ensures that a continuum of care is available and accessible in every region of the state.

The Community Support Services Subprogram administers a system of community-based services for people with severe disabilities. Services are coordinated through partnerships with developmental disabilities organizations and provided through community service providers. Federal, state, local, and private sources finance services, including independent living counseling, attendant care, and family respite care. The federal government waives Medicaid rules to allow states to be reimbursed for community-based services, if they can be provided at a lower cost than institutional care. Kansas operates waiver programs for individuals with head injuries, physical disabilities, developmental disabilities, and a dependency on medical equipment. The program oversees the two state hospitals for the developmentally disabled.

The Developmental Disability Council is a federally funded council that advocates for services to keep disabled individuals in the community.

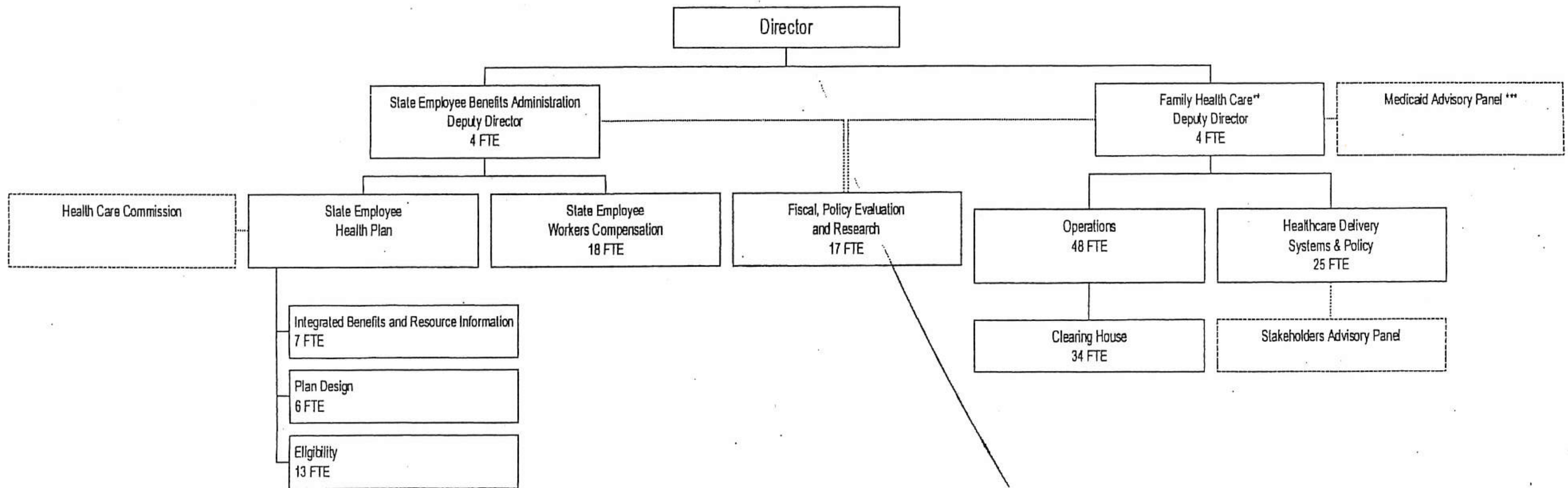
Goals and Objectives. The goals of the program include the following:

Maintain and improve the health of eligible children and adults while maintaining or reducing the rate of growth in expenditures.

Administer an effective community-based system of supports for individuals with mental illness, substance abuse, physical disabilities, and developmental disabilities.

Statutory History. The statute that gives the Department of Social and Rehabilitation Services authority to administer a medical assistance program is KSA 39-708c(a). KSA 39-708c and 39-709 specify eligibility criteria for the program and require the Secretary of SRS to develop a state plan to comply with federal requirements. Federal requirements concerning the Medicaid Program are contained in Title XIX of the Social Security Act. The 1998 Legislature enacted legislation that authorized implementation of the HealthWave insurance program for uninsured children.

The Treatment Act for Mentally Ill Persons (KSA 59-2901) sets the methods by which mentally ill patients are provided both voluntary and involuntary mental health treatments. KSA 65-4411 et seq. describe the distribution of state aid to community facilities for the developmentally disabled. The Developmentally Disabilities Reform Act is found in KSA 39-1801 et seq. The authority regarding substance abuse treatment can be found in KSA 65-4001.



Estimated Health Care Purchases

- Medicaid $1.3 billion
- State Employees $300 million
- Workers Compensation $16.1 million

Salaries $8.2 million

Other Operating Expenditures $62.2 million

- includes MMIS contract
- includes Clearing House contract

---

*Includes 5.5 FTE transferring from SRS to other Department of Administration divisions to support the programs transferring

**Formerly Medical Policy/Medicaid in SRS

*** Panel composed of the Secretaries of the Departments of Human Services, Aging, Health and Environment and Administration and the Commissioner of the Juvenile Justice Authority

6-1

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KANSAS
HEALTH
INSTITUTE

MEMO

Date: March 29, 2005

To: Health Care Strategies Committee

From: Robert F. St. Peter, M.D.
President and CEO
Kansas Health Institute

Subject: Organization of Medicaid functions within states

At the request of Legislative leaders, the Kansas Health Institute (KHI) prepared a series of memos on the organization of Medicaid functions within state governments. These memos were based on specific requests from the Legislature, with particular emphasis on those states utilizing a commission structure. Much of the initial information presented on how Medicaid is organized within states comes from a recent report from the National Governors Association entitled "Reorganizing State Health Agencies to Meet Changing Needs, State Restructuring Efforts in 2003."

The various memos and tables are attached here for your information. The specific documents include:

1) A table showing how the Medicaid program relates to social service and public health agencies in all 50 states
2) A table showing the nine states that have the Medicaid program separated from both social service and public health agencies
3) A short memo on Medicaid and health policy commissions in various states, highlighting Texas and Maryland
4) A follow-up memo on the commissions in Oklahoma and Colorado, with organizational charts
5) A table on key decisions relating to the establishment of a commission
6) Finally, a memo showing the composition of commissions in OK, CO and TX

We hope this information is useful in understanding how other states have approached the issue of reorganizing their Medicaid and health policy functions.

Senate Health Care Strategies Committee
Date: March 29, 2005
Attachment 2

Placement of the Medicaid program with Public Health and Social Services 2/25/2005

	Without Social Services	With Social Services	
Without Public Health	AL, AZ*, CO, FL*, GA, IL, MS, OK,TN [9]	AR, CT, HI, IN, IA, **KS***, MN, MO, NM, ND, PA, RI, SC, SD [14]	[23]
With Public Health	KY, LA, MD, MI, NY, UT, VA, WV, WY [9]	AK, CA, DE, ID, OH, ME, MA, MT, NE, NJ*, NV, NH, NC, OR*, TX, VT, WA*, WI [18]	[27]
	[18]	[32]	

*All or a portion of long-term care services are located in a separate agency (tentative list: six known states).

Note: about half of the states locate mental health programs in the same agency with Medicaid.

Definitions:

"Medicaid" = Regular medical component of Titles XIX (and XXI), and the single state agency designation

"Public Health" = Prevention, MCH, Vital Stats, Epidemiology, local health departments

"Social Services" = Cash, child care, foster care, and other direct assistance programs

Other programs receiving significant Medicaid funds, such as MR/DD waivers and state health care institutions, are located in a variety of organizational settings across states. If you have specific questions about the manner in which these programs are run in other states we would be happy to collect further information.

Composition of Medicaid agency when isolated from Social Services and Public Health

		Notes:
Dedicated cabinet level agency	AL AZ CO* MS OK*	
In another agency	TN	In the Department of Finance and Administration
Alongside a small number of other programs	FL	Includes health care quality assurance (for facilities and health care organizations), health statistics, and certificate of need
	GA	Includes medical boards, state employees benefits plan, and certificate of need
	IL	Includes Office of Inspector General, low-income heating and energy assistance, and child support enforcement

*Strong boards with control over Medicaid policy.

2/25/2005

KANSAS HEALTH INSTITUTE

MEMO

State Health Care and Medicaid Commissions

A Note on Commissions

Widespread use of commissions on both the state and the federal government levels began during the progressive era as a vehicle to remove some public business from undue influence by the executive, the legislature, and political parties. Commissions often operate independently outside of the traditional three-part structure of America government. Because they are independent, commissions are free to act as they see fit within the scope of their charge. Because commissioners are appointed by the governor or the legislature or some combination of the two for fixed terms of office, they are directly accountable for their official conduct. They may be removed from office at the end of their tenure, or earlier, for malfeasance or nonfeasance. For the reason that decisions are made publicly, commissions are believed to be more transparent than executive agency policy making. Finally, commissions allow expertise from the public at large to be applied to specific policy problems. Commissioners and staff alike become experts on specific areas of public policy. To recap, commissions are independent, autonomous, accountable, transparent, and expert.

Types of Commissions

To simplify matters, let us think of commissions generally as having two dimensions. They can be either permanent (that is, they do not have a fixed termination date in the enabling legislation), or temporary; and they can be either advisory (to the governor or the legislature or both) or policy making. The policy-making role of commissions began primarily as a regulatory function, typically regulating some aspect of commercial behavior. Over time, commissions have been used to administer public programs both inside and outside of the traditional structure of executive agencies of government.

Putting these two dimensions together in a two-by-two matrix yields four types of commissions: 1) temporary advisory, 2) temporary policy-making, 3) permanent advisory and 4) permanent policy-making. Although we have not undertaken a complete analysis of commissions, we speculate that temporary advisory commissions are the most common form currently employed. We also speculate that there are few, if any temporary policy-making commissions. Cells in the matrix below are filled with examples of commissions from the federal government.

	Advisory	Policy Making
Temporary	Commission to Reform Social Security	None likely exist
Permanent	Medicare Payment Advisory Commission	Federal Trade Commission Federal Communications Commission

In Kansas currently, we are adding another dimension to this typology. Each of the cells of the matrix above can be divided into two for commissions whose charge is Medicaid only and those who have a charge to consider health more broadly.

We have attempted to populate each of the relevant cells with examples from the states. Our examination likely did not identify every instance of a currently operating health/Medicaid commission in the states. The ones we show are intended to illustrate the similarities and differences among the states to help direct decision-making in Kansas. One thing is clear: there is no one right way to establish a commission. The charge, composition, and organizational structure must be determined by the problems to be solved and the policy-making environment that currently exists within the state.

		Advisory	Policy Making
Temporary	Medicaid only	OH	None likely exist
Temporary	General health focus	MA WY LA CO FL	None likely exist
Permanent	Medicaid only	ME	MS TX CO OK
Permanent	General health focus	VA	MD DE

No single commission model has yet been settled on in Kansas, but we can assume that it will be created as a permanent entity. A goal of the Kansas commission is that it would administer Medicaid (MA), coordinate other Medicaid services lodged in other departments, and possibly design and procure state employee health benefits. Additionally, after addressing the most pressing Medicaid issues, the Kansas commission would advise the governor or the legislature (to be determined in the legislation) about more general issues of health and health care financing and delivery. Such a commission is an interesting hybrid: it combines policy-making (for Medicaid) with advisory functions (for health generally) in one organization and directly administers some programs, while providing coordination and policy input (but not administration) to others. This is a unique design, but its uniqueness should not be a matter of concern – all commissions are unique. Perhaps the closest model to what Kansas hopes to achieve in the long run is the Texas Health and Human Services Commission. For this reason, we will concentrate on the Texas model more than any of the others.

Name: Texas Health and Human Services Commission

Time Frame: Permanent (with a sunset provision September, 1, 2009); established in 1995

Charge: "Provides leadership and direction, and fosters the spirit of innovation…. Has oversight responsibilities for [four] designated health and human service agencies (Department of Aging and Disability Services, Department of Assistive and Rehabilitative

Services, Department of Family and Protective Services, and Department of State Health Services), and administers certain health and human services programs including the Texas Medicaid Program, Children's Health Insurance Program, and Medicaid waste, fraud, and abuse investigations."

Membership: Eight appointed commissioners and one executive commissioner who is the chief executive of the staff. The executive commissioner is not the commission chairman. Commission members are appointed to two-year terms by the governor with the advice and consent of the Senate.

Staff and Supervision: Executive commissioner employs a large staff of policy, planning and evaluation employees that support the commission in addition to program staff who administer Medicaid.

Agency Relationships: Executive director of HHSC appoints the agency directors of the four health and human services agencies that report to him/her. Commission has oversight and coordinating role with the four agencies.

Other: The HHSC executive commissioner, for all practical purposes, is the chief executive officer of an umbrella agency. Where the Texas model differs from the traditional umbrella agency model is that the agency CEO reports to a commission rather than the governor.

The State of Maryland has combined administration of some health programs (although not Medicaid) in the Maryland Health Care Commission. The State of Maryland also expects that the Commission will help develop health policy and coordinate health policies for which it is not directly responsible. This role is somewhat like the one envisioned for the Kansas commission, therefore we describe its structure below.

Name: Maryland Health Care Commission

Time Frame: Permanent; established in 1999

Charge: Created through the consolidation of two existing commissions to "establish a streamlined health care regulatory system in the state in a manner such that a single state health policy can be better articulated, coordinated, and implemented." Specifically:

- Development of a comprehensive standard health benefit plan
- Establishment of the HMO Quality and Performance Evaluation System;
- Establishment of the Nursing Home and Hospital Performance Evaluation Guides and the Ambulatory Surgery Facility Consumer Guide;
- Development of recommendations for a patient safety system in Maryland and other special projects;
- Creation of a database on non-hospital health care services;
- Implementation of a certificate of need program for certain health care facilities and services;
- Adoption of a state health plan related to certificate of need decisions;
- Oversight of electronic claims clearinghouses.

Membership: Twelve commissioners appointed by the governor with the advice and consent of the Senate.

Staff and Supervision: Because it administers a number of programs it has an extensive operational staff. The number of staff specifically supporting the commission is not known at this time.

Agency Relationships: Unknown at this time.

Additional information

In addition to filling in the blanks with regards to the Texas and Maryland commissions, we will also closely examine the Colorado Medical Services Commission in our next installment. We will also discuss some of the aspects of commissioner selection and structural organization that may determine the success of the commission model.

February 25, 2005

KANSAS HEALTH INSTITUTE

MEMO

Health Care Commissions and Boards in Oklahoma and Colorado

Background

At last Friday's meeting, Senator Morris requested additional information on health care commissions and boards in Oklahoma and Colorado in regard to Medicaid programs in their states. The purpose of this memo is to fulfill that request. Both the Oklahoma Health Care Authority Board and the Colorado Medical Services Board are composed of appointed members and play key roles in the development of Medicaid policies within their states. In formation about each state is listed below.

OKLAHOMA HEALTH CARE AUTHORITY

The Oklahoma Health Care Authority is the State of Oklahoma's Medicaid Agency. According to its organization chart, the Authority appears to be a free-standing entity, governed by a board. The board appoints the chief executive officer of the Authority. The CEO, in turn, appoints the state Medicaid director. The current Medicaid director in Oklahoma is a physician. A medical advisory committee and a drug utilization review board also report to the chief executive officer of the Authority.

Name: Oklahoma Health Care Authority Board

Time Frame: Permanent

Charge: The board has the power to:

- Establish the policies of the Oklahoma Health care Authority.
- Appoint the Administrator of the Authority.
- Adopt and promulgate rules as necessary and appropriate to carry out the duties and responsibilities of the Authority. The Board is the rule-making body for the Authority.

- Adopt, publish and submit an annual business plan.

The operational areas of the Authority are:

- Medicaid operations
- Information services
- Financial services
- Management and Audit services
- Legal services
- Administrative services.

Membership: The Authority Board has seven members, two members appointed by the President Pro Tempore of the Senate, two members appointed by the Speaker of the House of Representatives, and three Members appointed by the governor. The Governor is required to appoint two consumer representatives. The other appointed members should include persons who have experience in medical care, health care delivery, health care finance, health insurance, or managed care. Consumer members are barred from having any financial or professional interest in medicine, health, or insurance. Board decisions are made by a majority vote of the members present. The Board meets monthly. Board members are not compensated for their services, but are reimbursed for travel expenses.

Staff and Supervision: All of the operational areas of Medicaid report through the Medicaid director to the CEO of the authority. Additionally, the following staff functions report to directly to the CEO: office of federal/state health policy, executive communications/information referral and government relations. Staff provide funds to Medicaid contractors, develop Medicaid payment policies, maximize federal funds, manage programs to fight waste, fraud, and abuse, maintain the operating systems that support Medicaid payments, develop cost-effective health care purchasing approaches, monitor contractor and provider performance, promte and preserve beneficiary rights and protections, and disseminates information to the legislature, congressional delegation, beneficiaries, and the general public.

Agency Relationships: The Authorities relationships with other agencies are not clear. For example, although the Authority appears to be independent, it may be linked with another agency for certain administrative functions. We do know that Medicaid funding

has been transferred from the Authority to the department of human services, office of juvenile affairs, department of mental health and substance abuse services, state department of health, and department of education. These transfers may imply that portions of the Medicaid program are administered by agencies other than the Authority.

COLORADO MEDICAL SERVICES BOARD

The Medical Services Board was created by the Colorado Legislature in 1994. During the 2001 Legislative session, the Children's Basic Health Plan Policy Board was repealed and two members of it were added to the Medical Services Board, bringing its membership to eleven. The Board is located within the Colorado Department of Health Care Policy and Financing.

Name: Colorado Medical Services Board

Time Frame: Permanent

Charge: The board has the authority to adopt rules that govern the Colorado Medicaid program and the Children Health Plan Plus program. The Board also has authority over the medically indigent, adult foster care, and home allowance programs. The Board hears each proposed rule twice, allowing time for public participation in the process of rule making. Terms of current board members are staggered: three terms will expire in 2005, two in 2006, two in 2007, and four in 2008.

Membership: The eleven members are appointed by the governor with the advice and consent of the Senate. The members are to select from persons who have knowledge of medical assistance programs. Each congressional district must be represented on the Board and no more than six members should be from the same political party. Board members are not compensated for their services, but are reimbursed for travel expenses.

Staff and Supervision: It appears as though the Board has a very small staff, if any, and that most staff support to the Board comes from the office of the executive director of the department of health care policy and financing. The Medical Services Board has a staff relationship to the executive board and is specifically charged with adopting department administrative rules.

Agency Relationships: None are apparent from the organizational chart and the charge of the Board.

Other Materials

See the following pages for:

- Organization charts of the Oklahoma Health Care Authority and the Colorado Medical Services Board
- Table of decision points for development of a health care commission to supervise Medicaid

March 1, 2005

2-13

State of Colorado

Health Care Policy & Financing

The mission of the Department of Health Care Policy & Financing is to purchase cost effective health care for qualified, low-income Coloradans.

EXECUTIVE DIRECTOR'S OFFICE
Reinertson, Karen

- Medical Services Board
- External Affairs — Prehmus, B.*
  - Program Asst. — Simon, L.
  - Customer Service Section — Brown
- Facility Coordinator — Lucero, P.
- Executive Project Coordinator, Governor's Advocate — Rodriguez, D.
- Communications Division — Bentz, R.
  - State Board Coordinator — Schupbach, J.

MEDICAL ASSISTANCE OFFICE — Chaumont, Vivianne M.*
- Support Central — Bloem, B.
- Contract Admin. — Bohm, T.
- Appeals Office — Hohn, J.
- HEALTH BENEFITS DIVISION — Karabatsos, Laurel
  - Acute Care Benefits Section — Gervais-Voss
  - Quality Imprv. Behav. Health Section — Kellow
  - Managed Care Benefits Section — Brookler
- RATES & ANALYSIS DIVISION — Gunter, Roger
  - Program Integrity Section — Mohan (Acting)
  - Data Section — Ziegenhagen
  - Rates Section — Bartholomew
- LONG TERM BENEFITS DIVISION — Manley, Viki
  - Community Based LTC Section — Ramsey
  - Systems Change Section — West
  - Nursing Facilities Section — Stone
- CLIENT SERVICES DIVISION — VACANT
  - Eligibility Section — Fowler
  - Benefits Coordination Section — Roberts

CHILD HEALTH PLAN PLUS OFFICE — Ladon, Barbara*
- Program Integration & Eval. Section — Hamer
- Contracts & Operations Section — Hartlaub
- Systems Section — Olson
- Delivery Systems Section — Heller

OPERATIONS & FINANCE OFFICE — Esgar, Lisa*
- Safety Net Financing Section — Underwood
- INFORMATION TECHNOLOGY DIVISION — Wagner, John
  - Privacy & Security Officer — Gefke
  - Information Tech Support Section — Showalter
  - Eligibility Sys Dev. Section — Holland
  - Information Systems Section — Dunn
  - IT Contracts & Monitoring Section — Moores
- BUDGET DIVISION — Strecker, Peter*
- CONTROLLER & OPERATIONS DIVISION — Reed, Phil*
  - Human Resources Unit — Smuda
  - Accounting Section — Maynard
  - Contracts & Purchasing Section — Coghlan

Karen Reinertson

February 14, 2005
Effective Date

2-14

oklahoma health care authority

General	Consumer	Provider	Calendar	Search

Organizational Chart

Health Care Authority Board

Medical Advisory Committee

Chief Executive Officer

Drug Utilization Review Board

Federal / State Health Policy

Financial Services

Medicaid Operations

Legal Services

Information Services Division

Management & Audit Services

Administrative Services

Executive Communications / Information and Referral

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This page was last updated: Fri, 07 Jan 2005 16:08:42 GMT

Decision Points

Issue	Options	Comments
Size of commission/board	Commonly selected sizes are five, seven, or eleven members. If all members attend and vote, an odd number of members should assure a majority vote on most issues.	
Characteristics of commissioners	Some health care commissions are composed primarily of health care providers and insurers, others exclude them entirely in favor of consumers. One commission we examined is composed only of legislators. A mix of characteristics is likely preferable. One commission we examined had the position of executive commissioner, which means that the CEO of the administrative body which reports to the commission is also a member of the commission.	
Source of appointment	Most commissions are appointed by the governor with the advice and consent of the Senate or both Houses of the Legislature. Another model is for the governor and the leadership of the Senate and the House of Representative to share making appointments.	
Terms of appointment	Appointment term of one, two and four years are common.	

Issue	Options	Comments
Time Frame	Permanent or temporary	
Charge	Several options exist here; • Determine Medicaid policy • Make Medicaid administrative rules • Oversee all aspects of Medicaid agency • Hire Medicaid director • Oversee other health and social services departments (e.g., health, human services, juvenile justice, aging, etc.) • Plan for non-Medicaid health system organization and financing changes	
Staff	Should the Medicaid director report directly to the commission or should he/she report to an executive position that, in turn, reports to the commission?	
Agency relationships	With which departments should the commission have a relationship? Should it be a line relationship or one defined (and narrowed in scope) by a memorandum of understanding? If the commission is truly independent, what methods does it have at its disposal to influence the behavior of executive agencies?	

The Kansas Health Institute
March 1, 2005

MEMO

The Structure of Commissions

All commissions are created by the Legislature. The Legislature can also withdraw their charters. Through the method of appointment, they are linked to both the executive and the Legislature. Implicitly, both commissioners and the executive director of the Authority serve at the pleasure of the Governor. If this implicit understanding is insufficient, it can be made explicit in the statute.

The length of tenure creates a check afforded by rotation in office. On the attached table we list the several issues related to membership on health care commissions in Texas, Oklahoma, and Colorado.

Attributes of Health Care Commission Membership In Oklahoma, Colorado, and Texas

Attribute	OK	CO	TX
Number of members	7	11	8 + Executive Commissioner
Term of office	4	4	2
Appointed by	Gov. (3) Senate (2) House (2)	Governor	Governor
Confirmed by Senate	No	Yes	Yes
Limit on number of members from one party	No	Yes	No
Geographical representation	Yes	Yes	No
Allows members from out of state	No	No	No

March 7, 2005

Kansas Insurance Department

Sandy Praeger COMMISSIONER OF INSURANCE

SENATE COMMITTEE
ON
HEALTH CARE STRATEGIES

Testimony In Support of
Senate Bill 306
By
Sandy Praeger
Commissioner of Insurance
March 29, 2005

Chairwoman and Members of the Committee:

Thank you for the opportunity to testify before the Health Care Strategies Committee in support of SB 306. This is a very positive step in addressing the availability and affordability of health care and health insurance through the coordination of purchasing and administration of health care services along with a focus on health promotion. Our department will do whatever we can to assist these efforts. We believe that through the efficiencies brought about by this coordination we can help to control health care expenditures and can promote improved quality of the services delivered.

The broad representation across several government agencies, the Legislature and the Governor's Office is critical to the success of this new "Authority." With the Authority in place for the first time in my memory we will have all entities involved with health services under one umbrella.

As I have mentioned before in front of this committee our department has been working with Health and Environment to improve the collection of health data so that it can be more easily accessed for analyses relating to quality, utilization and costs of health care services in Kansas. Having good data and good information will be an important component in guiding the work of the Authority. We believe that the changes that are being made in the storage and retrieval of health data will provide a valuable tool for the Authority. In addition, moving the Health Care Data Governing Board to the Authority will incorporate their work into the overall agenda of improving quality, cost and access to health care services.

Personal responsibility is a key component in any health agenda. The most effective way to control health care spending is to look at the diseases that require the highest utilization of health care services and develop educational programs and prevention strategies to prevent or control the frequency and severity of those disease

Senate Health Care Strategies Committee
Date: March 29, 2005
Attachment 3

420 SW 9TH STREET
TOPEKA, KANSAS 66612-1678
PHONE 785.296.3071
FAX 785.296.2283
CONSUMER HOTLINE
1.800.432.2484
WEBSITE
www.ksinsurance.org

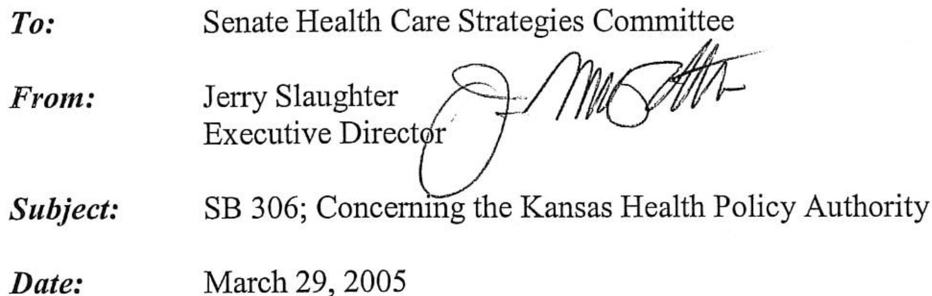
states. The Authority can provide the direction that will be needed to carry out that ambitious agenda.

I look forward to working with the Legislature, the Governor's Office and the various state agencies involved in this new Authority to achieve the stated goal of developing and maintaining a coordinated health policy agenda to improve the health of Kansans by increasing the quality, efficiency and effectiveness of health care services and public health programs.

KANSAS MEDICAL SOCIETY
KMS

623 SW 10th Avenue
Topeka KS 66612-1627
785.235.2383
800.332.0156
fax 785.235.5114

kmsonline.org



To: Senate Health Care Strategies Committee

From: Jerry Slaughter
Executive Director

Subject: SB 306; Concerning the Kansas Health Policy Authority

Date: March 29, 2005

The Kansas Medical Society appreciates the opportunity to appear in support of SB 306, which establishes the Kansas Health Policy Authority. As we read the bill, among its many responsibilities, the new Authority will have two principal functions: 1) to reorganize and consolidate responsibility for the state's health care purchasing, particularly Medicaid, into a single agency, and thereby improve efficiency, reduce duplication, and enhance the responsiveness of the state as a business partner; and 2) to establish a process for developing and advancing a coordinated statewide health policy agenda that includes health promotion, improved quality, efficiency, and effectiveness of health care delivery.

Regarding the part of the bill that includes the reorganization of the state's largest health care program, Medicaid, this change is long overdue. As legislators well know, Medicaid is one of the fastest growing components of the state budget. As it has grown more costly and complex over the past thirty-plus years, however, it has largely remained unchanged in terms of its fundamental culture and administration. Despite its programmatic complexity, Medicaid is essentially a state-administered health insurance program which is housed in a social service agency. If the program were created new today, it is safe to say it would probably not be assigned to the state agency responsible for state-run mental health facilities, community support services for children and adults, and substance abuse programs. It would most likely be housed in an agency that was focused on the arranging for and purchasing of health insurance, either directly or through third party intermediaries.

This legislation, much like the Governor's reorganization order, is the first real effort on the part of the state to re-think how it carries out the functions of purchasing health care benefits from physicians, hospitals and other private care providers. We believe it gives the state the opportunity to approach these programs with a new perspective, achieve efficiencies, and become a better business partner with the thousands of providers the state relies upon to care for individuals insured by the programs. Most everyone agrees

Senate Health Care Strategies Committee
Date: March 29, 2005
Attachment 4

the state simply can't afford to continue doing business as it has in the past, particularly with Medicaid costs increasing at such a rapid pace. We view this reorganization as a positive step in the right direction, one we hope will result in a better program for the population served, for the state, and for the providers who contract with the state to provide care for those individuals.

We are also supportive of the concept of an agency of state government assuring a public dialogue about the future of health care in our state, which is the second principal function of the Authority. In fact, the attributes of the voting membership of the Authority seems designed to emphasize its health planning and health promotion functions. The seven voting members must have knowledge in health promotion, public health improvement, evidence-based medicine, insurance, information systems, data analysis, economics, business and health care finance (New Section 1, subsection (e)). While these are very appropriate skills and experience for developing a statewide health policy agenda, they may not be the skills and experience necessary to guide policy of a state agency responsible for consolidating and operating the health care purchasing functions of Medicaid and other health programs. The committee may want to give some consideration to whether the structure and membership of the Authority are appropriate for its primary function, reorganizing Medicaid, as well as its health policy development function.

We commend the authors of this bill, the legislature, the Governor, and the Insurance Commissioner for moving this important public policy debate forward. We would encourage all to continue to work together to refine and improve this important health initiative as it continues through the legislative process.

Thomas L. Bell
President

TO: Senate Health Care Strategies Committee

FROM: Thomas L. Bell
President

DATE: March 29, 2005

RE: **SB 306**

Thank you for the opportunity to provide comments in support of SB 306. This bill would create The Office of Health Planning and Finance within The Department of Administration effective July 1, 2005. At the same time, it would establish the Kansas Health Policy Authority. The purpose of the Authority would be to develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. Duties within the Office of Health Planning and Finance would be transitioned to the Kansas Health Policy Authority by July 1, 2006.

Our focus with regard to this discussion has been the movement of the state's medical assistance program to this new office. We see this move as having the potential to reduce the bureaucracy within the Medicaid program. Right now, Medicaid is one layer in the Department of Social and Rehabilitation Services. SB 306 would allow more focus on the Medicaid program specifically. Our hope is that such extra focus would allow the program to function more efficiently.

Earlier this year, the President announced his budget proposal in which he proposed numerous changes to the Medicaid program. Whether or not you agree with the President's recommendations, there is no question that the Medicaid program is facing numerous changes in the way it operates. There is also no question that as these changes are debated in the coming years, there will continue to be tension between the state and federal government about what is the appropriate funding share for each level of government. Carving Medicaid out of the Department of Social and Rehabilitation Services will allow the state to better focus its communications with the federal government concerning the future of the Medicaid program.

Thank you for your consideration of our comments.

Senate Health Care Strategies Committee
Date: March 29, 2005
Attachment 5

Kansas Department of

Social and Rehabilitation Services

Gary Daniels, Acting Secretary

Senate Health Care Strategies Committee
March 29, 2005

SB 306 - Kansas Health Policy Authority

Office of the Secretary
Gary Daniels, Acting Secretary
785.296.3271

For additional information contact:
Public and Governmental Services Division
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Senate Health Care Strategies Committee
Date: March 29, 2005
Attachment 6

Kansas Department of Social and Rehabilitation Services
Gary Daniels, Acting Secretary

Senate Health Care Strategies Committee
March 29, 2005

SB 306 - Kansas Health Policy Authority

Chairperson Wagle and members of the Committee, I am Gary Daniels, Acting Secretary for the Kansas Department of Social and Rehabilitation Services. Thank you for the opportunity to testify regarding SB 306.

I arrived in Topeka on November 1, 2004 full of enthusiasm and excited that the Governor had invited me to participate in some very simple healthcare reform initiatives in Kansas. Actually, I was honored with the thought that I could contribute to the expansion of healthcare coverage to 40,000 children, 30,000 low wage working parents, and helping small businesses obtain health insurance for their employees. There were provisions for cost containment, prevention, programs on wellness, and even attempts to help Kansans acquire lower cost drugs. I could support these efforts. They are full of good Kansas values, simple and straightforward, and most of all, were fully paid for with a new assessment on tobacco products.

When I first arrived, I found several groups of SRS staff, cross-agency groups from SRS, the Department of Administration, the Department on Aging, and the Kansas Department of Health and Environment, all engaged in identifying the nuts and bolts for the consolidation of healthcare purchasing and policy. These groups had already been working months planning the administration and support for this move with a goal of keeping costs neutral. Shortly after I arrived, the Kansas City office of CMS indicated their approval and hundreds of provider and advocacy groups joined in a coalition to support these efforts. In February I accompanied the Governor to a meeting in Washington, D.C. with Mark McClellan, Administrator with the Centers for Medicare and Medicaid Services, regarding the deferrals in Kansas. He directed his staff to research how they might assist with the deferrals and was enthusiastic about the changes we described. He suggested a willingness to partner with Kansas in demonstrating Medicaid reform as we move forward with our reorganization.

One thing I noticed at SRS was the increased apprehension among the workforce that may be involved in the move. I immediately began to address the apprehension by chairing a number of question and answer sessions with staff and advocating that the staff moving and not moving be identified as soon as possible. Once identified, the staff moving became eager participants in the planning and looked forward to their new role in healthcare. The apprehension among staff not moving decreased and they focused their attention on what SRS would look like after the change.

There are some parts of the bill which would allow healthcare reform to begin as early as July 1, 2005. Sections 7-21 of SB 306 essentially transfers approximately 125 individuals from Medicaid in SRS to the Department of Administration. All other support functions are provided by existing resources in the Department of Administration or through memorandum of understanding with other agencies. This move has already received support from hundreds of provider and advocacy groups, is conceptually approved by CMS, and endorsed by the civil servants and departments involved in the move. It is simple, cost neutral, and allows reforms around healthcare purchasing to begin immediately. Enactment of these sections would streamline the overhead for state health care purchasing and allow the Medicaid program to be more nimble and responsive. The move sets the stage for the administration to begin reaching out to thousands of children, low wage families, and small businesses who are in desperate need of quality healthcare coverage and could be in place immediately. I would urge this Committee's passage of Sections 7 - 21 of the legislation. Because of the questions and concerns discussed earlier, I do not support the remainder of the legislation.

I would be happy to answer any questions from the Committee.

Testimony to the Senate Committee on Health Care Strategies on SB 306 – 3/29/05

Dear Senator Wagle, Senator Barnett and members of the Committee:

My name is Dr. Ira Stamm. I am a psychologist in independent practice in Topeka and Kansas City. Before entering private practice, I treated patients at the Menninger Clinic in Topeka, Kansas for twenty-three years. Before that I treated children, adolescents, and their families at the Boston University Medical Center. I also study, teach, and write about health care and health care insurance.

I stand before you, not as a lobbyist, but as a private citizen concerned about the uninsured in Kansas, as a health care provider, and as a survivor of prostate cancer. Early detection of my prostate cancer two and a half years ago has enhanced my chances of long term survival. Chapter 40-2, 164 of the Kansas insurance code mandates coverage for prostate cancer screening. It is entirely possible that without that mandate I would not be here today to speak to you. I want to thank you and every member of the Kansas legislature for having the wisdom and compassion to pass this and other health care mandates.

I have read Senate Bill 306 in its entirety. Several benchmark figures inform the healthcare debate. The administrative cost for Medicare is 1.9%. Like it or not, Medicare is a form of single payor health insurance. The administrative cost for the Canadian health care system is also 1.9%. Administrative costs for Medicaid are in the 4-6% range with Kansas administrative costs projected to be at 6.2% for fiscal year 2006. Administrative costs and profits for commercial insurance are 12-14%. It is widely accepted and documented that one of every three health care dollars in America goes towards the administration of medical care and insurance. It is this latter figure that everyone is clamoring to reduce.

Senate Bill 306 addresses the critical health needs of 263,000 Kansans who use Medicaid, 40,000 state employees, and 300,000 Kansans who are uninsured. This totals to 603,000 Kansans. It is the cost of providing care to Medicaid recipients and to the uninsured that threatens the financial solvency of Kansas and that Senate Bill 306 rightly addresses.

As a reminder, though, Kansas has 2.6 million citizens. 394,000 Kansans are covered by Medicare leaving 1.6 million to be covered by other insurance including commercial insurance. It is my belief that for true health care reform to occur in

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Kansas, all health care insurance in Kansas, including the commercial side, also needs to come under the jurisdiction of the Kansas health policy authority created by Senate Bill 306. Let me explain.

Each of us in this health care debate is like the proverbial blind men and women examining a different part of the health care elephant. With its responsibility to manage the dollars of the Kansas treasury and to balance the budget, the Kansas legislature through Senate Bill 306 focuses on those aspects of the public health system that drive those costs. Yet public sector and private sector patients access the same nursing homes, hospitals, and doctors and buy the same medications. Some commercial insurance companies have found ways to exploit the system by cost shifting care from their for-profit ledger to the public ledger. Although Senate Bill 306 creates a health care data base and authorizes the KHPA to gather data from all sectors, a truly integrated system would put all the functions of public and private health care insurance under the umbrella of the Kansas health policy authority. Imagine, all health care insurance in Kansas under one roof or umbrella. That would certainly enhance the ability of Kansas to create a seamless healthcare system that delivers the highest quality, lowest cost, evidence-driven, state-of-the-art medical care.

Senate Bill 306 transfers those functions from SRS to the Kansas healthy policy authority having to do with health care and health care funding. It also transfers similar functions from the Kansas Department of Health and Environment to the KHPA. *I am respectfully recommending that Senate Bill 306 authorize the transfer of all health insurance matters from the Kansas Insurance Department to the Kansas health policy authority.*

It is my understanding that the Kansas Insurance Department believes it does not have the full legislative authority to operate as a *regulatory authority*. For example, Insurance Commissioner Praeger has made it clear that her department does not have the authority to mediate in contract disputes between insurance companies and hospitals and doctors. For the Kansas health policy authority to be successful it has to have authority comparable to the Kansas Corporation Commission. If a public utility doing business in Kansas wants to increase its rates, the KCC conducts hearings, researches the matter, and then offers its ruling. Remarkably, this form of strong oversight and regulation does not happen in health care in

Kansas. I would encourage the Kansas legislature to include such regulatory authority for the Kansas health policy authority in Senate Bill 306.

One of the contributors to high health care costs is Greed and the excessive profits of the drug companies, insurance companies and some health care providers. Medicare and Medicaid already control the prices of services they allow – so like it or not we already have wage and price controls in the 49% of the insurance marketplace controlled by these two insurance programs. A question for Senate Bill 306 to consider is whether or not the Kansas health policy authority should have the authority to set prices in the marketplace for health care services and products.

Before concluding, I would like to call your attention to a letter to the editor that appeared in the Topeka Capital-Journal on March 8, 2005. The letter is written by the husband of a woman dying of cancer. Ironically, the woman was a 12 year employee of Blue Cross Blue Shield of Kansas. When she became too ill to work she went on disability. Her health care premium went from $250 a month to $940 a month, at a time when she could least afford it.

I would like to propose a simple legislative remedy that would have helped this woman and will prevent other Kansans with life threatening illnesses from becoming uninsured. I respectfully request that the following paragraphs be included in Senate Bill 306:

- *Any consumer who is currently insured by an insurance company doing business in Kansas who develops a catastrophic illness such as cancer, heart disease, diabetes, etc. (to be defined further) will continue to be insured for that illness and continue to retain their full health insurance coverage until the insured becomes eligible for Medicare.*

- *Premiums to the insured shall remain frozen at the dollar amount applicable when the insured first contracted the illness; or the premium to the individual can be increased in concert with the overall increases to the group plan of which the insured is or was a member-even if the insured is no longer a member of the organization which initially purchased that plan.*

Thank you for listening and for your courtesy.

Ira Stamm, Ph.D. ABPP
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Legislative Testimony

SB 306

March 29, 2005

Testimony before the Kansas Senate Health Care Strategies Committee
By Lew Ebert, President and CEO

THE KANSAS CHAMBER

The Force for Business

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The Kansas Chamber and its over 10,000 small, medium and large business members support the cost and quality provisions in SB 306. It is not a common practice that the Kansas Chamber supports the reorganization of government agencies, but an important element of the Kansas Chamber's agenda has become part of this bill. This measure the Kansas Chamber advocates for will allow cost and quality information to be published in a useable for so that consumers become better consumers of their health care dollar.

The changes originally requested in SB 212 have been agreed to by our Health Care Task Force, a special Kansas Chamber committee brought together to look at the rising costs of health care in Kansas. The Health Care Task Force members consist of small and large businesses, hospitals and insurance companies. The changes requested in SB 212, now in SB 306 have been agreed to by all members of the task force. Specifically, the bill makes the following changes:

- Removes confidentiality provisions preventing public disclosure of all relevant provider-specific comparison data while maintaining requirements that patients' identity and protected health information be kept confidential.
- Requires the Health Care Data Governing Board prepare and distribute/publish a plan for publishing data by July 1, 2006 and publish the data by January 1, 2007.
- Encourages the Health Care Data Governing Board to establish data collection elements that are consistent with other federal government data gathering initiatives.

The Kansas Chamber encourages the committee to support SB 306. Thank you for your time and I will be happy to answer any questions.

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The Kansas Chamber, with headquarters in Topeka, is the statewide business advocacy group moving Kansas towards becoming the best state in America to do business. The Kansas Chamber and its affiliate organization, The Kansas Chamber Federation, have more than 10,000 member businesses, including local and regional chambers of commerce and trade organizations. The Chamber represents small, medium and large employers all across Kansas.

SENATE BILL No. 306

By Committee on Ways and Means

3-23

Proposed Technical Amendments to SB 306 & HB 2531 March 28, 2005

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9 AN ACT establishing the Kansas health policy authority; prescribing
10 powers, duties and functions therefor; establishing a division of health
11 policy and finance and a director of health policy and finance within
12 the department of administration and transferring certain powers, du-
13 ties and functions thereto; amending K.S.A. 39-7,116, 39-7,121, 65-
14 6801, 65-6804, 65-6805, 65-6806, 65-6807 and 65-6809 and K.S.A.
15 2004 Supp. 39-7,118, 39-7,119, 39-7,120, 39-7,121a, 39-7,121d, 39-
16 7,121e and 65-6803 and repealing the existing sections; also amending
17 sections 9 through 21 of this act and repealing the existing sections;
18 also repealing K.S.A. 65-6808 and sections 7 and 8 of this act.
19
20 *Be it enacted by the Legislature of the State of Kansas:*
21 New Section 1. (a) On July 1, 2005, the Kansas health policy au-
22 thority is hereby established as a state agency within the executive branch
23 of state government.
24 (b) The Kansas health policy authority shall be composed of seven
25 voting members and seven nonvoting, ex officio members. The seven
26 voting members shall be appointed as follows:
27 (1) Four members shall be appointed by the governor;
28 (2) two members shall be appointed by the speaker of the house of
29 representatives; and
30 (3) one member shall be appointed by the president of the senate.
31 (c) The seven nonvoting, ex officio members of the Kansas health
32 policy authority are the director of health of the department of health
33 and environment, secretary of health and environment, secretary of social
34 and rehabilitation services, commissioner of insurance, secretary of ad-
35 ministration, secretary of aging, and the executive director of the authority
36 appointed pursuant to section 2, and amendments thereto.
37 (d) The appointment of each voting member of the Kansas health
38 policy authority shall be subject to confirmation by the senate as provided
39 in K.S.A. 75-4315b, and amendments thereto. Except as provided by
40 K.S.A. 46-2601, and amendments thereto, no person appointed as a vot-
41 ing member of the Kansas health policy authority shall exercise any
42 power, duty or function as a member of the authority until confirmed by
43 the senate. Each member shall hold office for a term of four years, except

1 as provided in subsection (d) for the first members appointed to the
2 Kansas health policy authority, and until a successor is appointed and
3 confirmed. Terms of voting members of the Kansas health policy au-
4 thority shall expire on March 15.
5 (e) Voting members of the Kansas health policy authority shall be
6 members of the general public who have knowledge and demonstrated
7 leadership in fields including, but not limited to, health care delivery,
8 health promotion, public health improvement, evidence-based medicine,
9 insurance, information systems, data analysis, health care finance, eco-
10 nomics, government, and business. A majority of the voting members of
11 the Kansas health policy authority shall be Kansas residents. No member
12 of the legislature shall be appointed as a voting member of the Kansas
13 health policy authority.
14 (f) The first voting members of the Kansas health policy authority
15 established by this section shall be appointed on or before August 1, 2005.
16 The terms of office of such members shall be as follows: (1) The governor
17 shall appoint one member for a term which shall expire on March 15,
18 2007, two members for a term which shall expire on March 15, 2008, and
19 one member for a term which shall expire on March 15, 2009; (2) the
20 speaker of the house of representatives shall appoint one member for a
21 term which shall expire on March 15, 2009, and one member for a term
22 which shall expire on March 15, 2007; and (3) the president of the senate
23 shall appoint one member for a term which shall expire on March 15,
24 2009. In addition to such terms, each of the first members appointed shall
25 serve until a successor is appointed and confirmed.
26 (g) The members of the Kansas health policy authority shall meet and
27 organize annually by electing one member as chairperson, except that the
28 governor shall designate the first chairperson of the Kansas health policy
29 authority from among the first members appointed. The Kansas health
30 policy authority shall meet at least monthly during the fiscal year ending
31 June 30, 2006, and thereafter not less than once per calendar quarter.
32 (h) Members of the Kansas health policy authority attending meet-
33 ings of the authority, or attending a subcommittee meeting thereof au-
34 thorized by the Kansas health policy authority, shall be paid subsistence
35 allowances, mileage and other expenses as provided in K.S.A. 75-3212,
36 and amendments thereto, for members of the legislature. Members on
37 the Kansas health policy authority shall not receive compensation for their
38 service on the authority.
39 (i) On July 1, 2013, the Kansas health policy authority is hereby
40 abolished.
41 New Sec. 2. (a) The Kansas health policy authority shall appoint the
42 executive director of the authority subject to confirmation by the senate
43 as provided in K.S.A. 75-4315b, and amendments thereto. The Kansas

1 health policy authority may appoint a temporary director to serve and to
2 administer and oversee the operations of the authority until such time as
3 an executive director can be appointed and commences employment.
4 (b) The executive director of the Kansas health policy authority shall
5 be in the unclassified service under the Kansas civil service act and shall
6 serve at the pleasure of the Kansas health policy authority. The executive
7 director of the Kansas health policy authority shall receive a salary fixed
8 by the Kansas health policy authority, subject to approval by the governor.
9 (c) The executive director shall have the authority to hire and super-
10 vise the other personnel of the Kansas health policy authority. Except as
11 otherwise provided by this act, all officers and employees of the Kansas
12 health policy authority shall be in the unclassified service under the Kan-
13 sas civil service act and shall serve at the pleasure of the executive director
14 of the Kansas health policy authority.

as provided in section 17, and amendments thereto, and

15 New Sec. 3. (a) The Kansas health policy authority is hereby au-
16 thorized to establish policies and to adopt rules and regulations for the
17 implementation and administration of the powers, duties and functions
18 prescribed for or transferred to the authority as provided by law.
19 (b) The Kansas health policy authority may enter into contracts as
20 may be necessary to perform the powers, duties and functions of authority
21 and as provided by law. As provided by this act or as otherwise the Kansas
22 health policy authority may enter into contracts with other state agencies
23 or with local governmental entities for the coordination of health care
24 services, including care and prevention programs and activities, and pub-
25 lic health programs.
26 (c) The Kansas health policy authority may appoint advisory com-
27 mittees as deemed necessary by the authority. The advisory committees
28 shall consult with and advise the Kansas health policy authority regarding
29 the matters referred thereto by the authority. Members of any advisory
30 committee created under this section attending meetings of such com-
31 mittee or attending a subcommittee meeting thereof authorized by such
32 committee shall be paid subsistence allowances, mileage and other ex-
33 penses as provided in K.S.A. 75-3223, and amendments thereto, but shall
34 receive no compensation for services as members of such advisory
35 committee.
36 New Sec. 4. The legislative coordinating council shall establish and
37 appoint members of the legislature from the senate and house of repre-
38 sentatives to serve as members of a special committee in accordance with
39 K.S.A. 46-1205, and amendments thereto. The special committee shall
40 have the exclusive responsibility to monitor operations and decisions of
41 the Kansas health policy authority and the legislative coordinating council
42 shall provide for the continuing existence of the special committee for
43 such period as deemed appropriate by the council.

New Sec. 5. The Kansas health policy authority shall develop and maintain a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion oriented public health strategies. The powers, duties and functions of the Kansas health policy authority are intended to be exercised to improve the health of the people of Kansas by increasing the quality, efficiency and effectiveness of health care services and public health programs.

New Sec. 6. (a) The Kansas health policy authority is responsible for the development of a statewide health policy agenda including health care and health promotion components. The Kansas health policy authority shall report to the legislature at the beginning of the regular session of the legislature in 2007 and at the beginning of each regular legislative session thereafter. The report of the Kansas health policy authority to the legislature shall include recommendations for implementation of the health policy agenda recommended by the authority. In accordance with the provisions of this act and the provisions of appropriation acts, the Kansas health policy authority shall assume powers, duties and functions in accordance with the provisions of this act.

(b) On January 1, 2006, the Kansas health policy authority shall assume the functions of the health care data governing board as provided by this act.

(c) On January 1, 2006, the Kansas health policy authority shall assume responsibility for the drug utilization review program, including oversight of the medicaid drug utilization review board, and the electronic claims management system as provided by this act.

(d) On or before March 1, 2006, the Kansas health policy authority shall submit a plan with recommendations for funding and any recommended legislation for the powers, duties and functions transferred to the authority on July 1, 2006, of the programs and activities specified in subsection (e).

(e) On July 1, 2006, the Kansas health policy authority shall assume operational and purchasing responsibility for (1) the regular medical portion of the state medicaid program, (2) the MediKan program, (3) the state children's health insurance program as provided in K.S.A. 38-2001 et seq., and amendments thereto, (4) the working healthy portion of the ticket to work program under the federal work incentive improvement act and the medicaid infrastructure grants received for the working healthy portion of the ticket to work program, (5) the medicaid management information system (MMIS), (6) the state health care benefits program as provided in K.S.A. ~~65-6501 through 65-6523~~ 75-6501 through 75-6523, and amendments thereto, and (7) the state workers compensation self-insurance fund and program as provided in K.S.A. 44-575 through 44-580, and amendments thereto.

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1 (f) At the beginning of the regular session of the legislature in 2007,
2 the Kansas health policy authority shall submit to the legislature recom-
3 mendations and an implementation plan for the transfer of additional
4 medicaid-funded programs to the Kansas health policy authority which
5 may include (1) mental health services, (2) home and community-based
6 services (HCBS) waiver programs, (3) nursing facilities, (4) substance
7 abuse prevention and treatment programs, and (5) the institutions, as
8 defined in K.S.A. 76-12a01, and amendments thereto.
9 (g) At the beginning of the regular session of the legislature in 2008,
10 the Kansas health policy authority shall submit to the legislature recom-
11 mendations and an implementation plan for the Kansas health policy au-
12 thority to assume responsibility for health care purchasing functions
13 within additional state agencies, which may include (1) the department
14 on aging, (2) the department of education for local education agencies,
15 (3) the juvenile justice authority and the juvenile correctional institutions
16 and facilities thereunder, and (4) the department of corrections and the
17 correctional institutions and facilities thereunder.
18 New Sec. 7. On July 1, 2005, the division of health policy and finance
19 is hereby established within the department of administration. The head
20 of the division of health policy and finance shall be the director of health
21 policy and finance, who shall be appointed by and serve at the pleasure
22 of the governor. The director of health policy and finance shall be in the
23 unclassified service under the Kansas civil service act and shall receive an
24 annual salary fixed by the governor. Under the supervision of the gover-
25 nor, the director of health policy and finance shall administer the division
26 of health policy and finance and shall perform such other powers, duties
27 and functions as may be prescribed by law.
28 New Sec. 8. (a) Subject to the provisions of appropriation acts, the
29 director of health policy and finance shall appoint, in accordance with the
30 provisions of the Kansas civil service act, such officers and employees as
31 may be needed, in the judgment of the director, to carry out the powers
32 and duties of the division of health policy and finance. All such officers
33 and employees shall be within the unclassified service under the Kansas
34 civil service act, unless otherwise specifically provided by law.
35 (b) The officers and employees of the division of health policy and
36 finance shall act for and exercise the powers of the director of health
37 policy and finance to the extent that authority to do so is delegated by
38 the director. Subject to the limitations of this act, the director of health
39 policy and finance may organize the division of health policy and finance
40 in the manner the director deems most efficient.
41 New Sec. 9. (a) The director of health policy and finance shall co-
42 ordinate health care planning, administration, and purchasing and analysis
43 of health care data for the state of Kansas with respect to the following

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1 health care programs administered by the state of Kansas:
2 (1) Developing, implementing, and administering programs that pro-
3 vide medical assistance, health insurance programs, or waivers granted
4 thereunder for persons who are needy, uninsured, or both, and that are
5 financed by federal funds or state funds, or both, including the following:
6 (A) The Kansas program of medical assistance established in accord-
7 ance with title XIX of the federal social security act, 42 U.S.C. § 1396 et
8 seq., and amendments thereto;
9 (B) the health benefits program for children established under K.S.A.
10 38-2001 et seq., and amendments thereto, and developed and submitted
11 in accordance with federal guidelines established under title XXI of the
12 federal social security act, section 4901 of public law 105-33, 42
13 U.S.C.§1397aa et seq., and amendments thereto;
14 (C) any program of medical assistance for needy persons financed by
15 state funds only, to the extent appropriations are made for such a
16 program;
17 (D) the working healthy portion of the ticket to work program under
18 the federal work incentive improvement act and the medicaid infrastruc-
19 ture grants received for the working healthy portion of the ticket to work
20 program; and
21 (E) the medicaid management information system (MMIS);
22 ~~(2) serving as the designated contact agency for the state of Kansas~~
23 ~~under K.S.A. 46-2507, and amendments thereto, with reference to federal~~
24 ~~health care reform measures; and~~
25 ~~(3)~~ (2) administering any other health care programs delegated to the
26 director by the governor or by a contract with another state agency.
27 (b) Except to the extent required by its single state agency role as
28 designated in section 10, and amendments thereto, the division of health
29 policy and finance shall not be responsible for health care planning, ad-
30 ministration, purchasing and data with respect to the following:
31 (1) The mental health reform act, K.S.A. 39-1601 et seq., and amend-
32 ments thereto;
33 (2) the developmental disabilities reform act, K.S.A. 39-1801 et seq.,
34 and amendments thereto;
35 (3) the mental health program of the state of Kansas as prescribed
36 under K.S.A. 75-3304a, and amendments thereto;
37 (4) the addiction and prevention services prescribed under K.S.A. 65-
38 4001 et seq., and amendments thereto; or
39 (5) any institution, as defined in K.S.A. 76-12a01, and amendments
40 thereto.
41 New Sec. 10. (a) The division of health policy and finance shall be
42 designated as the single state agency with responsibility for supervising
43 and administering the state plan for medical assistance under the federal

1 social security act, 42 U.S.C. § 1396 et seq., and amendments thereto.
2 The director shall develop state plans, as provided under the federal social
3 security act, whereby the state cooperates with the federal government
4 in its program of assisting the states financially in furnishing medical as-
5 sistance and services to eligible individuals.
6 (b) The director of health policy and finance shall undertake to co-
7 operate with the federal government on any other federal program pro-
8 viding federal financial assistance and services for medical assistance not
9 inconsistent with this act. The director of health policy and finance is not
10 required to develop a state plan for participation or cooperation in all
11 federal social security act programs relating to medical assistance or other
12 available federal programs that relate to medical assistance.
13 New Sec. 11. The director of health policy and finance shall have the
14 power, but is not required, to develop a state plan with regard to medical
15 assistance and services in which the federal government does not partic-
16 ipate, within the limits of appropriations therefor.
17 New Sec. 12. (a) Subject to the limitations of subsection (b), the
18 director of health policy and finance may enter into a contract with one
19 or more state agencies or local governmental entities providing for the
20 state agency or local governmental entity to perform services for the di-
21 vision of health policy and finance or delegating to the state agency or
22 local governmental entity the administration of certain functions, services
23 or programs under any of the programs for which the director of health
24 policy and finance or the division of health policy and finance is
25 responsible.
26 (b) With respect to any plan or program that is subject to or financed
27 in part under the federal social security act, 42 U.S.C. §1396 et seq., and
28 amendments thereto, the authority of the director of health policy and
29 finance or the division of health policy and finance to exercise adminis-
30 trative discretion in the administration or supervision of the plan or pro-
31 gram and to issue policies and to adopt rules and regulations on plan or
32 program matters shall not be delegated by the director of health policy
33 and finance, other than to officials and employees of the division of health
34 policy and finance. To the extent that the director of health policy and
35 finance enters into a contract with a state agency or local governmental
36 entity under this section, the other state agency or the local governmental
37 entity shall not have the authority to change or disapprove any adminis-
38 trative decision of the director of health policy and finance or the division
39 of health policy and finance or to otherwise substitute its judgment for
40 that of the director of health policy and finance or the division of health
41 policy and finance with respect to the application of policies issued or
42 rules and regulations adopted by the director of health policy and finance
43 for any plan or program that is subject to or financed in part under the

1 federal social security act, 42 U.S.C. §1396 et seq., and amendments
2 thereto.
3 New Sec. 13. (a) The director of health policy and finance shall have
4 the power and duty to establish general policies relating to the health care
5 programs under the director as provided in section 9, and amendments
6 thereto, and to adopt rules and regulations therefor.
7 (b) The director of health policy and finance shall advise the governor
8 and the legislature on all health care programs, policies and plans for
9 which the director of health policy and finance or the division of health
10 policy and finance is responsible under this act.
11 (c) The director of health policy and finance shall establish an ade-
12 quate system of financial records. The director of health policy and fi-
13 nance shall make periodic reports to the governor and shall make any
14 reports required by federal agencies.
15 (d) The director of health policy and finance may assist other de-
16 partments, agencies and institutions of the state and federal government
17 and of other states under interstate agreements, when so requested, by
18 performing services in conformity with the purposes of this act.
19 (e) All contracts of the division of health policy and finance shall be
20 made in the name of the "director of health policy and finance." In that
21 name, the director may sue and be sued. The grant of authority under
22 this subsection shall not be construed to be a waiver of any rights retained
23 by the state under the 11th amendment to the United States constitution
24 and shall be subject to and shall not supersede the provisions of any
25 appropriation act of this state.
26 (f) After consulting with any agency that has responsibility under a
27 contract with the division of health policy and finance for administration
28 of any of the programs of the division, the director of health policy and
29 finance shall prepare annually, at the time and in the form directed by
30 the governor, a budget covering the estimated receipts and expenditures
31 of the division of health policy and finance for the coming fiscal year.
32 (g) The director of health policy and finance shall have authority to
33 make grants of funds for the promotion of health care programs in the
34 state of Kansas, subject to the provisions of appropriation acts.
35 (h) The director of health policy and finance may receive grants, gifts,
36 bequests, money, or aid of any character whatsoever, for purposes con-
37 sistent with sections 9 through 14, and amendments thereto.
38 (i) The director of health policy and finance may enter into agree-
39 ments with other states or the agency designated as the single state agency
40 under the federal social security act, 42 U.S.C.§1396 et seq., and amend-
41 ments thereto, for another state setting out the manner for determining
42 the state of residence in disputed cases and the bearing or sharing of costs
43 associated with those cases.

Additional Technical Amendment
for SB 306 and HB 2531
March 29, 2005

1 (j) The director of health policy and finance shall establish such ad-
2 visory groups as are necessary to assist the division of health policy and
3 finance in carrying out its responsibilities under sections 9 through 14,
4 and amendments thereto, including the following:
5 (1) A consumer advisory board consisting of representatives of con-
6 sumers of health care services provided under title XIX of the federal
7 social security act, 42 U.S.C.§ 1396 et seq., and title XXI of the social
8 security act, 42 U.S.C. § 1397aa et seq., and amendments thereto, and
9 representatives of these consumers' family members; and
10 (2) a policy coordination board consisting of representatives from
11 those state agencies with which the director enters into a contract under
12 section 12, and amendments thereto, and representatives from any other
13 state agencies, as determined by the director.
14 (k) The director of health policy and finance shall perform any other
15 duties and services that are necessary to carry out the purposes of sections
16 9 through 14, and amendments thereto, and that are not inconsistent with
17 state law.

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18 New Sec. 14. On July 1, 2005, except as otherwise provided by this
19 act, all of the following powers, duties and functions of the department
20 of social and rehabilitation services and the secretary of social and reha-
21 bilitation services are hereby transferred to and imposed upon the division
22 of health policy and finance within the department of administration and
23 the director of health policy and finance established by this act:
24 (a) All of the powers, duties and functions of the secretary of social
25 and rehabilitation services under chapter 39 of the Kansas Statutes An-
26 notated, and amendments thereto, that relate to development, imple-
27 mentation and administration of programs that provide medical assis-
28 tance, health insurance programs or waivers granted thereunder for
29 persons who are needy or uninsured, or both, and that are financed by
30 federal funds or state funds, or both, including the following:
31 (1) The Kansas program of medical assistance established in accord-
32 ance with title XIX of the federal social security act, 42 U.S.C. § 1396 et
33 seq., and amendments thereto; and
34 (2) any program of medical assistance for needy persons financed by
35 state funds only;
36 (b) all of the powers, duties and functions of the secretary of social
37 and rehabilitation services with respect to the health benefits program for
38 children established under K.S.A. 38-2001 et seq., and amendments
39 thereto, and developed and submitted in accordance with federal guide-
40 lines established under title XXI of the federal social security act, section
41 4901 of public law 105-33, 42 U.S.C. §1397aa et seq., and amendments
42 thereto; ~~and~~
43 ~~(c)~~ all of the powers, duties and functions of the department of social

(c) the working healthy portion of the ticket to work program under the federal work incentive improvement act and the medicaid infrastructure grants received for the working healthy portion of the ticket to work program;

(d) the medicaid management information system (MMIS); and

(e)

1 (j) The director of health policy and finance shall establish such ad-
2 visory groups as are necessary to assist the division of health policy and
3 finance in carrying out its responsibilities under sections 9 through 14,
4 and amendments thereto, including the following:
5 (1) A consumer advisory board consisting of representatives of con-
6 sumers of health care services provided under title XIX of the federal
7 social security act, 42 U.S.C.§ 1396 et seq., and title XXI of the social
8 security act, 42 U.S.C. § 1397aa et seq., and amendments thereto, and
9 representatives of these consumers' family members; and
10 (2) a policy coordination board consisting of representatives from
11 those state agencies with which the director enters into a contract under
12 section 12, and amendments thereto, and representatives from any other
13 state agencies, as determined by the director.
14 (k) The director of health policy and finance shall perform any other
15 duties and services that are necessary to carry out the purposes of sections
16 9 through 14, and amendments thereto, and that are not inconsistent with
17 state law.
18 New Sec. 14. On July 1, 2005, except as otherwise provided by this
19 act, all of the following powers, duties and functions of the department
20 of social and rehabilitation services and the secretary of social and reha-
21 bilitation services are hereby transferred to and imposed upon the division
22 of health policy and finance within the department of administration and
23 the director of health policy and finance established by this act:
24 (a) All of the powers, duties and functions of the secretary of social
25 and rehabilitation services under chapter 39 of the Kansas Statutes An-
26 notated, and amendments thereto, that relate to development, imple-
27 mentation and administration of programs that provide medical assis-
28 tance, health insurance programs or waivers granted thereunder for
29 persons who are needy or uninsured, or both, and that are financed by
30 federal funds or state funds, or both, including the following:
31 (1) The Kansas program of medical assistance established in accord-
32 ance with title XIX of the federal social security act, 42 U.S.C. § 1396 et
33 seq., and amendments thereto; and
34 (2) any program of medical assistance for needy persons financed by
35 state funds only;
36 (b) all of the powers, duties and functions of the secretary of social
37 and rehabilitation services with respect to the health benefits program for
38 children established under K.S.A. 38-2001 et seq., and amendments
39 thereto, and developed and submitted in accordance with federal guide-
40 lines established under title XXI of the federal social security act, section
41 4901 of public law 105-33, 42 U.S.C. §1397aa et seq., and amendments
42 thereto; and
43 (c) all of the powers, duties and functions of the department of social

1 and rehabilitation services and secretary of social and rehabilitation serv-
2 ices associated with designation of the department of social and rehabil-
3 itation services as the single state agency under title XIX of the federal
4 social security act, 42 U.S.C. § 1396 et seq., and amendments thereto.
5 The designation of the department of social and rehabilitation services as
6 the single state agency for medicaid purposes is hereby transferred to the
7 division of health policy and finance.
8 New Sec. 15. (a) The division of health policy and finance within the
9 department of administration and the director of health policy and finance
10 established by this act shall be the successor in every way to the powers,
11 duties and functions of the department of social and rehabilitation serv-
12 ices and secretary of social and rehabilitation services in which the same
13 were vested prior to the effective date of this act and that are transferred
14 pursuant to section 14, and amendments thereto. Every act performed in
15 the exercise of such transferred powers, duties and functions by or under
16 the authority of the division of health policy and finance or the director
17 of health policy and finance within the department of administration shall
18 be deemed to have the same force and effect as if performed by the
19 department of social and rehabilitation services or secretary of social and
20 rehabilitation services in which such powers, duties and functions were
21 vested prior to July 1, 2005.
22 (b) ~~Whenever~~ the department of social and rehabilitation services or
23 the secretary of social and rehabilitation services, or words of like effect,
24 are referred to or designated by a statute, contract, memorandum of un-
25 derstanding, plan, grant, waiver or other document and such reference is
26 in regard to any of the powers, duties or functions transferred to the
27 division of health policy and finance or the director of health policy and
28 finance pursuant to section 14, and amendments thereto, such reference
29 or designation shall be deemed to apply to the division of health policy
30 and finance or the director of health policy and finance, respectively. The
31 provisions of this subsection shall not apply to references to or designa-
32 tions of the department of social and rehabilitation services or the sec-
33 retary of social and rehabilitation services, or words of like effect, by the
34 provisions of appropriation acts.
35 (c) All rules and regulations, orders and directives of the secretary of
36 social and rehabilitation services that relate to the functions transferred
37 by section 14, and amendments thereto, and that are in effect on July 1,
38 2005, shall continue to be effective and shall be deemed to be rules and
39 regulations, orders and directives of the director of health policy and
40 finance until revised, amended, revoked or nullified pursuant to law.
41 New Sec. 16. (a) The division of health policy and finance within the
42 department of administration shall succeed to all property, property
43 rights, and records that were used for or pertain to the performance of

From July 1, 2005, through June 30, 2006, whenever

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1 powers, duties and functions transferred to the division pursuant to sec-
2 tion 14, and amendments thereto. Any conflict as to the proper disposition
3 of property, personnel or records arising under this act shall be deter-
4 mined by the governor, whose decision shall be final.
5 (b) The provisions of this section shall not apply to the balances of
6 any funds or accounts thereof appropriated or reappropriated for the
7 department of social and rehabilitation services relating to the powers,
8 duties and functions transferred by section 14, and amendments thereto.
9 All such balances of any funds or accounts thereof shall be transferred by
10 and be subject to the provisions of appropriation acts.
11 New Sec. 17. (a) (1) All officers and employees of the department of
12 social and rehabilitation services who, immediately prior to the effective
13 date of this act, are engaged in the exercise and performance of the pow-
14 ers, duties and functions transferred to the division of health policy and
15 finance or the director of health policy and finance by section 14, and
16 amendments thereto, are transferred to the department of administration
17 on July 1, 2005, or on a later date or dates determined by the secretary
18 of social and rehabilitation services and the secretary of administration.
19 (2) All officers and employees of the department of social and reha-
20 bilitation services who are determined by the secretary of social and re-
21 habilitation services and the secretary of administration to be engaged in
22 providing administrative, technical or other support services that are es-
23 sential to the exercise and performance of the powers, duties and func-
24 tions transferred by section 14, and amendments thereto, are transferred
25 to the department of administration on July 1, 2005, or on a later date or
26 dates determined by the secretary of social and rehabilitation services and
27 the secretary of administration.
28 (3) All classified employees transferred under this subsection (a) shall
29 retain their status as classified employees. Thereafter, the secretary of
30 administration may convert vacant classified positions to positions that are
31 not classified as otherwise provided by law.
32 (b) Officers and employees of the department of social and rehabil-
33 itation services transferred by this act shall retain all retirement benefits
34 and leave balances and rights that had accrued or vested prior to the date
35 of transfer. The service of each such officer and employee so transferred
36 shall be deemed to have been continuous. Any subsequent transfers, lay-
37 offs or abolition of classified service positions under the Kansas civil serv-
38 ice act shall be made in accordance with the civil service laws and any
39 rules and regulations adopted thereunder. Nothing in this act shall affect
40 the classified status of any transferred person employed by the depart-
41 ment of social and rehabilitation services prior to the date of transfer.
42 ~~New Sec. 18. On July 1, 2005, the designation of the department of~~
43 ~~health and environment under K.S.A. 46-2507, and amendments thereto.~~

, except as otherwise provided by this act

The positions of all officers and employees of the department of administration performing duties and functions under the Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto, that are required under applicable federal law, rules and regulations, and policies to be under a merit-based personnel system, shall be in the classified service under the Kansas civil service act.

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as the contact agency for the state of Kansas with reference to federal health care reform measures is hereby transferred to and imposed upon the division of health policy and finance within the department of administration and the director of health policy and finance established by section 7, and amendments thereto.

New Sec. 19. (a) The division of health policy and finance within the department of administration and the director of health policy and finance established by section 7, and amendments thereto, shall be the successor in every way to the powers, duties and functions of the department of health and environment and secretary of health and environment in which the same were vested prior to July 1, 2005, and that are transferred pursuant to section 18, and amendments thereto. Every act performed in the exercise of such transferred powers, duties and functions by or under the authority of the division of health policy and finance or the director of health policy and finance within the department of administration shall be deemed to have the same force and effect as if performed by the department of health and environment or secretary of health and environment in which such powers, duties and functions were vested prior to July 1, 2005.

(b) From July 1, 2005, through June 30, 2006, whenever the department of health and environment or the secretary of health and environment, or words of like effect, are referred to or designated by a statute, contract, memorandum of understanding, plan, grant, waiver or other document and such reference is in regard to any of the powers, duties or functions transferred to the division of health policy and finance or the director of health policy and finance pursuant to section 18, and amendments thereto, such reference or designation shall be deemed to apply to the division of health policy and finance or the director of health policy and finance, respectively. The provisions of this subsection shall not apply to references to or designations of the department of health and environment or the secretary of health and environment, or words of like effect, by the provisions of appropriation acts.

(c) All rules and regulations, orders and directives of the secretary of health and environment that relate to the functions transferred by section 18, and amendments thereto, and that are in effect on July 1, 2005, shall continue to be effective and shall be deemed to be rules and regulations, orders and directives of the director of health policy and finance until revised, amended, revoked or nullified pursuant to law.

New Sec. 20. (a) On July 1, 2005, the division of health policy and finance within the department of administration shall succeed to all property, property rights, and records that were used for or pertain to the performance of powers, duties and functions transferred to the division pursuant to section 18, and amendments thereto. Any conflict as to the

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~~proper disposition of property, personnel or records arising under this act shall be determined by the governor, whose decision shall be final.~~

~~(b) The provisions of this section shall not apply to the balances of any funds or accounts thereof appropriated or reappropriated for the department of health and environment relating to the powers, duties and functions transferred by section 18, and amendments thereto. All such balances of any funds or accounts thereof shall be transferred by and be subject to the provisions of appropriation acts.~~

New Sec. ~~21~~. Liability for accrued compensation or salaries of each officer and employee who is transferred to the department of administration under this act shall be assumed and paid by the department of administration on July 1, 2005, or on the date of the transfer, whichever is later.

18

section 17, and amendments thereto,

New Sec. ~~22~~. (a) On January 1, 2006, except as otherwise provided by this act, all of the powers, duties and functions of the department of social and rehabilitation services and the secretary of social and rehabilitation services that relate to the restrictive drug formulary, the drug utilization review program, including the medicaid drug utilization review board, and the electronic pharmacy claims management system under K.S.A. 39-7,116, 39-7,118, 39-7,119, 39-7,120, 39-7,121 and K.S.A. 2004 Supp. 39-7,121a, 39-7,121d, 39-7,121e, and amendments thereto, are hereby transferred to and imposed upon the Kansas health policy authority established by section 1, and amendments thereto.

19

(b) The Kansas health policy authority shall be the successor in every way to such powers, duties and functions of the department of social and rehabilitation services and secretary of social and rehabilitation services in which the same were vested prior to January 1, 2006, and that are transferred pursuant to this section. Every act performed in the exercise of such transferred powers, duties and functions by or under the authority of the Kansas health policy authority shall be deemed to have the same force and effect as if performed by the department of social and rehabilitation services and secretary of social and rehabilitation services in which such powers, duties and functions were vested prior to January 1, 2006.

(c) On or after January 1, 2006, whenever the department of social and rehabilitation services or secretary of social and rehabilitation services or words of like effect, are referred to or designated by a statute, contract, memorandum of understanding, plan, grant, waiver or other document and such reference is in regard to any of the powers, duties or functions transferred to the Kansas health policy authority pursuant to this section, such reference or designation shall be deemed to apply to the Kansas health policy authority. The provisions of this subsection shall not apply to references to or designations of the department of social and rehabilitation services or the secretary of social and rehabilitation services, or

1 words of like effect, by the provisions of appropriation acts.
2 (d) All rules and regulations, orders and directives of the secretary of
3 social and rehabilitation services that relate to the functions transferred
4 pursuant to this section, and that are in effect on January 1, 2006, shall
5 continue to be effective and shall be deemed to be rules and regulations,
6 orders and directives of the Kansas health policy authority until revised,
7 amended, revoked or nullified pursuant to law.
8 (e) The Kansas health policy authority shall succeed to all property,
9 property rights, and records that were used for or pertain to the perform-
10 ance of powers, duties and functions transferred to the Kansas health
11 policy authority pursuant to this section. Any conflict as to the proper
12 disposition of property, personnel or records arising under this section
13 shall be determined by the governor, whose decision shall be final. The
14 provisions of this subsection shall not apply to the balances of any funds
15 or accounts thereof appropriated or reappropriated for the department
16 of social and rehabilitation services relating to the powers, duties and
17 functions transferred by this section. All such balances of any funds or
18 accounts thereof shall be transferred by and be subject to the provisions
19 of appropriation acts.
20 (f) (1) All officers and employees of the department of social and
21 rehabilitation services who, immediately prior to January 1, 2006, are
22 engaged in the exercise and performance of the powers, duties and func-
23 tions transferred to the Kansas health policy authority pursuant to this
24 section, are transferred to the Kansas health policy authority on January
25 1, 2006, or on a later date or dates determined by the secretary of social
26 and rehabilitation services and the Kansas health policy authority.
27 (2) All officers and employees of the department of social and reha-
28 bilitation services who are determined by the secretary of social and re-
29 habilitation services and the Kansas health policy authority to be engaged
30 in providing administrative, technical or other support services that are
31 essential to the exercise and performance of the powers, duties and func-
32 tions transferred pursuant to this section are transferred to the Kansas
33 health policy authority on January 1, 2006, or on a later date or dates
34 determined by the secretary of social and rehabilitation services and the
35 Kansas health policy authority.
36 (3) All classified employees transferred under this subsection (f) shall
37 retain their status as classified employees. Thereafter, the Kansas health
38 policy authority may convert vacant classified positions to positions that
39 are not classified as otherwise provided by law.
40 (g) Officers and employees of the department of social and rehabil-
41 itation services transferred by this section shall retain all retirement ben-
42 efits and leave balances and rights that had accrued or vested prior to the
43 date of transfer. The service of each such officer and employee so trans-

ferred shall be deemed to have been continuous. Any subsequent transfers, layoffs or abolition of classified service positions under the Kansas civil service act shall be made in accordance with the civil service laws and any rules and regulations adopted thereunder. Nothing in this act shall affect the classified status of any transferred person employed by the department of social and rehabilitation services prior to the date of transfer.

(h) Liability for accrued compensation or salaries of each officer and employee who is transferred to the Kansas health policy authority under this section shall be assumed and paid by the Kansas health policy authority on January 1, 2006, or on the date of the transfer, whichever is later.

New Sec. 23. (a) On January 1, 2006, except as otherwise provided by this act, all of the powers, duties and functions of the health care data governing board, department of health and environment and the secretary of health and environment that relate to the health care data system under K.S.A. 65-6801, 65-6802, 65-6804, 65-6805, 65-6806, 65-6807 and 65-6809 and K.S.A. 2004 Supp. 65-6803, and amendments thereto, are hereby transferred to and imposed upon the Kansas health policy authority established by section 1, and amendments thereto.

20

(b) The Kansas health policy authority shall be the successor in every way to such powers, duties and functions of the health care data governing board, department of health and environment and the secretary of health and environment in which the same were vested prior to January 1, 2006, and that are transferred pursuant to this section. Every act performed in the exercise of such transferred powers, duties and functions by or under the authority of the Kansas health policy authority shall be deemed to have the same force and effect as if performed by the health care data governing board, department of health and environment and the secretary of health and environment in which such powers, duties and functions were vested prior to January 1, 2006.

(c) On or after January 1, 2006, whenever the health care data governing board, department of health and environment or the secretary of health and environment or words of like effect, are referred to or designated by a statute, contract, memorandum of understanding, plan, grant, waiver or other document and such reference is in regard to any of the powers, duties or functions transferred to the Kansas health policy authority pursuant to this section, such reference or designation shall be deemed to apply to the Kansas health policy authority. The provisions of this subsection shall not apply to references to or designations of the health care data governing board, department of health and environment, or the secretary of health and environment, or words of like effect, by the provisions of appropriation acts.

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1 (d) All rules and regulations, orders and directives of the health care
2 data governing board or the secretary of health and environment that
3 relate to the functions transferred by this section, and that are in effect
4 on January 1, 2006, shall continue to be effective and shall be deemed to
5 be rules and regulations, orders and directives of the Kansas health policy
6 authority until revised, amended, revoked or nullified pursuant to law.
7 (e) The Kansas health policy authority shall succeed to all property,
8 property rights and records that were used for or pertain to the perform-
9 ance of powers, duties and functions transferred to the Kansas health
10 policy authority pursuant to this section. Any conflict as to the proper
11 disposition of property, personnel or records arising under this section
12 shall be determined by the governor, whose decision shall be final. The
13 provisions of this subsection shall not apply to the balances of any funds
14 or accounts thereof appropriated or reappropriated for the department
15 of health and environment relating to the powers, duties and functions
16 transferred by this section. All such balances of any funds or accounts
17 thereof shall be transferred by and be subject to the provisions of appro-
18 priation acts.
19 (f) (1) All officers and employees of the department of health and
20 environment who, immediately prior to January 1, 2006, are engaged in
21 the exercise and performance of the powers, duties and functions trans-
22 ferred to the Kansas health policy authority pursuant to this section, are
23 transferred to the Kansas health policy authority on January 1, 2006, or
24 on a later date or dates determined by the secretary of health and envi-
25 ronment and the Kansas health policy authority.
26 (2) All officers and employees of the department of health and en-
27 vironment who are determined by the secretary of health and environ-
28 ment and the Kansas health policy authority to be engaged in providing
29 administrative, technical or other support services that are essential to
30 the exercise and performance of the powers, duties and functions trans-
31 ferred by this section are transferred to the Kansas health policy authority
32 on January 1, 2006, or on a later date or dates determined by the secretary
33 of health and environment and the Kansas health policy authority.
34 (3) All classified employees transferred under this subsection (f) shall
35 retain their status as classified employees. Thereafter, the Kansas health
36 policy authority may convert vacant classified positions to positions that
37 are not classified as otherwise provided by law.
38 (g) Officers and employees of the department of health and environ-
39 ment transferred pursuant to this section shall retain all retirement ben-
40 efits and leave balances and rights that had accrued or vested prior to the
41 date of transfer. The service of each such officer and employee so trans-
42 ferred shall be deemed to have been continuous. Any subsequent trans-
43 fers, layoffs or abolition of classified service positions under the Kansas

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civil service act shall be made in accordance with the civil service laws and any rules and regulations adopted thereunder. Nothing in this act shall affect the classified status of any transferred person employed by the department of health and environment prior to the date of transfer.

(h) Liability for accrued compensation or salaries of each officer and employee who is transferred to the Kansas health policy authority under this section shall be assumed and paid by the Kansas health policy authority on January 1, 2006, or on the date of the transfer, whichever is later.

New Sec. 24. [21] (a) When any conflict arises as to the disposition of any property, power, duty or function as a result of any abolition or transfer made by or under the authority of this act, such conflict shall be resolved by the governor, whose decision shall be final.

(b) The provisions of this section shall not apply to the balances of any funds or accounts thereof appropriated or reappropriated, or the unexpended balance of any appropriation, for the department of social and rehabilitation services or for the department of health and environment relating to the powers, duties and functions transferred by or under authority of this act. All such balances of any funds or accounts thereof, or the unexpended balance of any appropriation, shall be transferred by and be subject to the provisions of appropriation acts.

New Sec. 25. [22] (a) No suit, action, or other proceeding, judicial or administrative, that is lawfully commenced or that could have been lawfully commenced, by or against any state agency or program mentioned in this act, or by or against any officer of the state in such officer's official capacity or in relation to the discharge of such officer's official duties, shall abate by reason of the governmental reorganization effected under the provisions of this act. The court may allow any such suit, action or other proceeding to be maintained by or against the successor of any such state agency or any officer affected.

(b) No criminal action that is commenced or that could have been commenced by the state shall abate by the taking effect of this act.

Sec. 26. [23] On January 1, 2006, K.S.A. 39-7,116 is hereby amended to read as follows: 39-7,116. As used in this act:

(a) "Restrictive drug formulary" means a list of prescription-only drugs established by the department which excludes in whole or in part reimbursement by the department for such drugs under a program administered by the department.

(b) The words and phrases used in this section shall have the same meanings as are ascribed to such words and phrases under K.S.A. 65-1626 and amendments thereto.

(c) "Physician" means a person licensed to practice medicine and surgery.

1 (d) ~~"Department" means the department of social and rehabilitation~~
2 ~~services~~ *"Authority" means the Kansas health policy authority.*
3 Sec. 27. On January 1, 2006, K.S.A. 2004 Supp. 39-7,118 is hereby
4 amended to read as follows: 39-7,118. The ~~secretary of social and reha-~~
5 ~~bilitation services~~ *Kansas health policy authority* shall implement a drug
6 utilization review program with the assistance of a medicaid drug utili-
7 zation review board as provided in K.S.A. 39-7,119 and amendments
8 thereto to assure the appropriate utilization of drugs by patients receiving
9 medical assistance under the medicaid program. The drug utilization re-
10 view program shall include:
11 (a) Monitoring of prescription information including overutilization
12 and underutilization of prescription-only drugs;
13 (b) making periodic reports of findings and recommendations to the
14 ~~secretary of social and rehabilitation services~~ *Kansas health policy au-*
15 *thority* and the United States department of health and human services
16 regarding the activities of the board, drug utilization review programs,
17 summary of interventions, assessments of education interventions and
18 drug utilization review cost estimates;
19 (c) providing for prospective and retrospective drug utilization re-
20 view, as specified in the federal omnibus budget reconciliation act of 1990
21 (public law 101-508);
22 (d) monitoring provider and recipient compliance with program
23 objectives;
24 (e) providing educational information on state program objectives,
25 directly or by contract, to private and public sector health care providers
26 to improve prescribing and dispensing practices;
27 (f) reviewing the increasing costs of purchasing prescription drugs
28 and making recommendations on cost containment;
29 (g) reviewing profiles of medicaid beneficiaries who have multiple
30 prescriptions above a level specified by the board; and
31 (h) recommending any modifications or changes to the medicaid pre-
32 scription drug program.
33 Sec. 28. On January 1, 2006, K.S.A. 2004 Supp. 39-7,119 is hereby
34 amended to read as follows: 39-7,119. (a) There is hereby created the
35 medicaid drug utilization review board which shall be responsible for the
36 implementation of retrospective and prospective drug utilization pro-
37 grams under the Kansas medicaid program.
38 (b) Except as provided in subsection (i), the board shall consist of at
39 least seven members appointed as follows:
40 (1) Two licensed physicians actively engaged in the practice of med-
41 icine, nominated by the Kansas medical society and appointed by the
42 ~~secretary of social and rehabilitation services~~ *Kansas health policy au-*
43 *thority* from a list of four nominees;

(2) one licensed physician actively engaged in the practice of osteopathic medicine, nominated by the Kansas association of osteopathic medicine and appointed by the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* from a list of four nominees;

(3) two licensed pharmacists actively engaged in the practice of pharmacy, nominated by the Kansas pharmacy association and appointed by the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* from a list of four nominees;

(4) one person licensed as a pharmacist and actively engaged in academic pharmacy, appointed by the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* from a list of four nominees provided by the university of Kansas;

(5) one licensed professional nurse actively engaged in long-term care nursing, nominated by the Kansas state nurses association and appointed by the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* from a list of four nominees.

(c) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* may add two additional members so long as no class of professional representatives exceeds 51% of the membership.

(d) The physician and pharmacist members shall have expertise in the clinically appropriate prescribing and dispensing of outpatient drugs.

(e) The appointments to the board shall be for terms of three years. In making the appointments, the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall provide for geographic balance in the representation on the board to the extent possible. Subject to the provisions of subsection (i), members may be reappointed.

(f) The board shall elect a chairperson from among board members who shall serve a one-year term. The chairperson may serve consecutive terms.

(g) The board, in accordance with K.S.A. 75-4319 and amendments thereto, may recess for a closed or executive meeting when it is considering matters relating to identifiable patients or providers.

(h) All actions of the medicaid drug utilization review board shall be upon the affirmative vote of five members of the board and the vote of each member present when action was taken shall be recorded by roll call vote.

(i) Upon the expiration of the term of office of any member of the medicaid drug utilization review board on or after the effective date of this act and in any case of a vacancy existing in the membership position of any member of the medicaid drug utilization review board on or after the effective date of this act, a successor shall be appointed by the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* so that as the terms of members expire, or vacancies occur, members are

appointed and the composition of the board is changed in accordance with the following and such appointment shall be made by the ~~secretary~~ *authority* in the following order of priority:

(1) One member shall be a licensed pharmacist who is actively performing or who has experience performing medicaid pharmacy services for a hospital and who is nominated by the Kansas hospital association and appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(2) one member shall be a licensed pharmacist who is actively performing or who has experience performing medicaid pharmacy services for a licensed adult care home and who is nominated by the state board of pharmacy and appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(3) one member shall be a licensed physician who is actively engaged in the general practice of allopathic medicine and who has practice experience with the state medicaid plan and who is nominated by the Kansas medical society and appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(4) one member shall be a licensed physician who is actively engaged in mental health practice providing care and treatment to persons with mental illness, who has practice experience with the state medicaid plan and who is nominated by the Kansas psychiatric society and appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(5) one member shall be a licensed physician who is the medical director of a nursing facility, who has practice experience with the state medicaid plan and who is nominated by the Kansas medical society and appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(6) one member shall be a licensed physician who is actively engaged in the general practice of osteopathic medicine, who has practice experience with the state medicaid plan and who is nominated by the Kansas association of osteopathic medicine and who is appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(7) one member shall be a licensed pharmacist who is actively engaged in retail pharmacy, who has practice experience with the state medicaid plan and who is nominated by the state board of pharmacy and appointed by the ~~secretary~~ *authority* from a list of two or more nominees;

(8) one member shall be a licensed pharmacist who is actively engaged in or who has experience in research pharmacy and who is nominated jointly by the Kansas task force for the pharmaceutical research and manufacturers association and the university of Kansas and appointed by the ~~secretary~~ *authority* from a list of two or more jointly nominated persons; and

(9) one member shall be a licensed advanced registered nurse prac-

titioner or physician assistant actively engaged in the practice of providing the health care and treatment services such person is licensed to perform, who has practice experience with the state medicaid plan and who is nominated jointly by the Kansas state nurses' association and the Kansas academy of physician assistants and appointed by the ~~secretary~~ *authority* from a list of two or more jointly nominated persons.

Sec. ~~29~~ 26. On January 1, 2006, K.S.A. 2004 Supp. 39-7,120 is hereby amended to read as follows: 39-7,120. (a) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall not restrict patient access to prescription-only drugs pursuant to a program of prior authorization or a restrictive formulary except by rules and regulations adopted in accordance with K.S.A. 77-415 *et seq.*, and amendments thereto. Prior to the promulgation of any such rules and regulations, the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall submit such proposed rules and regulations to the medicaid drug utilization review board for written comment. The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* may not implement permanent prior authorization until 30 days after receipt of comments by the drug utilization review board.

(b) When considering recommendations from the medicaid drug utilization review board regarding the prior authorization of a drug, the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall consider the net economic impact of such prior authorization, including, but not limited to, the costs of specific drugs, rebates or discounts pursuant to 42 U.S.C. 1396r-8, dispensing costs, dosing requirements and utilization of other drugs or other medicaid health care services which may be related to the prior authorization of such drug.

Sec. ~~30~~ 27. On January 1, 2006, K.S.A. 39-7,121 is hereby amended to read as follows: 39-7,121. (a) ~~On or before July 1, 1996, the department of social and rehabilitation services~~ *The Kansas health policy authority* shall establish and implement an electronic pharmacy claims management system in order to provide for the on-line adjudication of claims and for electronic prospective drug utilization review.

(b) The system shall provide for electronic point-of-sale review of drug therapy using predetermined standards to screen for potential drug therapy problems including incorrect drug dosage, adverse drug-drug interactions, drug-disease contraindications, therapeutic duplication, incorrect duration of drug treatment, drug-allergy interactions and clinical abuse or misuse.

(c) The ~~department~~ *authority* shall not utilize this system, or any other system or program to require that a recipient has utilized or failed with a drug usage or drug therapy prior to allowing the recipient to receive the product or therapy recommended by the recipient's physician.

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Sec. ~~31~~. [28] On January 1, 2006, K.S.A. 2004 Supp. 39-7,121a is hereby amended to read as follows: 39-7,121a. (a) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* may establish an advisory committee pursuant to K.S.A. 75-5313, and amendments thereto, to advise the ~~secretary~~ *authority* in the development of a preferred formulary listing of covered drugs by the state medicaid program.

(b) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall evaluate drugs and drug classes for inclusion in the state medicaid preferred drug formulary based on safety, effectiveness and clinical outcomes of such treatments. In addition, the ~~secretary~~ *authority* shall evaluate drugs and drug classes to determine whether inclusion of such drugs or drug classes in a starter dose program would be clinically efficacious and cost effective. If the factors of safety, effectiveness and clinical outcomes among drugs being considered in the same class indicate no therapeutic advantage, then the ~~secretary~~ *authority* shall consider the cost effectiveness and the net economic impact of such drugs in making recommendations for inclusion in the state medicaid preferred drug formulary. Drugs which do not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcomes over other drugs in the same class which have been selected for the preferred drug formulary may be excluded from the preferred drug formulary and may be subject to prior authorization in accordance with state and federal law, except, prior to July 1, 2003, where a prescriber has personally written "dispense as written" or "D.A.W.", or has signed the prescriber's name on the "dispense as written" signature line in accordance with K.S.A. 65-1637, and amendments thereto.

(c) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall consider the net economic impact of drugs selected or excluded from the preferred formulary and may gather information on the costs of specific drugs, rebates or discounts pursuant to 42 U.S.C. 1396r-8, dispensing costs, dosing requirements and utilization of other drugs or other medicaid health care services.

(d) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* may accept all services, including, but not limited to, disease state management, associated with the delivery of pharmacy benefits under the state medicaid program having a determinable cost effect in addition to the medicaid prescription drug rebates required pursuant to 42 U.S.C. section 1396r-8.

(e) The state medicaid preferred drug formulary shall be submitted to the medicaid drug utilization review board for review and policy recommendations.

Sec. ~~32~~. [29] On January 1, 2006, K.S.A. 2004 Supp. 39-7,121d is hereby amended to read as follows: 39-7,121d. (a) The state medicaid plan shall

1 include provisions for a program of differential dispensing fees for phar-
2 macies that provide prescriptions for adult care homes under a unit dose
3 system in accordance with rules and regulations of the state board of
4 pharmacy and that participate in the return of unused medications pro-
5 gram under the state medicaid plan.
6 (b) The state medicaid plan shall include provisions for differential
7 ingredient cost reimbursement of generic and brand name pharmaceu-
8 ticals. The ~~secretary of social and rehabilitation services~~ *Kansas health*
9 *policy authority* shall set the rates for differential cost reimbursement of
10 generic and brand name pharmaceuticals by rules and regulations.

30

11 Sec. ~~33~~. On January 1, 2006, K.S.A. 2004 Supp. 39-7,121e is hereby
12 amended to read as follows: 39-7,121e. (a) Except where a prescriber has
13 personally written "dispense as written" or "D.A.W.," or has signed the
14 prescriber's name on the "dispense as written" signature line in accord-
15 ance with K.S.A. 65-1637 and amendments thereto, the ~~secretary of social~~
16 ~~and rehabilitation services~~ *Kansas health policy authority* may limit re-
17 imbursement for a prescription under the medicaid program to the mul-
18 tisource generic equivalent drug.
19 (b) No pharmacist participating in the medical assistance program
20 shall be required to dispense a prescription-only drug that will not be
21 reimbursed by the medical assistance program.

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22 Sec. ~~34~~. On January 1, 2006, K.S.A. 65-6801 is hereby amended to
23 read as follows: 65-6801. (a) The legislature recognizes the urgent need
24 to provide health care consumers, third-party payors, providers and health
25 care planners with information regarding the trends in use and cost of
26 health care services in this state for improved decision-making. This is to
27 be accomplished by compiling a uniform set of data and establishing
28 mechanisms through which the data will be disseminated.
29 (b) It is the intent of the legislature to require that the information
30 necessary for a review and comparison of utilization patterns, cost, quality
31 and quantity of health care services be supplied to the health care data-
32 base by all providers of health care services and third-party payors to the
33 extent required by K.S.A. 65-6805 and amendments thereto and this sec-
34 tion and amendments thereto. The ~~secretary of health and environment~~
35 ~~at the direction of the health care data governing board~~ *Kansas health*
36 *policy authority* shall specify by rule and regulation the types of infor-
37 mation which shall be submitted and the method of submission.
38 (c) The information is to be compiled and made available in a form
39 prescribed by the ~~governing board~~ *Kansas health policy authority* to im-
40 prove the decision-making processes regarding access, identified needs,
41 patterns of medical care, price and use of health care services.

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42 Sec. ~~35~~. On January 1, 2006, K.S.A. 2004 Supp. 65-6803 is hereby
43 amended to read as follows: 65-6803. (a) ~~There is hereby created a~~ *On*

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January 1, 2006, the health care data governing board *is hereby abolished.*

~~(b) The board shall consist of 15 members appointed as follows: One member shall be appointed by the Kansas medical society, one member shall be appointed by the Kansas hospital association, one member shall be appointed by the executive vice chancellor of the university of Kansas school of medicine, one member who is a licensed professional nurse shall be appointed by the Kansas state nurses association, one member representing health care insurers or other commercial payors shall be appointed by the governor, one member representing a large business that is self-insured as to medical coverage for its employees shall be appointed by the governor, one member representing a small business that is self-insured as to medical coverage for its employees shall be appointed by the governor, one member representing adult care homes shall be appointed by the governor, one member representing the Kansas health institute, one member shall be appointed by the state board of regents, one member representing consumers of health care shall be appointed by the governor and one additional member the governor deems appropriate to serve on this board shall be appointed by the governor. The secretary of health and environment, the secretary of social and rehabilitation services and the insurance commissioner, or their designees, shall be voting members of the board. The secretary of health and environment, or the designee of the secretary, shall also serve as chairperson of the board. Board members and task force members shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings or subcommittee meetings of the board. The members appointed to the board shall serve for three-year terms or until their successors are appointed and qualified.~~

~~(c)~~ *(b)* The chairperson of the ~~health care data governing board~~ *Kansas health policy authority* may appoint a task force or task forces of interested citizens and providers of health care for the purpose of studying technical issues relating to the collection of health care data. At least one member of the ~~health care data governing board~~ *Kansas health policy authority* shall be a member of any task force appointed under this subsection.

~~(d) The board shall meet at least quarterly and at such other times deemed necessary by the chairperson.~~

~~(e)~~ *(c)* The ~~board~~ *Kansas health policy authority* shall develop policy regarding the collection of health care data and procedures for ensuring the confidentiality and security of these data. 33

Sec. 36. On January 1, 2006, K.S.A. 65-6804 is hereby amended to read as follows: 65-6804. (a) The ~~secretary of health and environment~~ *Kansas health policy authority* shall administer the health care database. In administering the health care database, the ~~secretary~~ *authority* shall

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receive health care data from those entities identified in K.S.A. 65-6805 and amendments thereto and provide for the dissemination of such data ~~as directed by the board~~.

(b) ~~As directed by the board, the secretary of health and environment~~ *The Kansas health policy authority* may contract with an organization experienced in health care data collection to collect the data from the health care facilities as described in subsection (h) of K.S.A. 65-425 and amendments thereto, build and maintain the database. The ~~secretary of health and environment~~ *Kansas health policy authority* may accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data required pursuant to this section.

(c) The ~~secretary of health and environment~~ *Kansas health policy authority* shall adopt rules and regulations approved by the board governing the acquisition, compilation and dissemination of all data collected pursuant to this act. The rules and regulations shall provide at a minimum that:

(1) Measures have been taken to provide system security for all data and information acquired under this act;

(2) data will be collected in the most efficient and cost-effective manner for both the department and providers of data;

(3) procedures will be developed to assure the confidentiality of patient records. Patient names, addresses and other personal identifiers will be omitted from the database;

(4) users may be charged for data preparation or information that is beyond the routine data disseminated and that the ~~secretary~~ *authority* shall establish by the adoption of such rules and regulations a system of fees for such data preparation or dissemination; and

(5) the ~~secretary of health and environment~~ *Kansas health policy authority* will ensure that the health care database will be kept current, accurate and accessible as prescribed by rules and regulations.

(d) Data and other information collected pursuant to this act shall be confidential, shall be disseminated only for statistical purposes pursuant to rules and regulations adopted by the ~~secretary of health and environment~~ *Kansas health policy authority* ~~and approved by the board~~ and shall not be disclosed or made public in any manner which would identify individuals. A violation of this subsection (d) is a class C misdemeanor.

(e) In addition to such criminal penalty under subsection (d), any individual whose identity is revealed in violation of subsection (d) may bring a civil action against the responsible person or persons for any damages to such individual caused by such violation.

Sec. ~~33~~ 34. On January 1, 2006, K.S.A. 65-6805 is hereby amended to

read as follows: 65-6805. Each medical care facility as defined by subsection (h) of K.S.A. 65-425 and amendments thereto; health care provider as defined in K.S.A. 40-3401 and amendments thereto; providers of health care as defined in subsection (f) of K.S.A. 65-5001 and amendments thereto; health care personnel as defined in subsection (e) of K.S.A. 65-5001 and amendments thereto; home health agency as defined by subsection (b) of K.S.A. 65-5101 and amendments thereto; psychiatric hospitals licensed under K.S.A. 75-3307b and amendments thereto; state institutions for the mentally retarded; community mental retardation facilities as defined under K.S.A. 65-4412 and amendments thereto; community mental health center as defined under K.S.A. 65-4432 and amendments thereto; adult care homes as defined by K.S.A. 39-923 and amendments thereto; laboratories described in K.S.A. 65-1,107 and amendments thereto; pharmacies; board of nursing; Kansas dental board; board of examiners in optometry; state board of pharmacy; state board of healing arts and third-party payors, including but not limited to, licensed insurers, medical and hospital service corporations, health maintenance organizations, fiscal intermediaries for government-funded programs and self-funded employee health plans, shall file health care data with the ~~secretary of health and environment~~ *Kansas health policy authority* as prescribed by the ~~board~~ *authority*. The provisions of this section shall not apply to any individual, facility or other entity under this section which uses spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination for the treatment or cure of disease.

Sec. ~~38~~ 35. On January 1, 2006, K.S.A. 65-6806 is hereby amended to read as follows: 65-6806. The ~~secretary of health and environment~~ *Kansas health policy authority* shall make the data available to interested parties on the basis prescribed by the ~~board~~ *authority* and as directed by rules and regulations *of the authority*.

Sec. ~~39~~ 36. On January 1, 2006, K.S.A. 65-6807 is hereby amended to read as follows: 65-6807. The ~~secretary of health and environment~~ *Kansas health policy authority* shall on or before February 1 each year make a report to the governor and the legislature as to health care data activity, including examples of policy analyses conducted and purposes for which the data was disseminated and utilized, and as to the progress made in compiling and making available the information specified under K.S.A. 65-6801 and amendments thereto.

Sec. ~~40~~ 37. On January 1, 2006, K.S.A. 65-6809 is hereby amended to read as follows: 65-6809. (a) There is hereby established in the state treasury the health care database fee fund. The ~~secretary of health and environment~~ *Kansas health policy authority* shall remit to the state treasurer, in accordance with the provisions of K.S.A. 75-4215, and amendments

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thereto, all moneys collected or received by the ~~secretary~~ *authority* from the following sources:

(1) Fees collected under K.S.A. 65-6804, and amendments thereto;

(2) moneys received by the ~~secretary~~ *authority* in the form of gifts, donations or grants;

(3) interest attributable to investment of moneys in the fund; and

(4) any other moneys provided by law.

Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the health care database fee fund.

(b) Moneys deposited in the health care database fee fund shall be expended to supplement maintenance costs of the database, provide technical assistance and training in the proper use of health care data and provide funding for dissemination of information from the database to the public. ~~If the performance audit required by K.S.A. 65-6808, and amendments thereto, is conducted under contract with a firm, as defined by K.S.A. 46-1112, and amendments thereto, the contract cost of that performance audit may be paid from the health care database fee fund.~~

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

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

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

(d) All expenditures from the health care database fee 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 health and environment~~ *Kansas health policy authority or the authority's designee* for the purposes set forth in this section.

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New Sec. ~~4~~. On July 1, 2006, the division of health policy and finance and the office of the director of health policy and finance established within the department of administration by section 7 are hereby abolished.

, and amendments thereto,

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Sec. ~~4~~. On July 1, 2006, section 9 of this act is hereby amended to read as follows: Sec. 9. (a) *On and after July 1, 2006,* the ~~director of health policy and finance~~ *Kansas health policy authority* shall coordinate health care planning, administration, and purchasing and analysis of health care data for the state of Kansas with respect to the following health care programs administered by the state of Kansas:

(1) Developing, implementing, and administering programs that provide medical assistance, health insurance programs, or waivers granted thereunder for persons who are needy, uninsured, or both, and that are

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1 financed by federal funds or state funds, or both, including the following:
2 (A) The Kansas program of medical assistance established in accord-
3 ance with title XIX of the federal social security act, 42 U.S.C. § 1396 et
4 seq., and amendments thereto;
5 (B) the health benefits program for children established under K.S.A.
6 38-2001 et seq., and amendments thereto, and developed and submitted
7 in accordance with federal guidelines established under title XXI of the
8 federal social security act, section 4901 of public law 105-33, 42 U.S.C.§
9 1397aa et seq., and amendments thereto;
10 (C) any program of medical assistance for needy persons financed by
11 state funds only, to the extent appropriations are made for such a
12 program;
13 (D) the working healthy portion of the ticket to work program under
14 the federal work incentive improvement act and the medicaid infrastruc-
15 ture grants received for the working healthy portion of the ticket to work
16 program; and
17 (E) the medicaid management information system (MMIS);
18 (2) serving as the designated contact agency for the state of Kansas
19 under K.S.A. 46-2507, and amendments thereto, with reference to federal
20 health care reform measures; and
21 (3) administering any other health care programs delegated to the
22 ~~director~~ *Kansas health policy authority* by the governor or by a contract
23 with another state agency.
24 (b) Except to the extent required by its single state agency role as
25 designated in section 10, and amendments thereto, *or as otherwise pro-*
26 *vided pursuant to this act* the ~~division of health policy and finance~~ *Kansas*
27 *health policy authority* shall not be responsible for health care planning,
28 administration, purchasing and data with respect to the following:
29 (1) The mental health reform act, K.S.A. 39-1601 et seq., and amend-
30 ments thereto;
31 (2) the developmental disabilities reform act, K.S.A. 39-1801 et seq.,
32 and amendments thereto;
33 (3) the mental health program of the state of Kansas as prescribed
34 under K.S.A. 75-3304a, and amendments thereto;
35 (4) the addiction and prevention services prescribed under K.S.A. 65-
36 4001 et seq., and amendments thereto; or
37 (5) any institution, as defined in K.S.A. 76-12a01, and amendments
38 thereto.
39 Sec. 43. On July 1, 2006, section 10 of this act is hereby amended to
40 read as follows: Sec. 10. (a) *On and after July 1, 2006,* the ~~division of~~
41 ~~health policy and finance~~ *Kansas health policy authority* shall be desig-
42 nated as the single state agency with responsibility for supervising and
43 administering the state plan for medical assistance under the federal social

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security act, 42 U.S.C. § 1396 et seq., and amendments thereto. The ~~director~~ *Kansas health policy authority* shall develop state plans, as provided under the federal social security act, whereby the state cooperates with the federal government in its program of assisting the states financially in furnishing medical assistance and services to eligible individuals.

(b) The ~~director of health policy and finance~~ *Kansas health policy authority* shall undertake to cooperate with the federal government on any other federal program providing federal financial assistance and services for medical assistance not inconsistent with this act. The ~~director of health policy and finance~~ *Kansas health policy authority* is not required to develop a state plan for participation or cooperation in all federal social security act programs relating to medical assistance or other available federal programs that relate to medical assistance.

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Sec. ~~44~~. On July 1, 2006, section 11 of this act is hereby amended to read as follows: Sec. 11. *On and after July 1, 2006,* the ~~director of health policy and finance~~ *Kansas health policy authority* shall have the power, but is not required, to develop a state plan with regard to medical assistance and services in which the federal government does not participate, within the limits of appropriations therefor.

42

Sec. ~~45~~. On July 1, 2006, section 12 of this act is hereby amended to read as follows: Sec. 12. (a) Subject to the limitations of subsection (b), the ~~director of health policy and finance~~ *Kansas health policy authority* may enter into a contract with one or more state agencies or local governmental entities providing for the state agency or local governmental entity to perform services for the division of health policy and finance or delegating to the state agency or local governmental entity the administration of certain functions, services or programs under any of the programs for which the ~~director of health policy and finance or the division of health policy and finance~~ *Kansas health policy authority* is responsible.

(b) With respect to any plan or program that is subject to or financed in part under the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto, the authority of the ~~director of health policy and finance or the division of health policy and finance~~ *Kansas health policy authority* to exercise administrative discretion in the administration or supervision of the plan or program and to issue policies and to adopt rules and regulations on plan or program matters shall not be delegated by the ~~director of health policy and finance~~ *Kansas health policy authority*, other than to officials and employees of the ~~division of health policy and finance~~ *authority*. To the extent that the ~~director of health policy and finance~~ *Kansas health policy authority* enters into a contract with a state agency or local governmental entity under this section, the other state agency or the local governmental entity shall not have the authority to change or disapprove any administrative decision of the ~~director of health policy and~~

~~finance or the division of health policy and finance~~ *Kansas health policy authority* or to otherwise substitute its judgment for that of the ~~director of health policy and finance or the division of health policy and finance~~ *Kansas health policy authority* with respect to the application of policies issued or rules and regulations adopted by the ~~director of health policy and finance~~ *Kansas health policy authority* for any plan or program that is subject to or financed in part under the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto.

Sec. ~~46~~ 43. On July 1, 2006, section 13 of this act is hereby amended to read as follows: Sec. 13. (a) *On and after July 1, 2006,* the ~~director of health policy and finance~~ *Kansas health policy authority* shall have the power and duty to establish general policies relating to the health care programs under the ~~director~~ *authority* as provided in section 9, and amendments thereto, and to adopt rules and regulations therefor.

(b) The ~~director of health policy and finance~~ *Kansas health policy authority* shall advise the governor and the legislature on all health care programs, policies and plans for which the ~~director of health policy and finance or the division of health policy and finance~~ *Kansas health policy authority* is responsible under this act.

(c) The ~~director of health policy and finance~~ *Kansas health policy authority* shall establish an adequate system of financial records. The ~~director of health policy and finance~~ *Kansas health policy authority* shall make periodic reports to the governor and shall make any reports required by federal agencies.

(d) The ~~director of health policy and finance~~ *Kansas health policy authority* may assist other departments, agencies and institutions of the state and federal government and of other states under interstate agreements, when so requested, by performing services in conformity with the purposes of this act.

(e) All contracts of the ~~division of health policy and finance~~ *Kansas health policy authority* shall be made in the name of the "~~director of health policy and finance~~ *Kansas health policy authority*." In that name, the ~~director~~ *Kansas health policy authority* may sue and be sued. The grant of authority under this subsection shall not be construed to be a waiver of any rights retained by the state under the 11th amendment to the United States constitution and shall be subject to and shall not supersede the provisions of any appropriation act of this state.

(f) After consulting with any agency that has responsibility under a contract with the ~~division of health policy and finance~~ *Kansas health policy authority* for administration of any of the programs of the ~~division~~ *authority*, the ~~director of health policy and finance~~ *Kansas health policy authority* shall prepare annually, at the time and in the form directed by the governor, a budget covering the estimated receipts and expenditures

1 of the ~~division of health policy and finance~~ *Kansas health policy authority*
2 for the coming fiscal year.
3 (g) The ~~director of health policy and finance~~ *Kansas health policy*
4 *authority* shall have authority to make grants of funds for the promotion
5 of health care programs in the state of Kansas, subject to the provisions
6 of appropriation acts.
7 (h) The ~~director of health policy and finance~~ *Kansas health policy*
8 *authority* may receive grants, gifts, bequests, money, or aid of any char-
9 acter whatsoever, for purposes consistent with sections 9 through 14, and
10 amendments thereto.
11 (i) The ~~director of health policy and finance~~ *Kansas health policy*
12 *authority* may enter into agreements with other states or the agency des-
13 ignated as the single state agency under the federal social security act, 42
14 U.S.C.§ 1396 et seq., and amendments thereto, for another state setting
15 out the manner for determining the state of residence in disputed cases
16 and the bearing or sharing of costs associated with those cases.
17 (j) The ~~director of health policy and finance~~ *Kansas health policy*
18 *authority* shall establish such advisory groups as are necessary to assist
19 the division of health policy and finance in carrying out its responsibilities
20 under sections 9 through 14, and amendments thereto, including the
21 following:
22 (1) A consumer advisory board consisting of representatives of con-
23 sumers of health care services provided under title XIX of the federal
24 social security act, 42 U.S.C.§ 1396 et seq., and title XXI of the social
25 security act, 42 U.S.C. § 1397aa et seq., and amendments thereto, and
26 representatives of these consumers' family members; and
27 (2) a policy coordination board consisting of representatives from
28 those state agencies with which the ~~director~~ *Kansas health policy au-*
29 *thority* enters into a contract under section 12, and amendments thereto,
30 and representatives from any other state agencies, as determined by the
31 ~~director~~ *Kansas health policy authority*.
32 (k) The ~~director of health policy and finance~~ *Kansas health policy*
33 *authority* shall perform any other duties and services that are necessary
34 to carry out the purposes of sections 9 through 14, and amendments
35 thereto, and that are not inconsistent with state law.
36 Sec. ~~47~~ 44. On July 1, 2006, section 14 of this act is hereby amended to
37 read as follows: Sec. 14. On *and after* July 1, ~~2005~~ *2006*, except as oth-
38 erwise provided by this act, all of the following powers, duties and func-
39 tions of the ~~department of social and rehabilitation services and the sec-~~
40 ~~retary of social and rehabilitation services~~ *division of health policy and*
41 *finance within the department of administration and the director of health*
42 *policy and finance* are hereby transferred to and imposed upon the ~~di-~~
43 ~~vision of health policy and finance within the department of administra-~~

1 ~~tion and the director of health policy and finance~~ *Kansas health policy*
2 *authority* established by ~~this act~~ *section 1, and amendments thereto*:
3 (a) All of the powers, duties and functions ~~of the secretary of social~~
4 ~~and rehabilitation services~~ under chapter 39 of the Kansas Statutes An-
5 notated, and amendments thereto, *that were transferred on July 1, 2005,*
6 *to the division of health planning and finance and the director of health*
7 *planning and finance and* that relate to development, implementation and
8 administration of programs that provide medical assistance, health insur-
9 ance programs or waivers granted thereunder for persons who are needy
10 or uninsured, or both, and that are financed by federal funds or state
11 funds, or both, including the following:
12 (1) The Kansas program of medical assistance established in accord-
13 ance with title XIX of the federal social security act, 42 U.S.C. § 1396 et
14 seq., and amendments thereto; and
15 (2) any program of medical assistance for needy persons financed by
16 state funds only;
17 (b) all of the powers, duties and functions ~~of the secretary of social~~
18 ~~and rehabilitation services~~ *that were transferred on July 1, 2005, to the*
19 *division of health planning and finance and the director of health planning*
20 *and finance* with respect to the health benefits program for children es-
21 tablished under K.S.A. 38-2001 et seq., and amendments thereto, and
22 developed and submitted in accordance with federal guidelines estab-
23 lished under title XXI of the federal social security act, section 4901 of
24 public law 105-33, 42 U.S.C. § 1397aa et seq., and amendments thereto;
25 and
26 (c) all of the powers, duties and functions of the ~~department of social~~
27 ~~and rehabilitation services and secretary of social and rehabilitation serv-~~
28 ~~ices~~ associated with designation ~~of the department of social and rehabil-~~
29 ~~itation services~~ as the single state agency under title XIX of the federal
30 social security act, 42 U.S.C. § 1396 et seq., and amendments thereto.
31 *On and after July 1, 2006*, the designation of the ~~department of social~~
32 ~~and rehabilitation services~~ *division of health and finance* as the single state
33 agency for medicaid purposes is hereby transferred to the ~~division of~~
34 ~~health policy and finance~~ *Kansas health policy authority*.
35 Sec. 46. On July 1, 2006, section 15 of this act is hereby amended to
36 read as follows: Sec. 15. (a) *On and after July 1, 2006*, the ~~division of~~
37 ~~health policy and finance within the department of administration and~~
38 ~~the director of health policy and finance established by this act~~ *Kansas*
39 *health policy authority* shall be the successor in every way to the powers,
40 duties and functions of the ~~department of social and rehabilitation serv-~~
41 ~~ices and secretary of social and rehabilitation services~~ *division of health*
42 *policy and finance and the director of health policy and finance* in which
43 the same were vested prior to ~~the effective date of this act~~ *July 1, 2006*,

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and that are transferred pursuant to section 14, and amendments thereto. Every act performed in the exercise of such transferred powers, duties and functions by or under the authority of the ~~division of health policy and finance or the director of health policy and finance within the department of administration~~ *Kansas health policy authority* shall be deemed to have the same force and effect as if performed by the ~~department of social and rehabilitation services or secretary of social and rehabilitation services~~ *division of health policy and finance and the director of health policy and finance* in which such powers, duties and functions were vested prior to July 1, ~~2005~~ *2006*.

(b) Whenever the ~~department of social and rehabilitation services or the secretary of social and rehabilitation services~~ *division of health policy and finance within the department of administration or the director of health policy and finance*, or words of like effect, are referred to or designated by a statute, contract, memorandum of understanding, plan, grant, waiver or other document and such reference is in regard to any of the powers, duties or functions transferred to the ~~division of health policy and finance or the director of health policy and finance~~ *Kansas health policy authority* pursuant to section 14, and amendments thereto, such reference or designation shall be deemed to apply to the ~~division of health policy and finance or the director of health policy and finance, respectively~~ *Kansas health policy authority*. The provisions of this subsection shall not apply to references to or designations of the ~~department of social and rehabilitation services or the secretary of social and rehabilitation services~~ *division of health policy and finance within the department of administration or the director of health policy and finance*, or words of like effect, by the provisions of appropriation acts.

(c) All rules and regulations, orders and directives of the ~~secretary of social and rehabilitation services~~ *director of health policy and finance* that relate to the functions transferred by section 14, and amendments thereto, and that are in effect on July 1, ~~2005~~ *2006*, shall continue to be effective and shall be deemed to be rules and regulations, orders and directives of the ~~director of health policy and finance~~ *Kansas health policy authority* until revised, amended, revoked or nullified pursuant to law.

Sec. 49. [46] On July 1, 2006, section 16 of this act is hereby amended to read as follows: Sec. 16. (a) *On July 1, 2006,* the ~~division of health policy and finance within the department of administration~~ *Kansas health policy authority* shall succeed to all property, property rights, and records that were used for or pertain to the performance of powers, duties and functions transferred to the ~~division~~ *Kansas health policy authority* pursuant to section 14, and amendments thereto. Any conflict as to the proper disposition of property, personnel or records arising under this act shall be determined by the governor, whose decision shall be final.

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1 (b) The provisions of this section shall not apply to the balances of
2 any funds or accounts thereof appropriated or reappropriated for the
3 department of ~~social and rehabilitation services~~ *administration* relating to
4 the powers, duties and functions transferred by section 14, and amend-
5 ments thereto. All such balances of any funds or accounts thereof shall
6 be transferred by and be subject to the provisions of appropriation acts.
7 Sec. ~~56~~. On July 1, 2006, section 17 of this act is hereby amended to
8 read as follows: Sec. 17. (a) (1) All officers and employees of the ~~depart-~~
9 ~~ment of social and rehabilitation services~~ *division of health policy and*
10 *finance within the department of administration* who, immediately prior
11 to ~~the effective date of this act~~ *July 1, 2006*, are engaged in the exercise
12 and performance of the powers, duties and functions transferred to the
13 ~~division of health policy and finance or the director of health policy and~~
14 ~~finance~~ *Kansas health policy authority* by section 14, and amendments
15 thereto, are transferred to the ~~department of administration~~ *Kansas*
16 *health policy authority* on July 1, ~~2005~~ *2006*, or on a later date or dates
17 determined by the ~~secretary of social and rehabilitation services~~ *Kansas*
18 *health policy authority* and the secretary of administration.
19 (2) All officers and employees of the department of ~~social and reha-~~
20 ~~bilitation services~~ *administration* who are determined by the ~~secretary of~~
21 ~~social and rehabilitation services~~ *Kansas health policy authority* and the
22 secretary of administration to be engaged in providing administrative,
23 technical or other support services that are essential to the exercise and
24 performance of the powers, duties and functions transferred by section
25 14, and amendments thereto, are transferred to the ~~department of ad-~~
26 ~~ministration~~ *Kansas health policy authority* on July 1, ~~2005~~ *2006*, or on a
27 later date or dates determined by the ~~secretary of social and rehabilitation~~
28 ~~services~~ *Kansas health policy authority* and the secretary of
29 administration.
30 (3) All classified employees transferred under this subsection (a) shall
31 retain their status as classified employees. Thereafter, the ~~secretary of~~
32 ~~administration~~ *Kansas health policy authority* may convert vacant classi-
33 fied positions to positions that are not classified as otherwise provided by
34 law.
35 (b) Officers and employees of the department of ~~social and rehabil-~~
36 ~~itation services~~ *administration* transferred by this ~~act~~ *section* shall retain
37 all retirement benefits and leave balances and rights that had accrued or
38 vested prior to the date of transfer. The service of each such officer and
39 employee so transferred shall be deemed to have been continuous. Any
40 subsequent transfers, layoffs or abolition of classified service positions
41 under the Kansas civil service act shall be made in accordance with the
42 civil service laws and any rules and regulations adopted thereunder. Noth-
43 ing in this act shall affect the classified status of any transferred person

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, except as otherwise provided by this act,

, except as otherwise provided by this act"; in line 34, after the period, by insert "The positions of all officers and employees of the ~~department of administration~~ ***Kansas health policy authority*** performing duties and functions under the Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto, that are required under applicable federal law, rules and regulations, and policies to be under a merit-based personnel system, shall be in the classified service under the Kansas civil service act."

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employed by the department of social and rehabilitation services *administration* prior to the date of transfer.

Sec. 51. On July 1, 2006, section 18 of this act is hereby amended as follows: Sec. 18. On July 1, 2005 *2006*, the designation *by this section* of the department of health and environment under K.S.A. 46-2507, and amendments thereto, *division of health policy and finance within the department of administration and the director of health policy and finance* as the contact agency for the state of Kansas with reference to federal health care reform measures is hereby transferred to and imposed upon the division of health policy and finance within the department of administration and the director of health policy and finance *Kansas health policy authority* established by section 7 *1*, and amendments thereto.

Sec. 52. On July 1, 2006, section 19 of this act is hereby amended to read as follows: Sec. 19. (a) *On July 1, 2006,* the division of health policy and finance within the department of administration and the director of health policy and finance *Kansas health policy authority* established by section 7 *1*, and amendments thereto, shall be the successor in every way to the powers, duties and functions of the department of health and environment and secretary of health and environment *division of health policy and finance within the department of administration and the director of health policy and finance* in which the same were vested prior to July 1, 2005 *2006*, and that are transferred pursuant to section 18, and amendments thereto. Every act performed in the exercise of such transferred powers, duties and functions by or under the authority of the division of health policy and finance or the director of health policy and finance within the department of administration *Kansas health policy authority* shall be deemed to have the same force and effect as if performed by the department of health and environment or secretary of health and environment *division of health policy and finance within the department of administration or the director of health policy and finance* in which such powers, duties and functions were vested prior to July 1, 2005 *2006*.

(b) From *On and after* July 1, 2005, through June 30, 2006, whenever the department of health and environment or the secretary of health and environment *division of health policy and finance within the department of administration or the director of health policy and finance*, or words of like effect, are referred to or designated by a statute, contract, memorandum of understanding, plan, grant, waiver or other document and such reference is in regard to any of the powers, duties or functions transferred to the division of health policy and finance or the director of health policy and finance *Kansas health policy authority* pursuant to section 18, and amendments thereto, such reference or designation shall be deemed to apply to the division of health policy and finance or the director of health policy and finance, respectively *Kansas health policy au-*

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1 ~~thority. The provisions of this subsection shall not apply to references to~~
2 ~~or designations of the department of health and environment or the sec-~~
3 ~~retary of health and environment *division of health policy and finance*~~
4 ~~*within the department of administration or the director of health policy*~~
5 ~~*and finance*, or words of like effect, by the provisions of appropriation~~
6 ~~acts.~~
7 ~~(c) All rules and regulations, orders and directives of the secretary of~~
8 ~~health and environment *director of health policy and finance* that relate~~
9 ~~to the functions transferred by section 18, and amendments thereto, and~~
10 ~~that are in effect on July 1, 2005 *2006*, shall continue to be effective and~~
11 ~~shall be deemed to be rules and regulations, orders and directives of the~~
12 ~~director of health policy and finance *Kansas health policy authority* until~~
13 ~~revised, amended, revoked or nullified pursuant to law.~~
14 ~~Sec. 53. On July 1, 2006, section 20 of this act is hereby amended to~~
15 ~~read as follows: Sec. 20. (a) On July 1, 2005 *2006*, the division of health~~
16 ~~policy and finance within the department of administration *Kansas health*~~
17 ~~*policy authority* shall succeed to all property, property rights, and records~~
18 ~~that were used for or pertain to the performance of powers, duties and~~
19 ~~functions transferred to the division *Kansas health policy authority* pur-~~
20 ~~suant to section 18, and amendments thereto. Any conflict as to the~~
21 ~~proper disposition of property, personnel or records arising under this act~~
22 ~~shall be determined by the governor, whose decision shall be final.~~
23 ~~(b) The provisions of this section shall not apply to the balances of~~
24 ~~any funds or accounts thereof appropriated or reappropriated for the~~
25 ~~department of health and environment *administration* relating to the~~
26 ~~powers, duties and functions transferred by section 18, and amendments~~
27 ~~thereto. All such balances of any funds or accounts thereof shall be trans-~~
28 ~~ferred by and be subject to the provisions of appropriation acts.~~
29 Sec. ~~54~~ [48]. On July 1, 2006, section 21 of this act is hereby amended to
30 read as follows: Sec. 21. Liability for accrued compensation or salaries of
31 each officer and employee who is transferred to the *Kansas health policy*
32 *authority from the* department of administration under ~~this act~~ [section 17, and amendments thereto,] shall be
33 assumed and paid by the ~~department of administration~~ *Kansas health*
34 *policy authority* on July 1, ~~2005~~ *2006*, or on the date of the transfer,
35 whichever is later.
36 Sec. ~~55~~ [49]. On January 1, 2006, K.S.A. 39-7,116, 39-7,121, 65-6801, 65-
37 6804, 65-6805, 65-6806, 65-6807, 65-6808 and 65-6809 and K.S.A. 2004
38 Supp. 39-7,118, 39-7,119, 39-7,120, 39-7,121a, 39-7,121d, 39-7,121e and
39 65-6803 are hereby repealed.
40 Sec. ~~56~~ [50]. On July 1, 2006, sections 7 through 21 of this act are hereby
41 repealed.
42 Sec. ~~57~~ [51]. This act shall take effect and be in force from and after its
43 publication in the statute book.