

AN ACT concerning health and healthcare; relating to health insurance coverage; expanding medical assistance eligibility; implementing a health insurance plan reinsurance program; directing the department of health and environment to study certain medicaid expansion topics; adding meeting days to the Robert G. (Bob) Bethell joint committee on home and community based services and KanCare oversight to monitor implementation; making and concerning appropriations for the fiscal years ending June 30, 2020, June 30, 2021, and June 30, 2022; amending K.S.A. 65-6207, 65-6208, 65-6209, 65-6210, 65-6211, 65-6212, 65-6217 and 65-6218 and K.S.A. 2019 Supp. 39-7,160 and 40-3213 and repealing the existing sections.

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

New Section 1. (a) Sections 1 through 13 and 16 through 19, and amendments thereto, shall be known and may be cited as the Kansas innovative solutions for affordable healthcare act.

(b) The legislature expressly consents to expand eligibility for receipt of benefits under the Kansas program of medical assistance, as required by K.S.A. 39-709(e)(2), and amendments thereto, by the passage and enactment of the act, subject to all requirements and limitations established in the act.

(c) The secretary of health and environment shall adopt rules and regulations as necessary to implement and administer the act.

(d) As used in sections 1 through 13 and 16 through 19, and amendments thereto, unless otherwise specified:

(1) "138% of the federal poverty level," or words of like effect, includes a 5% income disregard permitted under the federal patient protection and affordable care act.

(2) "Act" means the Kansas innovative solutions for affordable healthcare act.

New Sec. 2. (a) The secretary of health and environment and the insurance commissioner shall submit to the United States centers for medicare and medicaid services and

the United States department of the treasury any state plan amendment, waiver request or other approval request necessary to implement the act. At least 10 calendar days prior to submission of any such approval request to the United States centers for medicare and medicaid services or the United States department of the treasury, the secretary of health and environment or the insurance commissioner, as applicable, shall submit such approval request application to the state finance council.

(b) For purposes of eligibility determinations under the Kansas program of medical assistance on and after January 1, 2021, medical assistance shall be granted to any adult under 65 years of age who is not pregnant and whose income meets the limitation established in subsection (c), as permitted under the provisions of 42 U.S.C. § 1396a, as it exists on the effective date of the act, and subject to a 90% federal medical assistance percentage and all requirements and limitations established in the act.

(c) (1) The secretary of health and environment shall submit to the United States centers for medicare and medicaid services a waiver request under section 1115 of the federal social security act, 42 U.S.C. § 1315, as it exists on the effective date of the act, to provide medical assistance eligibility to individuals described in subsection (b) whose modified adjusted gross income does not exceed 138% of the federal poverty level.

(2) (A) Following submission to and approval by the state finance council in accordance with sections 20 and 22, the insurance commissioner shall submit to the United States department of the treasury and the United States centers for medicare and medicaid services a waiver request under section 1332 of the federal patient protection and affordable care act, 42 U.S.C. § 18052, as it exists on the effective date of the act, for a reinsurance program for

health insurance plans sold in the Kansas individual market that are qualified health plans, as defined in 42 U.S.C. § 18021(a). The insurance commissioner shall design the reinsurance program in coordination with the secretary of health and environment to offset any cost of the section 1115 waiver described in this paragraph to the United States government in order to meet federal budget neutrality requirements for medicaid waivers. The insurance commissioner shall implement the reinsurance program to begin on January 1, 2022.

(B) The secretary of health and environment shall submit to the United States centers for medicare and medicaid services a waiver request under section 1115 of the federal social security act, 42 U.S.C. § 1315, as it exists on the effective date of the act, to provide medical assistance eligibility to individuals described in subsection (b) whose modified adjusted gross income does not exceed 100% of the federal poverty level and to transition those individuals described in subsection (b) whose modified adjusted gross income is greater than 100% but does not exceed 138% of the federal poverty level to health insurance plans on the health benefit exchange in Kansas established under the federal patient protection and affordable care act. The secretary of health and environment shall implement medical assistance eligibility under this subparagraph to begin on January 1, 2022, in conjunction with the implementation of the reinsurance program under subparagraph (A).

(C) If the waiver request submission under subparagraph (A) is not approved by the state finance council in accordance with sections 20 and 22, or if both waiver requests under subparagraphs (A) and (B) are not approved by the United States centers for medicare and medicaid services and the United States department of the treasury, as applicable, then medical assistance eligibility under the act shall be determined in accordance with paragraph (1).

(d) The insurance commissioner shall identify and procure a contractor for services to prepare the section 1332 waiver for a reinsurance program described in this section. Such contractor shall have experience in developing and submitting section 1332 waivers for reinsurance programs.

New Sec. 3. (a) The secretary of health and environment shall refer each non-disabled adult applying for or receiving coverage under the act who is unemployed or working less than 20 hours per week to the Kansasworks program administered by the department of commerce. The secretary of commerce shall coordinate with the secretary of health and environment to certify to the secretary of health and environment each covered individual's compliance with this section. The secretary of commerce shall maintain a unique identifier for Kansasworks participants who are covered individuals under the act to track employment outcomes and progress toward employment.

(b) The secretary of health and environment shall evaluate each new applicant for coverage under the act for education status, employment status and any factors impacting the applicant's employment status, if less than full-time employment, and shall require each applicant to acknowledge the referral required under subsection (a). Such evaluation shall be a prerequisite for coverage under the act.

(c) A full-time student enrolled in a postsecondary educational institution or technical college, as defined by K.S.A. 72-3201b, and amendments thereto, shall be exempt from the referral required by subsection (a) for each year the student is enrolled in such educational setting.

(d) The secretary of health and environment shall report annually to the legislature, in

coordination with the secretary of commerce, on or before the first day of each regular session of the legislature regarding the employment outcomes of covered individuals under the act.

New Sec. 4. (a) (1) Except to the extent prohibited by 42 U.S.C. 1396o-1(b)(3), as it exists on the effective date of this act, the department of health and environment shall charge to each covered individual described in section 2(b), and amendments thereto, a monthly fee not to exceed \$25 per individual, but not to exceed a maximum of \$100 per month per family household, as a condition of participation in the program. The department may grant a hardship exemption from payment of the monthly fee, as determined by the secretary of health and environment.

(2) The department of health and environment shall remit all moneys collected or received for monthly fees charged under this subsection, except for the federal share of such fees required to be remitted to the United States centers for medicare and medicaid services, to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount remitted into the state treasury to the credit of the state general fund.

(b) The department of health and environment shall utilize the debt collection procedures authorized by K.S.A. 75-6201 et seq., and amendments thereto, for a covered individual under the act who is delinquent by 60 days or more in making a monthly fee payment.

(c) The secretary of health and environment may require each managed care organization providing services under the act to collect the monthly fee charged under subsection (a) in lieu of the department.

(d) On or before January 10, 2022, and on or before the first day of the regular session

of the legislature each year thereafter, the secretary of health and environment shall submit to the house of representatives standing committee on health and human services and the senate standing committee on public health and welfare an accounts receivable report for monthly fees collected under this section during the preceding calendar year.

New Sec. 5. (a) The secretary of health and environment may establish a health insurance coverage premium assistance program for individuals who meet the following requirements:

(1) The individual has an annual income that is 100% or greater than, but does not exceed 138% of, the federal poverty level, based on the modified adjusted gross income provisions set forth in section 2001(a)(1) of the federal patient protection and affordable care act; and

(2) the individual is eligible for health insurance coverage through an employer but cannot afford the health insurance coverage premiums, as determined by the secretary of health and environment.

(b) A program established under this section shall:

(1) Contain eligibility requirements that are the same as in sections 2 and 3, and amendments thereto; and

(2) provide that an individual's payment for a health insurance coverage premium may not exceed 2% of the individual's modified adjusted gross income, not to exceed 2% of the household's modified adjusted gross income in the aggregate with any premium charged to any other household individual participating in the premium assistance program.

New Sec. 6. (a) Except to the extent prohibited by 42 U.S.C. § 1396u-2(a)(2), as it

exists on the effective date of this act, the secretary of health and environment shall administer medical assistance benefits using a managed care delivery system using organizations subject to assessment of the privilege fee under K.S.A. 40-3213, and amendments thereto. If the United States centers for medicare and medicaid services determines that the assessment of a privilege fee provided in K.S.A. 40-3213, and amendments thereto, is unlawful or otherwise invalid, then the secretary of health and environment shall administer state medicaid services using a managed care delivery system.

(b) In awarding any contract for an entity to administer state medicaid services using a managed care delivery system, the secretary of health and environment shall:

(1) Not provide favorable or unfavorable treatment in awarding a contract based on an entity's for-profit or not-for-profit tax status;

(2) give preference in awarding a contract to an entity that provides health insurance coverage plans on the health benefit exchange in Kansas established under the federal patient protection and affordable care act; and

(3) require that any entity administering state medicaid services provide tiered benefit plans with enhanced benefits for covered individuals who demonstrate healthy behaviors, as determined by the secretary of health and environment, to be implemented on or before July 1, 2022.

New Sec. 7. If, at any point, the federal medical assistance percentage for coverage of medical assistance participants described in section 1902(a)(10)(A)(i)(VIII) of the federal social security act, 42 U.S.C. § 1396a, as it exists on the effective date of this section, becomes lower than 90%, then the secretary of health and environment shall terminate coverage under the act

over a 12-month period, beginning on the first day that the federal medical assistance percentage falls below 90%. No individual shall be newly enrolled for coverage under the act after such date.

New Sec. 8. (a) Section 7, and amendments thereto, shall be nonseverable from the remainder of the act. If the provisions of section 7, and amendments thereto, are not approved by the United States centers for medicare and medicaid services, then the act shall be null and void and shall have no force and effect.

(b) A denial of federal approval or federal financial participation that applies to any provision of the act not enumerated in subsection (a) shall not prohibit the secretary of health and environment from implementing any other provision of the act.

New Sec. 9. (a) All moneys collected or received by the secretary of health and environment for privilege fees collected pursuant to K.S.A. 40-3213, and amendments thereto, connected to covered individuals under the act shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the medicaid expansion privilege fee fund.

(b) There is hereby created in the state treasury the medicaid expansion privilege fee fund as a reappropriating fund. Moneys in the fund shall be expended for the purpose of medicaid medical assistance payments for covered individuals under the act. All expenditures from the 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 or the secretary's designee.

(c) The medicaid expansion privilege fee fund shall be used for the purposes set forth in the act and for no other governmental purposes. It is the intent of the legislature that the fund shall remain intact and inviolate for the purposes set forth in the act, and moneys in the fund shall not be subject to the provisions of K.S.A. 75-3722, 75-3725a and 75-3726a, and amendments thereto.

(d) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the medicaid expansion privilege fee fund interest earnings based on:

- (1) The average daily balance of moneys in the fund for the preceding month; and
- (2) the net earnings rate of the pooled money investment portfolio for the preceding month.

(e) On or before January 10, 2022, and on or before the first day of the regular session of the legislature each year thereafter, the secretary of health and environment shall prepare and deliver a report to the legislature that summarizes all expenditures from the medicaid expansion privilege fee fund, fund revenues and recommendations regarding the adequacy of the fund to support necessary program expenditures.

New Sec. 10. (a) On or before January 10, 2022, and on or before the first day of the regular session of the legislature each year thereafter, the secretary of health and environment shall prepare and deliver a report to the legislature that summarizes the cost savings achieved by the state from the movement of covered individuals from the KanCare program to coverage under the act, including, but not limited to, the MediKan program, the medically needy spend-down program and the breast and cervical cancer program.

(b) State cost savings shall be determined by calculating the cost of providing services to covered individuals in the KanCare program less the cost of services provided to covered individuals under the act.

New Sec. 11. (a) The secretary of corrections shall coordinate with county sheriffs who request assistance to assist in facilitating medicaid coverage for any state or county inmate incarcerated in a Kansas prison or jail during any time period that the inmate is eligible for coverage.

(b) On or before January 10, 2022, and on or before the first day of the regular session of the legislature each year thereafter, the secretary of corrections shall prepare and deliver a report to the legislature that identifies cost savings to the state from the use of the act to provide medicaid reimbursement for inmate inpatient hospitalization.

New Sec. 12. On or before February 15 of each year, the secretary of health and environment shall present a report to the house of representatives standing committee on appropriations and the senate standing committee on ways and means that summarizes the costs of the act and the cost savings and additional revenues generated during the preceding fiscal year.

New Sec. 13. The legislative post audit committee shall direct the legislative division of post audit to conduct an audit of the direct economic impact of the implementation of the act on the state general fund during the first two fiscal years following implementation of the act. Such audit shall be submitted to the legislature on or before the first day of the regular legislative session immediately following the end of the audited time period.

New Sec. 14. (a) The department of health and environment shall remit all moneys received by the department of health and environment from drug rebates associated with medical

assistance enrollees to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount into the state treasury to the credit of the state general fund.

(b) The department of health and environment shall certify the amount of moneys received by such agency from drug rebates associated with medical assistance enrollees on a monthly basis and shall transmit each such certification to the director of legislative research and the director of the budget.

(c) Upon receipt of each such certification, the director of legislative research and the director of the budget shall include such certified amount on any monthly report prepared by the legislative research department or the division of the budget that details state general fund receipts as a separate item entitled "drug rebates" under a category of other revenue sources.

(d) This section shall take effect and be in force on and after July 1, 2021.

New Sec. 15. (a) There is hereby established in the state treasury the federal medical assistance percentage stabilization fund to be administered by the secretary of health and environment. All expenditures from the federal medical assistance percentage stabilization 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 or the secretary's designee.

(b) Notwithstanding the provisions of any other statute, the attorney general is hereby authorized and directed to remit to the state treasurer, in accordance with the provisions of K.S.A. 75-4215, and amendments thereto, any moneys that are recovered by the attorney general on behalf of the state in the civil action *Texas v. United States*, no. 7:15-cv-00151-O (N.D. Tex.).

Upon receipt of each such remittance, the state treasurer shall deposit the entire amount into the state treasury to the credit of the federal medical assistance percentage stabilization fund.

(c) Beginning in fiscal year 2021, all transfers from the federal medical assistance percentage stabilization fund shall be used during any fiscal year to fund any additional title XIX costs incurred due to any decrease to the federal medical assistance percentage for the state of Kansas.

(d) Each fiscal year, on December 1 and June 30, beginning in fiscal year 2021, the secretary shall determine and certify the estimated amount of any reduced or increased title XIX costs incurred due to any increase or decrease to the federal medical assistance percentage for the state of Kansas in the current fiscal year. The secretary shall certify each such amount to the director of accounts and reports and shall transmit a copy of each such certification to the director of the budget and the director of legislative research. Upon receipt of any such certification indicating reduced costs, the director of accounts and reports shall transfer such certified amount of moneys from the state general fund to the federal medical assistance percentage stabilization fund. Upon receipt of any such certification indicating increased costs, the director of accounts and reports shall transfer such certified amount of moneys from the federal medical assistance percentage stabilization fund to the state general fund.

(e) The federal medical assistance percentage stabilization fund and any other moneys transferred pursuant to this section shall be used for the purposes set forth in this section and for no other governmental purposes. It is the intent of the legislature that the funds and the moneys deposited in this fund shall remain intact and inviolate for the purposes set forth in this section.

(f) As used in this section, "moneys that are recovered" includes damages, penalties,

attorney fees, costs, disbursements, refunds, rebates or any other monetary payment made or paid by any defendant by reason of any judgment, consent decree or settlement, after payment of any costs or fees allocated by court order.

(g) On or before September 1 of each year, the secretary of health and environment shall submit an annual report to the legislature and the legislative budget committee. The report shall include details of actual expenditures related to adjustments of the federal medical assistance percentage for the state of Kansas and all certified amounts transferred in and out of the federal medical assistance percentage stabilization fund.

New Sec. 16. (a) As used in this section:

(1) "Contractor" means a professional firm with experience in conducting rural hospital transformation projects and experience working in the state of Kansas.

(2) "Department" means the department of health and environment.

(3) "Implementation support" means support in implementing a transformation plan by one or more contractors in close collaboration with a target hospital.

(4) "Rural hospital" means a hospital located outside of a major urban or suburban area, but may be located within a metropolitan statistical area, as defined by the department.

(5) "Rural primary health center pilot initiative" means a program to support rural communities by preserving access to healthcare services and improving the health of the population through statutory and regulatory changes.

(6) "Rural hospital transformation program" means a program administered by the department to support rural hospitals in assessing viability and identifying new delivery models, strategic partnerships and implementing financial reform, delivery system reform or operational

changes that enable continued provision of healthcare services in and improving the health of rural communities.

(7) "Target hospital" means a rural hospital determined to be eligible by the department for the rural hospital transformation program.

(8) "Transformation plan" means a strategic plan developed by one or more contractors in close collaboration with a target hospital and local community stakeholders to provide recommendations and actionable steps to preserve healthcare services in the target hospital's community.

(b) The department shall establish an advisory committee comprised of one or more representatives from each of the following: The department of health and environment; the department of labor; the state board of regents; the Kansas hospital association; the Kansas medical society; the community care network of Kansas; the association of community mental health centers of Kansas; the state board of healing arts; the Kansas farm bureau; the emergency medical services board; and other public and private stakeholders as deemed appropriate by the department.

(c) The department, in coordination with the advisory committee, shall establish and manage the rural hospital transformation program and shall identify one or more contractors to provide consultation to each approved target hospital for the creation of a transformation plan, including:

(1) Assessing community health needs by analyzing patient access and utilization patterns and social determinants of health, including transportation, housing and food security, that impact health outcomes;

(2) understanding the landscape of rural healthcare, including hospital-based and outpatient services;

(3) developing hospital-specific strategic and operational transformation plans tailored to the target hospital and community to improve viability;

(4) providing support for the target hospital to implement the transformation plan; and

(5) engaging with local healthcare and other community leaders and residents to develop a holistic understanding of promising practices, opportunities and barriers to care.

(d) A target hospital may submit an application to the department for review and approval to receive consultation from identified contractors for the development of a transformation plan. Such application shall be made on a form and in a manner determined by the department, in coordination with the advisory committee.

(e) Each transformation plan shall be developed through coordination between the contractor, target hospital, target hospital community stakeholders and other appropriate stakeholders. The transformation plan shall include a timeline for implementation and shall be submitted to the department. The department shall receive periodic progress updates on the implementation of the transformation plan, as determined by the department, and monitor the progress of target hospitals.

(f) The department, in coordination with the advisory committee, shall identify state statutes and rules and regulations that may need to be amended or otherwise altered to permit eligible hospitals to participate in the rural primary health center pilot initiative.

(g) The department shall coordinate with the Kansas hospital association to submit an application to the United States centers for medicare and medicaid services to permit the

establishment of the rural primary health center pilot initiative.

(h) The department shall provide periodic updates on the rural health transformation program and the rural primary health center pilot initiative to the house of representatives standing committee on health and human services and the senate standing committee on public health and welfare upon the request of each such committee.

New Sec. 17. (a) The insurance department shall analyze and prepare a report detailing any cost shifting from hospitals to commercial health insurance plans as a result of implementation of the Kansas innovative solutions for affordable healthcare act.

(b) The insurance department shall compile such report using data from the Kansas health insurance informations system, data calls and other data sources available to the department. Using such data, the insurance department shall determine a base rate paid to hospitals in Kansas for healthcare services from commercial insurance companies as a percentage of the current published medicare allowable rates established by the United States centers for medicare and medicaid services, categorized by the seven geographic rating areas in Kansas established by the United States centers for medicare and medicaid services.

(c) Such report shall include such data for the current calendar year and historical data for the 10 years prior to such year, except that such historical data shall not include data prior to calendar year 2018.

(d) Such report shall be submitted to the house of representatives standing committee on health and human services and the senate standing committee on public health and welfare on or before January 10, 2022, and on or before the first day of the regular session of the legislature each year thereafter.

New Sec. 18. (a) The insurance department shall study and prepare a report on any risks and benefits associated with converting the health benefit exchange operated in Kansas under the federal patient protection and affordable care act from a federally facilitated health benefit exchange to a state-based health benefit exchange. To assist with the completion of such study and report, the insurance department shall identify and procure a contractor with experience in developing a state-based health benefit exchange under the federal patient protection and affordable care act.

(b) Such study and report shall include, but not be limited to, any financial impacts to commercial health insurance premium rates from such conversion and any additional flexibility allowed to the state in plan design, benefits and income levels on a state-based health benefit exchange.

(c) Such study and report shall be submitted to the house of representatives standing committee on health and human services and the senate standing committee on public health and welfare on or before January 11, 2021.

New Sec. 19. (a) The secretary of health and environment, in coordination with the Kansas hospital association, Kansas medical society, community care network of Kansas and other private and public stakeholders as deemed appropriate by the secretary, shall establish a task force to develop a plan to measure and report uncompensated care incurred by Kansas healthcare providers and hospitals when reimbursement for care provided to a patient is not collected.

(b) The task force shall define "uncompensated care" to include, but not be limited to:

(1) "Charity care," defined as expenses for care for which the hospital never expects to

be reimbursed;

(2) "bad debt," defined as expenses incurred when a hospital cannot obtain reimbursement for services because the patient is unable or unwilling to pay for such services; and

(3) "uncompensated care," defined as the sum of bad debt and charity care expenses.

(c) The task force shall identify and research data elements that are already available, in order to minimize administrative burdens on healthcare providers and hospitals.

(d) Such report shall include such data for the current calendar year and historical data for the 10 years prior to such year, except that such historical data shall not include data prior to calendar year 2018.

(e) Such report shall be submitted to the house of representatives standing committee on health and human services and the senate standing committee on public health and welfare on or before January 10, 2022, and on or before the first day of the regular session of the legislature each year thereafter.

Sec. 20.

INSURANCE DEPARTMENT

(a) Notwithstanding the provisions of K.S.A. 39-709(e)(2) or 40-112, and amendments thereto, or any other statute to the contrary, during the fiscal years ending June 30, 2020, and June 30, 2021, in addition to the other purposes for which expenditures may be made by the above agency from moneys appropriated from the insurance department service regulation fund for fiscal years 2020 and 2021 by section 47(a) of chapter 68 of the 2019 Session Laws of Kansas, this or any other appropriation act of the 2020 regular session of the legislature,

expenditures shall be made by the above agency from such moneys to:

(1) (A) Study any risks and benefits associated with converting the health benefit exchange operated in Kansas under the federal patient protection and affordable care act from a federally facilitated health benefit exchange to a state-based health benefit exchange;

(B) procure the services of a contractor with experience in developing a state-based health benefit exchange in order to facilitate such study; and

(C) submit a report based on such study to the legislature on or before January 11, 2021; and

(2) (A) prepare a waiver request under section 1332 of the federal patient protection and affordable care act, 42 U.S.C. § 18052, as it exists on the effective date of the act, including any required actuarial analysis, for submission to the United States centers for medicare and medicaid services to implement a reinsurance program for health insurance plans on the health benefit exchange in Kansas established under the federal patient protection and affordable care act, except that such request shall not be submitted without authorization by the state finance council in accordance with section 22;

(B) procure the services of a contractor with experience in developing section 1332 waivers for reinsurance programs to prepare such waiver request;

(C) develop such waiver request in coordination with the secretary of health and environment to offset costs associated with any potential expansion of medical assistance benefits, including scenarios for expansion for individuals with a modified adjusted gross income not exceeding 100% and 138% of the federal poverty level;

(D) determine the extent to which a \$35 million annual appropriation for a health

insurance plan reinsurance program would decrease health insurance premiums on the health benefit exchange in Kansas; and

(E) not later than 150 days after the effective date of this act, submit such prepared waiver request and actuarial analysis to the state finance council for approval prior to submission to the United States centers for medicare and medicaid services.

Sec. 21.

DEPARTMENT OF HEALTH AND ENVIRONMENT –
DIVISION OF HEALTH CARE FINANCE

(a) During the fiscal years ending June 30, 2020, and June 30, 2021, in addition to the other purposes for which expenditures may be made by the above agency from moneys appropriated from the state general fund or from any special revenue fund or funds for fiscal years 2020 and 2021 by section 81 of chapter 68 of the 2019 Session Laws of Kansas, this or any other appropriation act of the 2020 regular session of the legislature, expenditures shall be made by the above agency from such moneys to submit to the United States centers for medicare and medicaid services, prior to January 1, 2021, a waiver request to allow for medicaid reimbursement for inpatient psychiatric acute care.

(b) On the effective date of this act, the provisions of section 81(l) of chapter 68 of the 2019 Session Laws of Kansas shall be null and void and shall have no force and effect.

Sec. 22.

STATE FINANCE COUNCIL

(a) There is appropriated for the above agency from the state general fund for the fiscal year ending June 30, 2022, the following:

Health insurance plan reinsurance..... \$35,000,000

Provided, That all moneys in the health insurance plan reinsurance account shall be used for the insurance department to implement the health insurance plan reinsurance program established by the Kansas innovative solutions for affordable healthcare act and section 21: *Provided further*, That the state finance council is hereby authorized to approve the implementation of the health benefit reinsurance program to commence on January 1, 2022: *And provided further*, That the state finance council acting on this matter is hereby characterized as a matter of legislative delegation and subject to the guidelines prescribed in K.S.A. 75-3711c(c), and amendments thereto, except that the state finance council may act upon such matter while the legislature is in session.

Sec. 23. K.S.A. 2019 Supp. 39-7,160 is hereby amended to read as follows: 39-7,160.

(a) There is hereby established the Robert G. (Bob) Bethell joint committee on home and community based services and KanCare oversight. The joint committee shall review the number of individuals who are transferred from state or private institutions and long-term care facilities to the home and community based services and the associated cost savings and other outcomes of the money-follows-the-person program. The joint committee shall review the funding targets recommended by the interim report submitted for the 2007 legislature by the joint committee on legislative budget and use them as guidelines for future funding planning and policy making. The joint committee shall have oversight of savings resulting from the transfer of individuals from state or private institutions to home and community based services. As used in K.S.A. 2019 Supp. 39-7,159 through 39-7,162, and amendments thereto, "savings" means the difference between the average cost of providing services for individuals in an institutional setting and the cost of providing services in a home and community based setting. The joint committee shall study and determine the effectiveness of the program and cost-analysis of the state institutions or long-term care facilities based on the success of the transfer of individuals to home and community based services. The joint committee shall consider the issues of whether sufficient funding is provided for enhancement of wages and benefits of direct individual care workers and

their staff training and whether adequate progress is being made to transfer individuals from the institutions and to move them from the waiver waiting lists to receive home and community based services. The joint committee shall review and ensure that any proceeds resulting from the successful transfer be applied to the system of provision of services for long-term care and home and community based services. The joint committee shall monitor and study the implementation and operations of the home and community based service programs, the children's health insurance program, the program for the all-inclusive care of the elderly and the state medicaid programs including, but not limited to, access to and quality of services provided and any financial information and budgetary issues. Any state agency shall provide data and information on KanCare programs, including, but not limited to, pay for performance measures, quality measures and enrollment and disenrollment in specific plans, KanCare provider network data and appeals and grievances made to the KanCare ombudsman, to the joint committee, as requested.

(b) The joint committee shall consist of 11 members of the legislature appointed as follows: (1) Two members of the house committee on health and human services appointed by the speaker of the house of representatives; (2) one member of the house committee on health and human services appointed by the minority leader of the house of representatives; (3) two members of the senate committee on public health and welfare appointed by the president of the senate; (4) one member of the senate committee on public health and welfare appointed by the minority leader of the senate; (5) two members of the house of representatives appointed by the speaker of the house of representatives, one of whom shall be a member of the house committee on appropriations; (6) one member of the house of representatives appointed by the minority

leader of the house of representatives; and (7) two members of the senate appointed by the president of the senate, one of whom shall be a member of the senate committee on ways and means.

(c) Members shall be appointed for terms coinciding with the legislative terms for which such members are elected or appointed. All members appointed to fill vacancies in the membership of the joint committee and all members appointed to succeed members appointed to membership on the joint committee shall be appointed in the manner provided for the original appointment of the member succeeded.

(d) (1) The members originally appointed as members of the joint committee shall meet upon the call of the member appointed by the speaker of the house of representatives, who shall be the first chairperson, within 30 days of the effective date of this act. The vice-chairperson of the joint committee shall be appointed by the president of the senate. Chairperson and vice-chairperson shall alternate annually between the members appointed by the speaker of the house of representatives and the president of the senate. The ranking minority member shall be from the same chamber as the chairperson. ~~On and after the effective date of this act,~~ Except as provided in paragraph (2), the joint committee shall meet at least once in January and once in April when the legislature is in regular session and at least once for two consecutive days during each of the third and fourth calendar quarters, on the call of the chairperson, but not to exceed six meetings in a calendar year, except additional meetings may be held on call of the chairperson when urgent circumstances exist which require such meetings. Six members of the joint committee shall constitute a quorum.

(2) During calendar year 2021 and calendar year 2022, the joint committee shall meet

for one additional day per meeting in order to monitor the implementation of the Kansas innovative solutions for affordable healthcare act and to review the following topics relating to such implementation: Payment integrity and eligibility audits; baseline and trend data detailing the amounts that hospitals are paid from commercial insurance plans as a percentage of medicare allowable rates established by the United States centers for medicare and medicaid services; outcomes related to section 3, and amendments thereto; health outcomes for individuals covered under the act; budget projections and actual expenditures related to implementation of the act; and expenses incurred by hospitals arising from charity care and services provided to patients who are unwilling or unable to pay for such services.

(e) (1) At the beginning of each regular session of the legislature, the committee shall submit to the president of the senate, the speaker of the house of representatives, the house committee on health and human services and the senate committee on public health and welfare a written report on numbers of individuals transferred from the state or private institutions to the home and community based services including the average daily census in the state institutions and long-term care facilities, savings resulting from the transfer certified by the secretary for aging and disability services in a quarterly report filed in accordance with K.S.A. 2019 Supp. 39-7,162, and amendments thereto, and the current balance in the home and community based services savings fund of the Kansas department for aging and disability services.

(2) Such report submitted under this subsection shall also include, but not be limited to, the following information on the KanCare program:

(A) Quality of care and health outcomes of individuals receiving state medicaid services under the KanCare program, as compared to the provision of state medicaid services

prior to January 1, 2013;

(B) integration and coordination of health care procedures for individuals receiving state medicaid services under the KanCare program;

(C) availability of information to the public about the provision of state medicaid services under the KanCare program, including, but not limited to, accessibility to health services, expenditures for health services, extent of consumer satisfaction with health services provided and grievance procedures, including quantitative case data and summaries of case resolution by the KanCare ombudsman;

(D) provisions for community outreach and efforts to promote the public understanding of the KanCare program;

(E) comparison of the actual medicaid costs expended in providing state medicaid services under the KanCare program after January 1, 2013, to the actual costs expended under the provision of state medicaid services prior to January 1, 2013, including the manner in which such cost expenditures are calculated;

(F) comparison of the estimated costs expended in a managed care system of providing state medicaid services under the KanCare program after January 1, 2013, to the actual costs expended under the KanCare program of providing state medicaid services after January 1, 2013;

(G) comparison of caseload information for individuals receiving state medicaid services prior to January 1, 2013, to the caseload information for individuals receiving state medicaid services under the KanCare program after January 1, 2013; and

(H) all written testimony provided to the joint committee regarding the impact of the provision of state medicaid services under the KanCare program upon residents of adult care

homes.

(3) The joint committee shall consider the external quality review reports and quality assessment and performance improvement program plans of each managed care organization providing state medicaid services under the KanCare program in the development of the report submitted under this subsection.

(4) The report submitted under this subsection shall be published on the official website of the legislative research department.

(f) Members of the committee shall have access to any medical assistance report and caseload data generated by the Kansas department of health and environment division of health care finance. Members of the committee shall have access to any report submitted by the Kansas department of health and environment division of health care finance to the centers for medicare and medicaid services of the United States department of health and human services.

(g) Members of the committee shall be paid compensation, travel expenses and subsistence expenses or allowance as provided in K.S.A. 75-3212, and amendments thereto, for attendance at any meeting of the joint committee or any subcommittee meeting authorized by the committee.

(h) In accordance with K.S.A. 46-1204, and amendments thereto, the legislative coordinating council may provide for such professional services as may be requested by the joint committee.

(i) The joint committee may make recommendations and introduce legislation as it deems necessary in performing its functions.

Sec. 24. K.S.A. 2019 Supp. 40-3213 is hereby amended to read as follows: 40-3213. (a)

Every health maintenance organization and medicare provider organization subject to this act shall pay to the commissioner the following fees:

- (1) For filing an application for a certificate of authority, \$150;
- (2) for filing each annual report, \$50;
- (3) for filing an amendment to the certificate of authority, \$10.

(b) Every health maintenance organization subject to this act shall pay annually to the commissioner at the time such organization files its annual report, a privilege fee in an amount equal to ~~the following percentages~~ 5.77% of the total of all premiums, subscription charges or any other term that may be used to describe the charges made by such organization to enrollees: ~~3.31% during the reporting period beginning January 1, 2015, and ending December 31, 2017; and 5.77% on and after January 1, 2018.~~ In such computations all such organizations shall be entitled to deduct therefrom any premiums or subscription charges returned on account of cancellations and dividends returned to enrollees. If the commissioner shall determine at any time that the application of the privilege fee, or a change in the rate of the privilege fee, would cause a denial of, reduction in or elimination of federal financial assistance to the state or to any health maintenance organization subject to this act, the commissioner is hereby authorized to terminate the operation of such privilege fee or the change in such privilege fee.

(c) For the purpose of insuring the collection of the privilege fee provided for by subsection (b), every health maintenance organization subject to this act and required by subsection (b) to pay such privilege fee shall at the time it files its annual report, as required by K.S.A. 40-3220, and amendments thereto, make a return, generated by or at the direction of its chief officer or principal managing director, under penalty of K.S.A. 2019 Supp. 21-5824, and

amendments thereto, to the commissioner, stating the amount of all premiums, assessments and charges received by the health maintenance organization, whether in cash or notes, during the year ending on the last day of the preceding calendar year. Upon the receipt of such returns the commissioner of insurance shall verify such returns and reconcile the fees pursuant to subsection (f) upon such organization on the basis and at the rate provided in this section.

(d) Premiums or other charges received by an insurance company from the operation of a health maintenance organization subject to this act shall not be subject to any fee or tax imposed under the provisions of K.S.A. 40-252, and amendments thereto.

(e) Fees charged under this section shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, except as provided in section 9, and amendments thereto, the state treasurer shall deposit the entire amount in the state treasury to the credit of the medical assistance fee fund created by K.S.A. 2019 Supp. 40-3236, and amendments thereto.

(f) (1) ~~On and after January 1, 2018,~~ In addition to any other filing or return required by this section, each health maintenance organization shall submit a report to the commissioner on or before March 31 and September 30 of each year containing an estimate of the total amount of all premiums, subscription charges or any other term that may be used to describe the charges made by such organization to enrollees that the organization expects to collect during the current calendar year. Upon filing each March 31 report, the organization shall submit payment equal to ½ of the privilege fee that would be assessed by the commissioner for the current calendar year based upon the organization's reported estimate. Upon filing each September 30 report, the organization shall submit payment equal to the balance of the privilege fee that would be

assessed by the commissioner for the current calendar year based upon the organization's reported estimates.

(2) Any amount of privilege fees actually owed by a health maintenance organization during any calendar year in excess of estimated privilege fees paid shall be assessed by the commissioner and shall be due and payable upon issuance of such assessment.

(3) Any amount of estimated privilege fees paid by a health maintenance organization during any calendar year in excess of privilege fees actually owed shall be reconciled when the commissioner assesses privilege fees in the ensuing calendar year. The commissioner shall credit such excess amount against future privilege fee assessments. Any such excess amount paid by a health maintenance organization that is no longer doing business in Kansas and that no longer has a duty to pay the privilege fee shall be refunded by the commissioner from funds appropriated by the legislature for such purpose.

Sec. 25. K.S.A. 65-6207 is hereby amended to read as follows: 65-6207. As used in K.S.A. 65-6207 ~~to through~~ 65-6220, ~~inclusive~~, and amendments thereto, ~~the following have the meaning respectively ascribed thereto~~, unless the context requires otherwise:

(a) "Annual hospital medicaid expansion support surcharge" means the product of the number of unduplicated medicaid expansion enrollees multiplied by \$233.

(b) "Assessment revenues" means the revenues generated directly by the assessment and surcharge imposed by K.S.A. 65-6208 and 65-6213, and amendments thereto, any penalty assessments and all interest credited to the fund under this act and any federal matching funds obtained through the use of such assessments, surcharges, penalties and interest amounts.

(c) "Department" means the Kansas department for aging and disability services or the

~~Kansas~~ department of health and environment, or both.

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

~~(e)~~(e) "Health maintenance organization" ~~has the meaning~~ means the same as provided in K.S.A. 40-3202, and amendments thereto.

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

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

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

~~(g) "Assessment revenues" means the revenues generated directly by the assessments imposed by K.S.A. 65-6208 and 65-6213, and amendments thereto, any penalty assessments and all interest credited to the fund under this act, and any federal matching funds obtained through the use of such assessments, penalties and interest amounts.~~

(i) "Unduplicated medicaid expansion enrollee" means each individual who becomes eligible for and enrolls in the Kansas program of medical assistance under K.S.A. 39-709(e)(2), and amendments thereto, and is eligible for a 90% federal medical assistance percentage pursuant to 42 U.S.C. § 1396d(y)(1).

Sec. 26. K.S.A. 65-6208 is hereby amended to read as follows: 65-6208. (a) Subject to

the provisions of K.S.A. 65-6209, and amendments thereto, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to 1.83% of each hospital's net inpatient operating revenue for the hospital's fiscal year 2010. In the event that a hospital does not have a complete twelve-month 2010 fiscal year, the assessment under this section shall be \$200,000 until such date that such hospital has completed the hospital's first twelve-month fiscal year. Upon completing such first twelve-month fiscal year, such hospital's assessment under this section shall be the amount equal to 1.83% of such hospital's net operating revenue for such first completed twelve-month fiscal year.

(b) An annual hospital medicaid expansion support surcharge shall be imposed on each hospital provider in an amount equal to its proportionate share as determined by the healthcare access improvement panel in accordance with K.S.A. 65-6218(d), and amendments thereto, except that such surcharge shall not exceed \$35 million for any calendar year and no surcharge shall be imposed for any period after the federal medical assistance percentage described in 42 U.S.C. § 1396d(y)(1) becomes lower than 90%. Upon final approval, notice of the amount of such surcharge shall be transmitted by the healthcare access improvement panel to the department. Upon receipt of such notice, the department shall promptly provide notice to each hospital provider in accordance with K.S.A. 65-6211(b), and amendments thereto.

(c) Nothing in this act shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon hospital providers or a tax or assessment measured by the income or earnings of a hospital provider.

Sec. 27. K.S.A. 65-6209 is hereby amended to read as follows: 65-6209. (a) A hospital provider that is a state agency, the authority, as defined in K.S.A. 76-3304, and amendments

thereto, a state educational institution, as defined in K.S.A. 76-711, and amendments thereto, or a critical access hospital, as defined in K.S.A. 65-468, and amendments thereto, is exempt from the assessment imposed by K.S.A. 65-6208(a), and amendments thereto, but not the surcharge imposed by K.S.A. 65-6208(b), and amendments thereto.

(b) A hospital operated by the department in the course of performing its mental health or developmental disabilities functions is exempt from the assessment imposed by K.S.A. 65-6208(a), and amendments thereto, but not the surcharge imposed by K.S.A. 65-6208(b), and amendments thereto.

Sec. 28. K.S.A. 65-6210 is hereby amended to read as follows: 65-6210. (a) (1) The assessment and surcharge imposed by K.S.A. 65-6208, and amendments thereto, for any state fiscal year to which this statute applies shall be due and payable:

(A) If the assessment is imposed under K.S.A. 65-6208(a), and amendments thereto, in equal installments on or before June 30 and December 31, commencing with whichever date first occurs after the hospital has received payments for 150 days after the effective date of the payment methodology approved by the United States centers for medicare and medicaid services; or

(B) if the surcharge is imposed under K.S.A. 65-6208(b), and amendments thereto, in equal installments on or before September 15 and March 15.

(2) No installment payment of an assessment under ~~this act~~ K.S.A. 65-6208(a), and amendments thereto, shall be due and payable, ~~however,~~ until after:

~~(+)~~(A) The hospital provider receives written notice from the department that the payment methodologies to hospitals required under this act have been approved by the United

States centers for medicare and medicaid services ~~of the United States department of health and human services~~ under 42 C.F.R. § 433.68 for the assessment imposed by K.S.A. 65-6208(a), and amendments thereto, has been granted by the United States centers for medicare and medicaid services ~~of the United States department of health and human services~~; and

~~(2)~~(B) in the case of a hospital provider, the hospital has received payments for 150 days after the effective date of the payment methodology approved by the United States centers for medicare and medicaid services.

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

(c) (1) If a hospital provider fails to pay the full amount of an installment when due, including any extensions granted under this section, there shall be added to the assessment or surcharge imposed by K.S.A. 65-6208, and amendments thereto, unless waived by the department for reasonable cause, a penalty assessment equal to the lesser of:

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

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

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

(d) The effective date for the payment methodology applicable to hospital providers

approved by the United States centers for medicare and medicaid services shall be ~~the date of~~ July 1 or January 1, whichever date is designated in the state plan submitted by the department of health and environment for approval by the United States centers for medicare and medicaid services.

Sec. 29. K.S.A. 65-6211 is hereby amended to read as follows: 65-6211. (a) After December 31 of each year, except as otherwise provided in this subsection, and on or before March 31 of the succeeding year, the department shall send a notice of assessment imposed under K.S.A. 65-6208(a), and amendments thereto, to every hospital provider subject to assessment under this act. ~~(b)~~—The hospital provider notice of assessment shall notify the hospital provider of its assessment for the state fiscal year commencing on the next July 1.

(b) On or before August 15 and February 15 of each year, the department shall send a notice of surcharge imposed under K.S.A. 65-6208(b), and amendments thereto, to each hospital provider subject to the surcharge. The department shall send the first such notice on or before August 15, 2021.

(c) If a hospital provider operates, conducts or maintains more than one licensed hospital in the state, the hospital provider shall pay ~~the~~ any assessment or surcharge imposed under K.S.A. 65-6208(a) or (b), and amendments thereto, for each hospital separately.

(d) Notwithstanding any other provision in this act, in the case of a person who ceases to operate, conduct or maintain a hospital ~~in respect of~~ for which the person is subject to assessment in K.S.A. 65-6208(a), and amendments thereto, as a hospital provider, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under K.S.A. 65-6208(a), and amendments thereto, by a fraction, the

numerator of which is the number of the days during the year during which the provider operates, conducts or maintains a hospital and the denominator of which is 365. Immediately upon ceasing to operate, conduct or maintain a hospital, the person shall pay the adjusted assessment for that state fiscal year, to the extent not previously paid.

(e) Notwithstanding any other provision in this act, in the case of a person who ceases to operate, conduct or maintain a hospital for which the person is subject to surcharge in K.S.A. 65-6208(b), and amendments thereto, as a hospital provider, the surcharge for the six-month period in which the cessation occurs shall be adjusted by multiplying the surcharge computed under K.S.A. 65-6208(b), and amendments thereto, by a fraction, the numerator of which is the number of the days during the six months during which the provider operates, conducts or maintains a hospital and the denominator of which is the days in the same six-month period. Immediately upon ceasing to operate, conduct or maintain a hospital, the person shall pay the adjusted assessment for that six-month period, to the extent not previously paid.

(f) Notwithstanding any other provision in this act, a person who commences operating, conducting or maintaining a hospital shall pay the assessment computed under ~~subsection (a) of~~ K.S.A. 65-6208(a), and amendments thereto, in installments on the due dates stated in the notice and on the regular installment due dates for the state fiscal year occurring after the due dates of the initial notice.

Sec. 30. K.S.A. 65-6212 is hereby amended to read as follows: 65-6212. (a) The assessment imposed by K.S.A. 65-6208(a), and amendments thereto, shall not take effect or shall cease to be imposed and any moneys remaining in the fund attributable to assessments imposed under K.S.A. 65-6208(a), and amendments thereto, shall be refunded to hospital providers in

proportion to the amounts paid by them if the payments to hospitals required under ~~subsection (a) of~~ K.S.A. 65-6218(a), and amendments thereto, are changed or are not eligible for federal matching funds under title XIX or XXI of the federal social security act.

(b) The assessment and surcharge imposed by K.S.A. 65-6208, and amendments thereto, shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under title XIX of the federal social security act. Moneys in the health care access improvement fund or the hospital medicaid expansion support surcharge fund derived from assessments or surcharges imposed prior thereto shall be disbursed in accordance with ~~subsection (a) of~~ K.S.A. 65-6218, and amendments thereto, to the extent that federal matching is not reduced due to the impermissibility of the assessments and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

Sec. 31. K.S.A. 65-6217 is hereby amended to read as follows: 65-6217. (a) There is hereby created in the state treasury the health care access improvement fund, ~~which shall to~~ be administered by the secretary of health and environment. All moneys received for the assessments imposed by K.S.A. 65-6208(a) and 65-6213, and amendments thereto, including any penalty assessments imposed thereon, shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the health care access improvement fund. All expenditures from the health care access improvement fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of health and environment or the secretary's designee.

(b) There is hereby created in the state treasury the hospital medicaid expansion support surcharge fund to be administered by the secretary of health and environment. All moneys received for the surcharge imposed by K.S.A. 65-6208(b), and amendments thereto, including any penalty assessments imposed thereon, shall be remitted to the state treasurer in accordance with K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount into the state treasury to the credit of the hospital medicaid expansion support surcharge fund. All expenditures from the hospital medicaid expansion support surcharge 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 or the secretary's designee.

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

(~~e~~)(d) The ~~fund is~~ funds are created for the purpose of receiving moneys in accordance with this act and disbursing moneys only for the purpose of improving health care delivery and related health activities, notwithstanding any other provision of law.

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

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

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

~~(e)~~(f) The ~~fund~~ funds shall consist of the following:

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

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

(3) all other moneys received for the ~~fund~~ funds from any other source.

~~(f)~~(g) (1) On July 1 of each fiscal year, the director of accounts and reports shall record a debit to the state treasurer's receivables for the health care access improvement fund and shall record a corresponding credit to the health care access improvement fund in an amount certified by the director of the budget ~~which that~~ shall be equal to the sum of 80% of the moneys estimated by the director of the budget to be received from the assessment imposed on hospital providers pursuant to K.S.A. 65-6208(a), and amendments thereto, and credited to the health care access improvement fund during such fiscal year, plus 53% of the moneys estimated by the director of the budget to be received from the assessment imposed on health maintenance organizations pursuant to K.S.A. 65-6213, and amendments thereto, and credited to the health care access improvement fund during such fiscal year, except that such amount shall be proportionally adjusted during such fiscal year with respect to any change in the moneys estimated by the director of the budget to be received for such assessments under K.S.A. 65-6208(a) and 65-6213, and amendments thereto, deposited in the state treasury and credited to the health care access improvement fund during such fiscal year. Among other appropriate factors, the director of the budget shall take into consideration the estimated and actual receipts from such assessments for the current fiscal year and the preceding fiscal year in determining the

amount to be certified under this ~~subsection (f)~~ paragraph. All moneys received for the assessments imposed pursuant to K.S.A. 65-6208(a) and 65-6213, and amendments thereto, deposited in the state treasury and credited to the health care access improvement fund during a fiscal year shall reduce the amount debited and credited to the health care access improvement fund under this ~~subsection (f)~~ paragraph for such fiscal year.

(2) On July 1 of each fiscal year, the director of accounts and reports shall record a debit to the state treasurer's receivables for the hospital medicaid expansion support surcharge fund and shall record a corresponding credit to the hospital medicaid expansion support surcharge fund in an amount certified by the director of the budget that shall be equal to 100% of the moneys estimated by the director of the budget to be received from any surcharge imposed on hospital providers in accordance with K.S.A. 65-6208(b), and amendments thereto, and credited to the hospital medicaid expansion support surcharge fund during such fiscal year, except that such amount shall be proportionally adjusted during such fiscal year with respect to any change in the moneys estimated by the director of the budget to be received for such surcharges in accordance with K.S.A. 65-6208(b), and amendments thereto, deposited in the state treasury and credited to the hospital medicaid expansion support surcharge fund during such fiscal year. Among other appropriate factors, the director of the budget shall take into consideration the estimated and actual receipts from such surcharges for the current fiscal year and the preceding fiscal year in determining the amount to be certified under this paragraph. All moneys received for the surcharge imposed under K.S.A. 65-6208(b), and amendments thereto, deposited in the state treasury and credited to the hospital medicaid expansion support surcharge fund during a fiscal year shall reduce the amount debited and credited to the hospital medicaid

expansion support surcharge fund under this paragraph for such fiscal year.

~~(3)~~ (4) On June 30 of each fiscal year, the director of accounts and reports shall adjust the amounts debited and credited to the state treasurer's receivables and to the health care access improvement fund and the hospital medicaid expansion support surcharge fund pursuant to this subsection ~~(f)~~, to reflect all moneys actually received for the assessments imposed pursuant to K.S.A. 65-6208 and 65-6213, and amendments thereto, deposited in the state treasury and credited to the health care access improvement fund and the hospital medicaid expansion support surcharge fund during the current fiscal year.

~~(3)~~(4) The director of accounts and reports shall notify the state treasurer of all amounts debited and credited to the health care access improvement fund and the hospital medicaid expansion support surcharge fund pursuant to this subsection ~~(f)~~ and all reductions and adjustments thereto made pursuant to this subsection ~~(f)~~. The state treasurer shall enter all such amounts debited and credited and shall make reductions and adjustments thereto on the books and records kept and maintained for the health care access improvement fund by the state treasurer in accordance with the notice thereof.

Sec. 32. K.S.A. 65-6218 is hereby amended to read as follows: 65-6218. (a) Assessment revenues generated from the hospital provider assessments under K.S.A. 65-6208(a), and amendments thereto, shall be disbursed as follows:

(1) Not less than 80% of assessment revenues shall be disbursed to hospital providers through a combination of medicaid access improvement payments and increased medicaid rates on designated diagnostic related groupings, procedures or codes;

(2) not more than 20% of assessment revenues shall be disbursed to providers who are

persons licensed to practice medicine and surgery or dentistry through increased medicaid rates on designated procedures and codes; and

(3) not more than 3.2% of hospital provider assessment revenues shall be used to fund health care access improvement programs in undergraduate, graduate or continuing medical education, including the medical student loan act.

(b) Assessment revenues generated from the health maintenance organization assessment shall be disbursed as follows:

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

(2) not more than 30% of health maintenance organization assessment revenues shall be disbursed to fund activities to increase access to dental care, primary care safety net clinics, increased medicaid rates on designated procedures and codes for providers who are persons licensed to practice dentistry, and home and community-based services;

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

(c) Surcharge revenues generated from the hospital medicaid expansion support surcharge under K.S.A. 65-6208(b), and amendments thereto, shall be disbursed to offset the costs to the state related to medicaid expansion beneficiaries as calculated in K.S.A. 65-6207(a), and amendments thereto.

~~(e)~~(d) For the purposes of administering and selecting the disbursements described in subsections (a) and (b) ~~of this section~~ and oversight of the calculation of the annual hospital

medicaid expansion support payment and any surcharge under K.S.A. 65-6208(b), and amendments thereto, the health care access improvement panel is hereby established. The panel shall consist of the following: Three members appointed by the Kansas hospital association, two members who are persons licensed to practice medicine and surgery appointed by the Kansas medical society, one member appointed by each health maintenance organization that has a medicaid managed care contract with the ~~Kansas~~ department ~~for aging and disability services of~~ health and environment, one member appointed by the ~~Kansas association for the medically underserved,~~ community care network of Kansas and one representative of the department of health and environment appointed by the governor. The panel shall meet as soon as possible subsequent to the effective date of this act and shall elect a chairperson from among the members appointed by the Kansas hospital association.

(e) The panel shall use the following procedure to approve collection of surcharge revenues under K.S.A. 65-6208(b) for each calendar year beginning with calendar year 2021 based upon the total number of unduplicated medicaid expansion enrollees for such year:

(1) By July 15, the department shall certify to the panel the total number of unduplicated medicaid expansion enrollees for the period beginning on January 1 and ending on June 30.

(2) The panel shall review the number certified by the department, consult with the department regarding any proposed deletions and certify the final number of unduplicated medicaid expansion enrollees for such period by August 1.

(3) Each hospital's share of the annual hospital medicaid expansion support surcharge shall be determined by the panel based upon such hospital's proportion of total hospital revenues.

and the amount shall be certified to the department by August 15. The surcharge for any hospital that has not yet filed a medicare cost report shall pay the lowest surcharge payable by its hospital licensure category as defined by K.S.A. 65-425, and amendments thereto.

(4) For the period beginning on July 1 and ending on December 31, any additional unduplicated medicaid expansion enrollees who were not counted in the first half of the calendar year shall be certified to the panel by the department by January 15. The panel shall follow the same process as described in paragraphs (2) and (3). No enrollee shall be certified more than once in any calendar year.

(5) For purposes of this subsection, the total surcharge revenues to be certified for any calendar year shall not exceed \$35 million, and any annual hospital medicaid expansion support surcharge in excess of \$35 million shall be disregarded.

(6) As used in this subsection:

(A) "Total hospital revenues" means the sum of inpatient and outpatient revenues for all hospital providers as reflected in the applicable medicare cost report.

(B) "Applicable medicare cost report" means, for calendar year 2021, such report filed by each hospital for calendar year 2016 or, if the hospital did not file a medicare cost report for calendar year 2016, the first year that the hospital filed a medicare cost report. For each calendar year after 2021, the applicable medicare cost report shall advance by one year.

(f) A representative of the panel shall be required to make an annual report to the legislature regarding the collection and distribution of all funds received and distributed under this act.

Sec. 33. K.S.A. 65-6207, 65-6208, 65-6209, 65-6210, 65-6211, 65-6212, 65-6217 and

65-6218 and K.S.A. 2019 Supp. 39-7,160 and 40-3213 are hereby repealed.

Sec. 34. This act shall take effect and be in force from and after its publication in the Kansas register.