Approved 3-2-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p.m. on February 27, 1992 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Senator Doug Walker
Tom Bell, Kansas Hospital Association
Besty Topper, United Community Services of Johnson County
Linda Kenney, Department of Health and Environment
Jerry Slaughter, Kansas Medical Society
Kenda Bartlett, Concerned Women for America
Robert Epps, SRS
Cleta Renyer, Right-to-Life
Tom Hitchcock, Board of Pharmacy
Harold Riehm, Kansas Osteopathic Medicine
Larry Buening, Board of Healing Arts

Chairman Ehrlich called the meeting to order at 10:00 a.m.

Hearing on:
SB 631 - Development of a comprehensive program of health services for pregnant women and children.
Senator Walker submitted written testimony in support of **SB 631** and stated the bill directs the Department of Health and Environment, in cooperation with SRS, the Commissioner of Education, and the Insurance Commissioner, to submit a plan to the legislature for consolidating all health programs for pregnant women and children into one comprehensive program under a single state agency. The plan would include time lines for implementation and costs estimates, and identify necessary federal waivers, sources of funding and the services to be provided under the plan. He also stated the plan would make extensive use of case managers. (Attachment 1)

Tom Bell, Kansas Hospital Association, submitted written testimony in support of the collaboration among the different state agencies that currently deal with these various health issues and guiding principles as addressed in **SB 631**. KHA agreed that the plan should be submitted to the Commission on the Future of Health Care in Kansas. (Attachment 2)

Betsy Topper, United Community Services of Johnson County, submitted written testimony in support of the concept of **SB 631,** but suggested additional language be added to make explicit comprehensive health services for pregnant women and children be based on documented and prioritized needs, along with other recommendations. (Attachment 3) Committee discussion related to censorship, and the need to have community involvement that represented a cross section of the community rather than people on a board who want to make a name for themselves.

Linda Kenney, Bureau of Family Health, Department of Health and Environment submitted written testimony on **SB 631** that stated some aspects of the bill are unclear and there appears to be a number of assumptions underlying this bill. Ms. Kenney stated that KDHE supports the development of such proposal as related in the bill, but noted a need for additional expertise

and resources to develop such a plan of this complexity. (Attachment 4) State agencies that have staff time and expertise, such as KDHE, being able to collaborate with other agencies, was discussed, along with the fiscal note of the bill.

Jerry Slaughter, Kansas Medical Society, submitted written testimony and appeared in support of **SB 631**, however, the only issue in question was whether there is an effort already underway by the Department of SRS and KDHE to obtain a Robert Wood Johnson Foundation grant specifically for the development of a comprehensive health program for children. (Attachment 5)

Kenda Bartlett, Concerned Women for America, submitted written testimony and stated her concern with **SB 631** was the list of minimum requirements for the program that "a physical, developmental and mental health assessment of all children" would be made at birth, and she is also concerned if such a program would be manageable. Various provisions of the bill were pointed out and suggested modification be made that would benefit all the families of Kansas and not work to undermine them. (Attachment 6) It was pointed out during Committee discussion that the intent of the bill was not to weaken the family, but identify and deal with the section of society where the family is not functioning.

Robert Epps, SRS, submitted written testimony on **SB 631** and stated the elements of the bill would have a dramatic impact on SRS especially the Medicaid program and administrative expense in coordinating the proposal. (Attachment 7) During Committee discussion, a letter from SRS Secretary Whiteman, dated February 10, was discussed that pointed out her support of the concept of the bill, that the proposal be submitted to the Governor, Joint Committee on Health Care Decisions for the 1990s, and the Commission on the Future of Health Care in Kansas, which would demonstrate that it would be more efficient, cost effective and practical to consolidate all the health programs for pregnant women and children and current programs provided by the Department of SRS.

Cleta Renyer, Right to Life, expressed her concern with line 31, **SB 631**, that addressed comprehensive prenatal services for all pregnant women, and what a woman would be counseled to do if a sonogram showed a possible defect. (Attachment 8)

Written testimony was received from the National Organization for Women and Planned Parenthood of Kansas in support of **SB 631.** (Attachment 9 and 10)

Hearing on SB 673 -Providing false information to obtain a prescription only.
Submitting written testimony and appearing in support of **SB 673** were Jerry Slaughter, KMS, (Attachment 11); Tom Hitchcock, Board of Pharmacy, (Attachment 12); Harold E. Riehm, Kansas Association of Osteopathic Medicine, (Attachment 13); and Lawrence T. Buening, Board of Healing Arts, (Attachment 14). The bill would amend two separate statutes that would "plug a hole" that exists where a nonlegitimate patient obtains a legitimate drug for illegitimate purposes.

Final Action on SB 673.
After discussion on specific language in the bill, Senator Ward made a motion to strike the second "a" and insert "any" on page 3, line 43, and strike "a misdemeanor for" on page 3, line 43; and on page 4, in line 1, before the period, insert "under K.S.A. 21-4214", seconded by Senator Salisbury. No discussion followed. The motion carried. The Chairman asked for wishes of the Committee on **SB 673 as amended**. Senator Ward made a motion to recommend the bill as amended favorably for passage, seconded by Senator Langworthy. No discussion followed. The motion carried. Senator Ward will carry the bill.

The meeting was adjourned at 11:00 a.m. The next meeting of the Committee is scheduled for March 2, 1992, 10:00 a.m., Room 526-S.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-27-92

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Cleta Renyer	Sabetha	Right To Life of Ks.
Kenda Bartlett	Leavenworth	CWA of KS
Kathleen Clark	Topeka	Washburn School
Laurie Mulanax	Overland Park	KU Med. Center University
Carolyn Bloom	Eudora	KS. Physical Therapy Assoc
Lynda Lynn	Topeka	KDOA
Mr & Mrs Roy Key Jr	Great Bend	
Larry Buening	Topeka	Bd of Healing Arts.
Harold Riehm	Topeka	KAOM
Tom Bell	"	KHA
Candy Bahner, PT Belvue		KPTA
Lisa Getz		Wichita Hospitals
Janet Neff		KDHE
Linda Kenney		KDHE
Robert Epps		SRS
Jim McBride		observer
Keith R Landis		Christian Science Committee on Publication for Kansas
Marilyn Bradt		KINH
John Grace		KAHA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-27-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
M.K. BOHLMAN, MD	St. Joseph Family Practice
344 South Volutsia	Residency, Wichita, KS
Wichita, KS 67211	
S.J. SAMUELSON, M.D.	ST. JOSEPH FAMILY PRACTICE
2510 E. PAWNEE #902	WICHITA, KS
WICHITA, KS 67211	
J. West, MD	
1131 S. Clifton, St. Joseph Family Practice	
Wichita, KS 67218	
S Todd Stephens	"
Marla Ullom-Minnich	" "
709 S. Greenwood Wichita, KS 67211	" "
Pete DeWitt	" "
R. Sweet MD	" "
Tom Hitchcock	Bd. Pharmacy
Doug Bowman	Children & Youth Advisory Comm.
George Goebel	AARP-SLC-CCTF
[illegible]	KSM-Doc Practicum
Sydney Hardman	KS Action for Children

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-27-98

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Betsy Topper, 6400 Glenwood, Ste 205 OP KS 66202-4021	United Community Services of Jo Co
Jerry Slaughter Topeka	KMS
Maureen Collins	Planned Parenthood
John Peterson	Ks Assn Prof Psychologists
Dennis Heinrich Larned	Citizen

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
MIAMI, BOURBON, LINN,
ANDERSON, ALLEN AND
NEOSHO COUNTIES
212 FIRST
OSAWATOMIE, KANSAS 66064
(913) 755-4192 (HOME)
(913) 296-7380 (STATE CAPITOL)

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
MEMBER: CONFIRMATIONS
EDUCATION
ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
PUBLIC HEALTH AND WELFARE

TESTIMONY FAVORING PASSAGE OF SENATE BILL 631

Senate Bill 631 directs Health and Environment, in cooperation with SRS, the Commissioner of Education and the Insurance Commissioner, to submit a plan to the legislature for consolidating all health programs for pregnant women and children into one comprehensive program under a single state agency. This plan should include time lines for implementation and cost estimates. It should identify necessary federal waivers, sources of funding and the services to be provided under the plan. The plan should also make extensive use of case managers.

This bill compliments the recommendations of the SRS Task Force presented by the Prevention sub committee and the Children's Initiatives Committee. I would like to read an excerpt from the Children's Committee Report:

"Currently there are approximately 25 different programs operating in different parts of the state which address child health needs. These programs are administered by schools, the Department of SRS, The Department of Health and Environment, local health departments and other agencies . Coordination between programs is sometimes lacking and gaps in service continue to exist.

"The state should vigorously pursue an avenue to combine all state funds for children's health programs into a single, coordinated program by FY 1998 in order to ensure access to primary health care for every Kansas child and eliminate gaps in care, particularly for young children and adolescents from families not covered by insurance or government programs.

" Until such a comprehensive, coordinated, consolidated approach to service delivery can be developed, the following interim strategies, which can be components in such a system, are recommended."

The report goes on to explain several other short term recommendations.

This bill starts these agencies down the path of health care reform planning. Its focus will be a single health program to address the health needs of children and explore the benefits and the drawbacks to such an approach. We are asking the agencies to study this option and present a plan.

Senate P H & W
Attachment # 1
2-27-92

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 26, 1992

TO: Senate Public Health and Welfare Committee

FROM: The Kansas Hospital Association

RE: **SENATE BILL 631**

The Kansas Hospital Association appreciates the opportunity to comment on the provisions of Senate Bill 631. This bill would require the development of a proposal for consolidating all health programs for pregnant women and children into one comprehensive program to assure that all Kansas children receive primary and preventive health care services. There are a number of reasons we think Senate Bill 631 is a good proposal.

First, the bill requires a comprehensive plan to assure access for all pregnant women and children. The Legislature has heard many times of the benefits of preventive and prenatal care, both in terms of quality of life issues and long-term savings.

Second, the bill sets out the plan's guiding principles. These principles include prenatal services, comprehensive medical care for all children under 18, including dental care and sight and hearing tests, an assessment of all children at birth, and a case management system. In so doing, Senate Bill 631 recognizes that this task is huge and can become very complex. It therefore relies initially on as much outside expertise as possible in the development of this plan.

Third, Senate Bill 631 requires collaboration among the different state agencies that currently deal with these various health issues. We think such collaboration is absolutely necessary.

Fourth, Senate Bill 631 recognizes the role of the Commission on the Future of Health Care in Kansas by requiring that the plan be submitted to this Commission. As we have stated before, we think the 403 Commission is the proper place for consideration of any kind of comprehensive health reform proposals. This bill would allow the Commission to assume that role.

Senate P. H&W
attachment # 2
2-27-92

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

Finally, Senate Bill 631 parallels an effort that is currently underway. With the encouragement of the 403 Commission, the state is submitting a grant proposal to the Robert Wood Johnson Foundation to help in development and implementation of a "Child Health Access Program." This program would be based on most of the same principles outlined in Senate Bill 631. The Department of Social and Rehabilitation Services has been the lead agency in developing this proposal. We recommend that the Committee discuss Senate Bill 631 in light of this project to ensure the efforts currently underway are in sync with this bill and can be the focal point of the proposal envisioned by this legislation.

Thank you for your consideration of our comments.

/cdc

TESTIMONY BEFORE
SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
Hearing on S.B. 631
February 27, 1992

Good morning. My name is Betsy Topper. I am communications/public affairs director for United Community Services, a private nonprofit research-based agency engaged in health and human service planning for Johnson County, Kansas. UCS collects and disseminates data on health and human service needs in the county; facilitates cooperative arrangements among private social service agencies, local government and other community members to improve the local delivery of health and human services; advocates public policy decisions that positively affect human service delivery; and annually recommends allocations of more than one million public and private dollars to programs benefiting Johnson County residents. Throughout its 25 year history, UCS has worked to create a seamless system of services for the county's low income and otherwise disadvantaged population.

In 1992, UCS has played a key role, with the Johnson County Public Health Department and the Johnson County Medical Society, in establishing the Johnson County Health Partnership, a public-private consortium for primary care and support services for the county's medically indigent.

Also in 1992, UCS has undertaken the Blueprint for Families and Children, a local needs assessment across all age groups and issue areas that will wrap up in the fall with a conference to mobilize community resources to address priority needs.

Our experience with these projects and others like them is the basis of my testimony today. Also, my testimony today reflects the views of both UCS and our neighbor to the north, the United Way of Wyandotte County.

UCS commends this committee for supporting comprehensive health services

Senate P. H&W
Attachment #3
2-27-92

for pregnant women and children. In that sense, UCS is a proponent of this bill.

We would issue a number of caveats to our support and urge you to consider the following:

1) Add language to the bill to make explicit that comprehensive health services for pregnant women and children be based on documented, and, where necessary, prioritized needs rather than on current programming as a starting point.

2) Use the word "system" rather than the word "program" to refer to these comprehensive health services. Systems thinking is different from program thinking. It allows for novel connections, previously unanticipated collaborations, expanded support for both clients and service providers, efficiencies of cost and manpower, etc., etc.

Examples -- Johnson County Health Department
Boy Scouts

3) Assign case managers by family unit to the extent possible. Where the family is already tied into another case management system, create a system for that case manager to know what health services the women and children in the family are receiving. Case management tied to each and every agency or cluster of services is not case management. It is duplication. Ensure that case managers, wherever they are, are adequately trained and given sufficient information and resources to build connections for their clients among necessary services and support systems.

4) Encourage physical, developmental and mental health assessments of all children at birth but urge caution in how and when results are reported to parents. Especially discourage projecting long term prognoses that might compromise parents' capacity to bond with their newborn. Where parents

must be told of major diabilities, physical or mental health problems, ensure that support services begin immediately for both parents and child.

5) Finally, rather than a single point of entry in each community, allow communities a say in deciding how many points are necessary, depending on geographic area, population patterns, public transportation, demographics (including work status of the target population), and the appropriate providers of services identified to participate in the "system." Allow for various definitions of "catchment area" -- county, multi-county or, in some cases parts of counties.

The Blueprint developed by the Special Committee on Children's Intitiaties has encouraged each community to conduct a community wide needs assessment on children needs. Perhaps the results of these local assessments could guide decisions about appropriate locations and numbers of points of entry.

Thank you for allowing UCS this opportunity to testify.

Conferee: *Betsy Topper*
United Community Services of Johnson County
432-8424

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment

Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony presented to

Senate Public Health & Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 631

This bill mandates that the secretaries of KDHE, SRS and KSBE and others develop a written plan by January 1, 1993, to consolidate all health programs for pregnant women and children into one comprehensive program under one state agency. Components for the plan and services to be provided are enumerated.

Some aspects of the bill are unclear such as: 1) how a mental health assessment will be completed for a child at birth, 2) how each family member of a child entering the program is assigned a case manager, thus expanding the service population to all Kansas families with children under age 18, and 3) the bill avoids the issue of financing.

There appear to be a number of assumptions underlying this bill. Questions relating to these include the following: 1) Is it assumed that existing resources are adequate to provide the full range of services to <u>all</u> pregnant women and children under age 18? 2) Are federal waivers possible for all existing programs to allow consolidation of services or resources? 3) Is one year sufficient time for developing such a plan? 4) Do existing state agency staff have the time and expertise to develop the plan? 5) Do the three primary state agencies have the will to collaborate on this bill in the best interest of the health of mothers and children? 6) Do the three agencies have sufficiently similar perspectives on the nature of the problem and how to approach it? These questions should be addressed and resolved in order to fully understand the impacts of S.B. 631.

The planning phase of a proposal to provide health care coverage for all pregnant women and children would involve a great deal of staff time. We lack not only the time but also the expertise to develop such a far-reaching and complex proposal.

<u>Recommendations:</u>

KDHE supports health care reform to provide universal health care coverage for all Kansans including comprehensive services for pregnant women and children. The agency supports the development of a proposal but notes a need for additional expertise and resources to develop a plan of this complexity. Cost for development of this plan is estimated at $150,000 per year for two years for consultant services. No fiscal note for this activity is included in the Governor's budget.

Testimony presented by: Linda Kenney, Acting Director
Bureau of Family Health
February 27, 1992

Senate P. H & W
Attachment #4
2-27-92

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 27, 1992

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 631; Concerning Development of a Comprehensive Program of Health Services for Pregnant Women and Children

The Kansas Medical Society appreciates the opportunity to appear in support of SB 631, which would require that a plan be developed to consolidate all health programs for pregnant women and children into one comprehensive program. A more integrated and coordinated approach to providing services to pregnant women and children is a positive step forward which should allow the more effective application of resources to this population.

The only issue which the committee may want to consider is that there is already underway an effort by the Department of SRS and KDHE to obtain a Robert Wood Johnson Foundation grant specifically for the development of a comprehensive health program for children. Whether SB 631 would be duplicative of that or not could be determined by talking to those involved with the development of the grant. In any event, you may want to consider coordinating those efforts.

We appreciate the opportunity to appear in support of this bill.

JS:ns

Senate P. H&W
Attachment #5
2-27-92

MCH

2001 L Street, N.W. Suite 308
Washington, D.C. 20036
202-775-0436

Association of Maternal and Child Health Programs

THE MATERNAL AND CHILD HEALTH (MCH) SERVICES BLOCK GRANT

WHAT IS THE TITLE V MCH PROGRAM?

Authorized over 55 years ago as part of the Social Security Act, the goal of this public health program is to improve the health of all mothers and children consistent with national health objectives established by the Secretary of Health and Human Services. It is the only federal program devoted exclusively to maternal and child health. The majority of funds are provided to states to assure effective MCH policies and programs, especially for: low income families; families with limited access to care; and families with children with special health care needs due to chronic or disabling conditions. The program has always operated as a federal/state partnership, with states exercising considerable authority in priority setting, allocating funds and delivering services to fit state and local needs and characteristics. Although the program became a block grant in 1981, OBRA '89 amendments to Title V introduced stricter requirements for use of funds and for state planning and reporting.

HOW DO STATE MCH PROGRAMS SUPPORT SERVICES AT THE COMMUNITY LEVEL?

Through grants, contracts, or reimbursements to local providers or by directly operating programs, state Title V programs support the availability and accessibility of community health services especially for Medicaid insured, uninsured and underinsured families. Title V-supported programs provide prenatal care to over half a million pregnant women, or well over one-third of births to low-income women. Over two and a half million children receive Title V supported well-child or primary health care, and nearly one-half million children with chronic illnesses or disabilities receive specialized health and family support services.

OBRA '89 mandated that state programs develop family-centered, community-based, coordinated care systems for children with special health care needs. State programs are also developing community-based networks of preventive and primary care that coordinate and integrate public and private sector resources and programs for pregnant women, mothers, infants, children and adolescents. Three-fourths of the state programs have supported local "one-stop shopping" models integrating access to Title V, the WIC food program, Medicaid and other health or social services at one site. All state Title V programs support some home visiting services, although these services are extremely limited in many states due to funding constraints.

HOW DO TITLE V PROGRAMS ASSURE STATEWIDE SERVICE SYSTEMS THAT IMPROVE THE HEALTH OF MOTHERS AND CHILDREN?

State Title V programs conduct needs assessments to identify health problems, assess service gaps and barriers, and target resources. States develop standards to assure quality care, monitor services, and provide training and technical assistance on emerging health problems and on new clinical and service approaches.

(OVER)

State Title V programs are required to coordinate with other related federal health, education and social service programs. Coordination with Medicaid has greatly intensified in most states in recent years, with MCH programs providing the technical expertise and the service delivery systems to ensure that expanded Medicaid eligibility and benefits translate into improved access to services, and to improved health status. OBRA '89 required state MCH programs to identify and assist eligible infants and pregnant women in obtaining Medicaid. As part of these efforts, MCH programs use multi-program application forms, conduct on-site presumptive eligibility determinations, use outstationed Medicaid workers, and conduct outreach. OBRA '89 also required programs to establish toll-free information lines to help parents locate Title V and Medicaid providers. Title V programs also work with Medicaid to develop standards for EPSDT and enhanced prenatal services, provide case management for Medicaid clients, recruit providers, and evaluate services.

HOW DOES THE PROGRAM FUNDING WORK?

Title V is a federally appropriated program that requires states to match 3 dollars for every 4 federal dollars; many states provide additional state funds. Current authorized federal funding for Title V is $686 million. For appropriations up to $600 million, 85% of the appropriation is allocated to the states, and 15% is "set-aside" at the federal level for demonstration, research and training, and service projects, including those for genetics, hemophilia, and university-affiliated service and training programs. For appropriations exceeding $600 million, OBRA '89 created a second "set-aside" of 12.75% to fund six types of demonstration projects: home visiting; provider participation; integrated service delivery; non-profit hospital MCH centers; rural programs; and community projects for children with special health care needs.

OBRA '89 also placed new requirements on states' use of funds, including limiting administrative costs to 10%; requiring maintenance of state MCH funding at FY '89 levels; and requiring that 30% of funds be spent respectively on preventive and primary care for children, and on services for children with special health care needs.

HAVE APPROPRIATIONS MET NEEDS?

In 1981, the Select Panel for the Promotion of Child Health (the last comprehensive national study of federal child health policy and programs), recommended that the Title V appropriation be increased to over $800 million. In 1992, the appropriation had reached $ 650 million. The economic problems being experienced by states are increasing needs for service while shrinking resources to address them. The result is a widening gap between needs and services available to prevent infant mortality and assure the health of children and adolescents. Increased appropriations which allow for real program growth are necessary for state Title V programs to meet these needs and to effectively comply with new OBRA '89 requirements.

MATERNAL AND CHILD HEALTH FRAMEWORK

FOR

ANALYZING HEALTH CARE REFORM PLANS

Association of Maternal and Child Health Programs

5-4

MATERNAL AND CHILD HEALTH FRAMEWORK FOR ANALYZING HEALTH CARE REFORM PLANS

PREAMBLE

National attention currently is focused on ways to better support children and families, and to assure access to health care for all. The Association of Maternal and Child Health Programs (AMCHP), a national nonprofit organization which brings together state public health programs addressing the needs of women in their reproductive years, children, youth, and families, shares both these goals. As public health experts with a mandate to assure the health of all mothers and children, AMCHP members are particularly concerned about the intersection of the goals of financing and comprehensive services.

There has been growing recognition that the piecemeal, inadequately financed, and often conflicting or overlapping programs and policies currently in place are not sufficient to achieve significant progress in reaching either of these goals. A large number of proposals to assure access to health care have been advanced: some focus only on children and pregnant women, some encompass the entire population, and some of the latter give priority to women and children in phased-in approaches. While all of these proposals aim to improve the financing of health care, they vary greatly in provisions for assuring that care is available, accessible, comprehensive, of high quality, and cost-effective, particularly in promoting the health of women and children.

As the national debate evolves about alternative approaches to resolving the health care financing dilemma, there appears to be a growing awareness that financing reform alone will not be sufficient to ensure that the Year 2000 health objectives for the nation are achieved. The organization, administration and delivery of health services must be part of the deliberations if we are truly to achieve health care reform. These considerations are particularly important to maternal and child health status. Health care will be incomplete if we fail to address services and activities known to improve birth outcomes, protect children and youth from preventable disease, disability and death, promote healthy development, and improve family functioning. These services are important to the health of all families, and must be responsive to the special needs of children and youth with chronic illness and disabilities and their families.

MCH Principles For Health Care Reform

The Association of Maternal and Child Health Programs has developed the following framework to describe what it believes are the essential components of service delivery and financing systems needed to meet the needs of all families. Four major principles are central to the framework:

- Universal access to appropriate, comprehensive, coordinated, continuous care regardless of age; family composition, income or employment status; residence; citizenship status; or diagnosis or functional status should be regarded as fundamental to promoting, assuring and improving health status.

- Public health prevention and promotion and organized health care delivery systems must complement financing mechanisms to assure that community-based, family-centered health and support services are in place to promote the optimal health and well-being of women, children and families.

- Consumer and family involvement in health care system design, implementation and monitoring is key to ensuring the quality and efficacy of care.

- Federal, state and local public health agencies have expertise, current mandates and critical roles to play in assessment, policy development and assurance of health services that must be incorporated in any comprehensive health care reform agenda.

This framework does not identify a specific agency or program to carry out functions related to public health and personal health service systems infrastructure, organization, or administration. The AMCHP concurs, however, with the Institute of Medicine that the critical roles of assessment, policy development and assurance must be carried out by public health agencies at federal, state and local levels if the health care system is to function well. Further, recognizing that women and children have special needs which require specific expertise and an accountable locus of public responsibility, there will continue to be a need for mandates, financing and an infrastructure to ensure ongoing attention to their needs.

The AMCHP believes that the historical mission and current mandates of the Title V Maternal and Child Health Services Block Grant program are consistent with the public health agency roles that are necessary in health care system reform. Roles currently implemented by state Maternal and Child Health programs which are consistent with those in the framework include: monitoring health status and services, and developing plans, policies and programs to improve them; providing financial support, technical assistance, training and other supports to facilitate development and maintenance of systems of coordinated, community-based comprehensive care; and collecting, analyzing and reporting data to assure services quality and accountability.

Title V has long served as a residual financer of health care, a role that is likely to diminish considerably, although not entirely, when significant reform in health care financing occurs. It is likely that MCH professional expertise and financial resources will continue to be needed to support services availability, and an infrastructure of comprehensive care integrating social, education and support services with medical care. Such resources also will be needed to develop, pilot and evaluate new intervention and systems strategies.

State Title V programs played an important role in implementing Medicaid expansions by consulting in development of and administering benefit packages; recruiting and certifying providers to serve increased numbers of women and children; and by coordinating care for families with multiple and special needs. 1989 amendments to Title V reinforced the role of the MCH program in assuring preventive, primary and specialty health and support services for <u>all</u> mothers and children, and explicitly stated the program role in providing, promoting and facilitating the development of community-based, family-centered, coordinated systems of care. The AMCHP believes that MCH programs' expertise will continue to be needed under universal financing to assure that increased access results in improved health outcomes.

This framework has been developed by the Association for use by state and national policymakers, program administrators and advocates in evaluating or developing health care reform plans and proposals. The Association has not made recommendations for financing mechanisms: the AMCHP framework focuses instead on needed MCH services and system capacities.

FRAMEWORK FOR MATERNAL AND CHILD HEALTH (MCH) SYSTEMS INFRASTRUCTURE

1. **Disease prevention and health promotion services are universally available to women, children and their families through public health activities. Accountability for developing, coordinating, monitoring and evaluating these services and programs rests with public health agencies. Joint planning and implementation is carried out with community-level public and private agencies, organizations, and providers, and with consumers and families. These services and activities should include:**

   A. Ongoing surveillance of health status and services;

   B. Implementation of primary prevention strategies (e.g., relative to injury, lead poisoning, AIDS, chronic disease, immunization, etc.) with targeting to populations at risk;

   C. Implementation of systems of comprehensive secondary prevention services (including, for example, newborn screening; genetics disease screening and counseling; regionalized systems of perinatal and neonatal high-risk services; high-risk tracking and follow-up services; early intervention services; and infectious disease control);

   D. Development and implementation of public information and outreach programs designed to improve health care access and utilization, with targeting to reach culturally diverse as well as high-risk populations; and

   E. Development and implementation of comprehensive health education programs and risk reduction activities (addressing family life; parenting skills; substance abuse; AIDS; family planning; preconceptional care, etc.) available throughout the life span in age-appropriate settings.

Public accountability for MCH systems planning, quality assurance, and coordination is defined in public health statutes to include:

A. MCH Data Systems Design and Management

- Establishing information systems that allow reporting of uniform data across multiple service providers, payers and programs; and
- Producing data useful for national, state and community assessment and monitoring of health status, service quality (process, content, outcome), utilization, and costs.

B. Assignment of responsibility to an identified unit of the health agency, directed and staffed by individuals with public MCH expertise, for data-based needs assessment and public planning processes which include racially and culturally representative consumer-family and provider participation, and for reporting related to the health of women, children and families.

C. Coordination of public and private MCH services and financing through the designated MCH unit addressing:

- Development of (or adoption of national) uniform definitions of benefits and services across service sectors;
- Development and adoption of policies, procedures and service delivery mechanisms implemented at state and community levels that facilitate access to programs and services (including, for example, common forms, co-location of intake and/or service delivery, etc.);
- Development of state and local interagency agreements delineating service provision, coordination, financing, program planning, and administrative roles; and
- Effective use of available public (federal, state and local) and private financial resources to maximize client access to care and expand the scope of available health and support services.

D. Responsibility for MCH services quality assurance through the MCH unit assuring that:

- Both publicly and privately provided or financed health services are delivered consistent with nationally recognized professional standards of care;
- As needed, standards of care for enhanced health and support services (e.g, children with special health care needs, high-risk perinatal, etc.) are developed and promulgated;
- Providers meet credentialing requirements;
- Service provision is monitored on an ongoing basis through structured review processes;
- Mechanisms exist for regular review and revision of standards to reflect changes in technology and/or state-of-the-art practices;
- Monitoring includes evaluation of family/consumer satisfaction, provider satisfaction, delivery process, cost, and health status outcomes;
- Practices and/or programs determined ineffective in contributing to desired health outcomes are discontinued;
- Mechanisms exist for dissemination of information on best practices; and
- Adequate funds and other resources are directed toward service demonstrations and education and training for state and local MCH service providers.

3. **Provider/Service availability is assured by the MCH unit in collaboration with all state and community-level private and public sector providers, agencies and payers to:**

A. Develop guidelines for adequate distribution and mix of preventive, primary and specialty service providers needed within defined geographic areas (at community, regional and state levels);

B. Encourage appropriate use of mid-level practitioners and alternative providers such as appropriately skilled and supervised lay health workers;

C. Develop requirements or incentives to assure full participation and equitable geographic distribution of service providers offering primary, specialty and subspecialty care;

D. Support, through policies, training and financial support as necessary, regionalized specialty services;

E. Develop mechanisms to assist families in using services (e.g., transportation, support for medically-related stays); and to

F. Organize and support, as needed, basic and enhanced health and family support services particularly for populations of women, children and youth with special needs (e.g., parent training, respite care, home visiting, age-appropriate assessment of risk, adolescent pregnancy and parenting services, etc.).

1. **All women, children and families have access to health care financing regardless of age; family composition, income, or employment status; citizenship; or diagnosis or functional status. To ensure access, the plan/program:**

   A. Provides health care coverage for all members of the family unit without waiting periods. Families are defined to include an individual, the individual's spouse, and children of the individual and spouse, including foster children and children in the process of adoption;

   B. Has simple application forms, enrollment procedures and assistance that assure access regardless of language used and include interpreter and translation services;

   C. Is affordable for families. Provides, without cost-sharing, coverage for all MCH preventive services regardless of family income. Cost-sharing is not imposed for any services for low-income families.

   D. Establishes any cost-sharing at graduated levels relative to income and resources, and consistent regardless of risk. Limits are applied to any premiums, deductibles, copayments and out-of-pocket expenditures, and include annual and lifetime caps to limit family liability;

   E. Provides continuation and conversion mechanisms related to age; diagnosis or functional status; and changes in employment or employer plans; and

   F. Includes coverage for catastrophic care.

2. **The plan provides payment for a comprehensive, continuous and coordinated array of MCH personal health services that includes preventive, primary, specialty and long-term care and support services, provided, as appropriate, in offices, clinics, schools, homes, and other alternative settings. Covered MCH services include:**

   A. Reproductive health care, including routine exams, breast and cervical cancer screening, sexually transmitted disease screening/treatment, etc.;

   B. Family planning, including education, contraceptive care, pregnancy testing and counseling;

   C. Preconceptional care, including risk assessment (with genetic screening and consultation as appropriate), health promotion and intervention to reduce risks;

   D. Risk appropriate prenatal care in accordance with standards of the American College of Obstetricians and Gynecologists;

   E. Well-child examinations which include all appropriate screening services and immunizations according to standards of the American Academy of Pediatrics;

   F. Developmentally appropriate anticipatory guidance (client and/or parent education);

   G. Preventive dental care, including exam, prophylaxis; and sealants as appropriate;

   H. Outpatient diagnosis, evaluation, and treatment of suspected health or developmental problems;

   I. Home visiting services to provide enhanced risk-appropriate maternal and child health assessment, education and support;

   J. Care coordination (case management), including designation of a "medical home" or primary care provider;

   K. Risk-appropriate perinatal and neonatal care, including transfer to special perinatal centers for mother and/or infant;

   L. Outpatient provider services for diagnosis and treatment of acute or episodic health conditions;

   M. Outpatient surgery;

   N. Emergency room care;

   O. Prescription drugs;

   P. Optical, hearing devices;

   Q. Curative dental care;

   R. Inpatient evaluation of suspected health or developmental problems;

   S. Inpatient care and treatment (including surgery and post-operative care);

   T. Allied health and related services such as social work; nutrition; occupational, physical, speech, language and respiratory therapies; audiology;

   U. Mental health care (outpatient and inpatient);

   V. Alcoholism and drug addiction treatment services (outpatient and inpatient);

   W. Early Intervention services provided in age-appropriate community settings;

Parent (caregiver) training as appropriate and necessary to support child health and developmental services for high-risk children; and

Y. Specialty and support services for chronic health and developmental impairments and conditions, including habilitative medical equipment, assistive devices (for mobility, communication and activities of daily living) and supplies (including special formulae, etc.); therapeutic day care; hospice care; and long-term chronic care (home-based and community congregate settings).

3. The plan incorporates consumer-oriented administrative policies and procedures that assure appropriate quality, utilization, efficiency and cost-efficiency.

A. Appropriate duration, scope, frequency of and settings for provision of covered secondary and tertiary level services are determined through precertification or prior authorization performed by appropriately credentialed and MCH-experienced health professionals:

- Precertification decision-making is guided by standards of care or protocols for acute, recurring and chronic illness and health impairments;
- Consultations and second opinions are paid for under the plan upon consumer, primary care provider or authorization review personnel request; and
- Mechanisms exist to obtain information on and include consideration of individual client (family) perspectives regarding service needs and service delivery (provider and/or setting) preferences.

B. Procedures are implemented to reduce family and provider burden in forms completion and to expedite payment to clients and/or providers, which include:

- Simple claims processing forms and procedures;
- Coordination of claims conducted by insurers or providers, and not families;
- Requirements that providers accept as. nt of benefits other than family deductible and copayment amounts; and
- Formal appeals processes applicable to beneficiaries and providers.

C. Provider payment rates and mechanisms assure adequate participation by the full range of needed MCH health professions through:

- Adequate reimbursement levels to assure that all health clinicians (including mid-level practitioners, specialists and subspecialists) and facilities participate as providers under the plan;
- Appropriate reimbursement schedules to assure that no providers are required to bear a disproportionate share of costs; and
- Timely and efficient provider payments, with provider access to consultation and assistance in implementing the billing process.

D. Cost controls are established through mechanisms such as:

- Implementation of incentives for provision and utilization of MCH preventive health services;
- Use of a range of MCH health care providers and service delivery site alternatives;
- Use of managed care arrangements in conjunction with MCH provider and service quality controls and monitoring;
- Prohibitions regarding balance billing; and
- Established limits on the percentage of costs for administration.

The MCH Framework for Analyzing Health Care Reform Plans was developed by a special subcommittee of the AMCHP's Finance and Children with Special Health Care Needs Committees and was approved by the Association's Executive Council in November, 1991. Assistance in development and editing of the document was provided by Holly Grason, M.A., Deputy Director. Consultation was provided by New England SERVE. Development of this document was supported in part through a cooperative agreement with the Maternal and Child Health Bureau, Department of Health and Human Services, No. MCU 116046-01. For information or additional copies, contact:

Association of Maternal and Child Health Programs • 2001 L Street, N.W. • Washington, DC 20036 • (202) 775-0436

Richard P. Nelson, M.D.
President

Catherine A. Hess, M.S.W.
Executive Director

5-9

Concerned Women for America

370 L'Enfant Promenade, S.W., Suite 800 Washington, D.C. 20024 (202) 488-7000
P.O. Box 46 Leavenworth, KS 66048 (913)682-8393

Beverly LaHaye
President

Kenda Bartlett
Kansas
Area Representative

27 February 92

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
Senator Roy Ehrlich, Chairman
SB 631

Mr. Chairman and members of the Committee, CWA of Kansas rises today in opposition to SB 631. We do not fault the intent of this bill as stated in Section 1. In this time of tight money and budgets it is commendable to try and consolidate services so that services are not duplicated or do not overlap. Such a consolidation should make it easier for the citizens of the state who need these services to tap into the system and use it in a most efficient and effective way.

Our concern is with the scope of this bill. In the list of minimum requirements for the program it is stated on lines 32 and 33 that "a physical, developmental and mental health assessment of all children" will be made at birth. Does this mean that every child that is born in the state of Kansas will undergo this assessment? The program requirements include comprehensive medical and dental care for all children under the age of 18. If this means literally all of the children in the state, we are wondering if such a program would even be manageable.

We also must ask the question where are the parents during all of this comprehensive care? This program would establish a "case management system" that would assign each family member a case manager who would then oversee the care of every member of the family. What does this do to parental responsibility in the area of health care for their family? What if I as a parent disagreed with the health care decisions that the case manager might make?

In the Special Committee on Children's Initiatives Interim Study Report's Statement of Committee Philosophy, they stated, "We believe that families and the circumstances of family life will remain the most critical factor in determining how children develop. At a time when the family is undergoing extraordinary social, demographic, and economic change and instability, society must ask what it can do to strengthen families and support the healthy development of our children." If this is, in fact,

Senate P.H.W.
Attachment #6
2-27-92

the philosophy of the legislature, then the legislature should do all that it can to see that it supports the family in every way possible. We do not think that taking over the responsibilities of parents is a way to strengthen the family. When the parents are made to feel that they are not accountable and responsible, that eliminates their motivation to be good parents. It fosters the attitude that they don't have to try since the government will step in and do what they will not.

We would ask that you look at ways to help the families of Kansas provide for the medical needs of their families in the most unobtrusive ways possible. Prenatal care is very important, and providing proper medical and dental care for children is also important, but this should be a primary function of the family, and the state should work to see that parents are reinforced in their commitment to the care of their children and not have the state usurp their authority.

The Interim study report says "Providing support to families at critical times is an investment strategy that pays big dividends." The state should provide support not take over the role of the parent. Let us provide the parents with all the support they need to make intelligent, healthy choices in regards to their children's health care.

We also have concerns with subsection (7) on page 2. We are aware that there is a concerted effort to see that social services can be accessed through the public school system. HCR 5035, which is now before the Senate Education Committee, addresses this issue. We would hope that the "single point of access" for this program is not in the public schools.

CWA of Kansas would ask that you look long and hard at the provisions of this program and modify its provisions so that this comprehensive program would benefit all the familiesof Kansas and not work to undermine them. Thank you.

Kenda Bartlett

Kenda Bartlett
Area Representative

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
On Behalf Of Donna L. Whiteman, Secretary

Senate Committee on Public Health and Welfare
Testimony on Senate Bill 631

February 27, 1992

Mr. Chairman and members of the committee, I thank you for the opportunity to speak in opposition to SB 631.

SB 631 establishes a task force comprised of the Secretaries of Health and Environment and SRS along with the Commissioners of Education and Insurance to develop a proposal that would consolidate all health programs for children and pregnant women into one comprehensive program under one state agency. Such proposal would be aimed at providing services to all children and pregnant women in the State, regardless of their ability to pay for such services, through a single access point.

Universal access to care for all infants and pregnant women is critical in order to reduce the high infant mortality and morbidity rates. It is important that the state look at any changes that can be made which will help women and children seeking health services to better negotiate a complex, and often fragmented web of programs.

Having reviewed SB 631 we would like to offer the following concerns:

- While the bill itself only mandates a proposal be developed and, therefore, has only a minimal initial impact, the elements which must be part of the proposal and the ultimate implementation of such would have a dramatic impact on SRS.

- SB 631 appears to mandate services for all pregnant women and children in Kansas and could result in a major budgetary impact. It is presumed that some of the cost would be federally funded for those who are Medicaid eligible. However, there will also be substantial numbers of persons not qualifying for Medicaid who, in the absence of an approved federal waiver, would be totally state funded.

- There appears to be no income or asset test to qualify for services. Services are to be provided regardless of clients' ability to pay.

- A single point of access to the services offered must be provided. This will require a great degree of coordination among services provided and agency staff involved. This could be problematic as it may require substantial numbers of SRS workers to be outplaced or require that all services be handled through SRS offices.

- SB 631 should be evaluated based on the administrative expense in developing the proposal and on the overall impact of the comprehensive program.

Senate P. HCW
Attachment #7
2-27-92

- SRS is a proponent of the concept comprehensive prenatal and child health care. Establishing a separate agency would, however, weaken the ability of the new separate agency to secure necessary funding and administrative support. SRS cannot release it's authority to function as the Single State Agency for administering the Medicaid program. SRS also has in place mechanisms to process health insurance claims and determine eligibility. The agencies mentioned in this Bill are already working together to provide comprehensive prenatal and child health care. These cooperative efforts need to be continued at both the central office and community level.

Robert L. Epps
Commissioner
Income Support/Medical Services
(913) 296-6750

MEDICAID SERVICES

PROGRAMS:	Maternal	Children	Hospital	Physician	Home Health	Dental	Durable Medical Equipment	Pharmacy	Home and Community-Based Services for Technology-Assisted Children Waiver
	All pregnant women at or under 150% of federal poverty level (FPL)	Age 1 and under at or under 150% FPL Ages 2-5 at or under 133% FPL Ages 6-8 at or under 100% FPL.	All Medicaid eligible	All Medicaid eligible	All Medicaid eligible	All Medicaid eligible under 21 years of age, and adults residing in Intermediate Care Facilities	All Medicaid eligible	All Medicaid eligible	All children ages 16 and under who would not be Medicaid eligible without severe medical condition. Also must be KAN Be Healthy
SERVICES	Prenatal Care Delivery Postnatal care. Prenatal Health Promotion and Risk Reduction. Nutrition counselling.	Well-child checkups (KAN Be Healthy screenings) up to age 20. Immunizations Newborn Home visits. Attendant Care for Independent Living for chronically disabled children. **All medically necessary services and items for KAN Be Healthy participants.**	Outpatient Services -Emergency Room -Supplies -Diagnostic -Lab -Operating Room -Oxygen -Nursing Inpatient Services -Room -Diagnostic -Supplies -Lab -Drugs -Oxygen -Intensive Care -Rehabilitation Unit -Nursing	12 office visits per year. 24 office visits per year for KAN Be Healthy participants, which can be exceeded with prior authorization. -Diagnostic & Therapeutic Services -Laboratory	Unlimited nursing Oxygen Blood Medically necessary services prescribed by a physician.	KAN Be Healthy -Oral exam -X-rays -Prophylaxis -Fluoride -Sealants -Space maintainers -Amalgams -Resins -Crowns -Endodontia -Root Canal -Peridontia -Apiectomy -Dentures -Orthodontia -Extractions Oral Surgery	DME for purchase and rental. -Wheelchairs -Pumps -Enteral and parenteral nutrition -Ventilators -Oxygen -Patient Lifts -Ostomy -Canes/ Crutches -Glucose Monitor -Dressings -Needles/ Syringes	All products from manufacturers with master rebate contract with Health Care Financing Administration, with the exception of federally allowable exclusions.	Nursing care. All medically necessary equipment and supplies to maintain child at home.

RIGHT TO LIFE
OF KANSAS, INC.

Crosby Place Mall
717 S. Kansas Ave. Topeka, Ks. 66603 (913) 233-8601

Feb. 27, 1992

Testimony On Senate Bill 631

Members of the committee, my name is Cleta Renyer, lobbyist for The Right To Life Of Kansas.
Line 31 on this bill about comprehensive prenatal services for all pregnant women poses very real concens for us, Kansas being a very pro-choice state when it comes to the child in the womb. What will become of the baby if a sonogram shows a possible defect? What will the women be counseled to do with this "product of conception (baby)?

This bill really scares me because it smacks of socialism. Government programs are taking over more and more of the lives of my chilred and grand-children. This is all happening so slowly, they aren't aware of it.

I am not against mothers having good health care for their unborn or after birth. I am not against helping when temporary help is needed, but this bill specifically says, "all pregnant women, all children under 18 years, all medical and health care, all dental care, sight and hearing tests plus glasses and hearing aids as needed."

What ever happened to letting parents being responsible?
Where is all of the money coming from for such extreme legislation?
We urge the committee to report this bill adversely.

Respectfully submitted,

Cleta Renyer

Senate P. H & W
Attachment # 8
2-27-92

KANSAS

NATIONAL ORGANIZATION FOR WOMEN

To: Senate Committee on
Public Health and Welfare

From: Amy C. Bixler
National Organization
for Women

Re: In Support of
Senate Bill No. 631

Date: February 27, 1992

Chairman Ehrlich and Members of the Committee

The National Organization for Women (N.O.W.), as a strong advocate of women's and children's rights, offers our full support for Senate Bill No. 631.

This Bill would establish a joint committee to investigate, consider, and propose legislation for the health and care of children and pregnant women, including the much-needed prenatal care. There has been a great deal of rhetoric in this country lately in support of "children's issues" and "family issues", but little has been done to effectuate this. Our children are indeed our greatest, and unfortunately, our most over-looked resource. Further, the accessibility of affordable health care for all women and children is in many areas simply non-existent. The two are undeniably linked; one cannot consider any women's issues without taking into account issues concerning women of child-bearing age. Logic dictates that child-bearing issues directly influence child care issues, and the cycle continues.

Let Senate Bill 631 be seen as a first step in an on-going effort to provide affordable health care for all women and their children.

Senate P. H&W
Attachment # 9
2-27-92

To: Senate Committee on Public Health and Welfare

From: Maureen Collins,
Planned Parenthood of Kansas

Re: Testimony in Support of Senate Bill 631

Date: February 27, 1992

Chairman Ehrlich and Members of the Committee

Planned Parenthood of Kansas enthusiastically supports Senate Bill 631 as a significant effort toward studying the problem of accessing affordable, quality health care for all women and children.

This new joint committee should consider a comprehensive, interdisciplinary, long-range plan that covers both the public and private sectors.

To be effective, it should include state intervention into the problem of maternal drug-use and consequently drug-exposed infants.

Further, there must be more of an effort by the state toward providing family planning services. Starting a health care program only after a woman becomes pregnant is short-sighted.

Planned Parenthood applauds this committee's concern for this issue, and will closely monitor the progress of Senate Bill 631.

Senate P. H & W
Attachment 10
2-27-92

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 27, 1992

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: Senate Bill 673, Narcotics Obtained by Fraudulent Means

The Kansas Medical Society enthusiastically supports the provisions of SB 673. This bill was introduced by your Committee at our request because of a flaw in current law governing prescription-only drugs.

It has been brought to our attention that if a person provides false information to a physician for the purpose of obtaining narcotics, that information is legally protected by the physician-patient privilege statute. Furthermore, even if the false information were not protected from being used as evidence, this kind of physician "duping" would not constitute obtaining a prescription drug by fraudulent means.

Passage of SB 673 would enable physicians to assist in the detection and prosecution of individuals who purposely divert narcotic and other prescription substances from legitimate medical usage to the illegal drug market. We urge you to recommend SB 673 for passage.

Thank you for considering our position on this important matter.

CW/cb

Senate P. H&W
Attachment # 11
2-27-92

Kansas State Board of Pharmacy

LANDON STATE OFFICE BUILDING
900 JACKSON AVENUE, ROOM 513
TOPEKA, KANSAS 66612-1220
PHONE (913) 296-4056

STATE OF KANSAS

JOAN FINNEY
GOVERNOR

SB 673

SENATE PUBLIC HEALTH
AND WELFARE COMMITTEE

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS TOM HITCHCOCK AND I SERVE AS EXECUTIVE SECRETARY OF THE BOARD OF PHARMACY. I APPEAR BEFORE YOU TODAY IN SUPPORT OF SB 673.

THE BILL WILL AMEND TWO SEPARATE STATUTES THAT IS NECESSARY TO PLUG A HOLE THAT EXISTS WHERE A NONLEGITIMATE PATIENT WANTS TO OBTAIN A LEGITIMATE DRUG FOR ILLEGITIMATE PURPOSES. THIS TYPE OF PATIENT IS OFTEN REFERRED TO AS A "PROFESSIONAL PATIENT" AND THE DRUG IS ALMOST ALWAYS A CONTROLLED SUBSTANCE DRUG THAT INDEED HAS A TENDENCY FOR ABUSE.

INCLUDED IN BOTH THE STATE AND FEDERAL CONTROLLED SUBSTANCES (CS) ACT, IT DENOTES THAT A PRESCRIPTION FOR A CS MUST BE ISSUED FOR A LEGITIMATE MEDICAL PURPOSE AND THE RESPONSIBILITY FOR PROPER PRESCRIBING AND DISPENSING OF A CS IS UPON THE PRACTITIONER. HOWEVER, A CORRESPONDING RESPONSIBILITY RESTS WITH THE PHARMACIST WHO FILLS THE PRESCRIPTION. THE PERSON FILLING AN UNLAWFUL PRESCRIPTION, AS WELL AS THE PERSON ISSUING IT, SHALL BE SUBJECT TO THE PENALTIES PROVIDED FOR VIOLATIONS OF THE PROVISIONS OF LAW RELATING TO CONTROLLED SUBSTANCES.

Senate P. H & W
Attachment #2
2-27-92

UNDER THE CURRENT STATUTES, THE ONLY ACTION A PRACTITIONER MAY TAKE WHEN CONFRONTED BY THE PROFESSIONAL PATIENT IS TO REFUSE TO TREAT SUCH PATIENT. LIKEWISE, A PHARMACIST MAY ONLY REFUSE TO FILL THE CS PRESCRIPTION WHEN THE PROFESSIONAL PATIENT PRESENTS SUCH WHICH WAS OBTAINED WITH FRAUDULENT INFORMATION. UPON REFUSAL, THE PROFESSIONAL PATIENT MERELY CONTINUES DOWN THE STREET UNTIL THEY FIND A PRACTITIONER THAT WILL SWALLOW THEIR FRAUD OR WITH AN OBTAINED PRESCRIPTION, KEEP GOING TO OTHER PHARMACIES UNTIL SOME INNOCENT PHARMACIST FILLS THE PRESCRIPTION.

THE BOARD OF PHARMACY RESPECTFULLY REQUESTS THE FAVORABLE PASSAGE OUT OF COMMITTEE OF SB 673.

THANK YOU.

Feb, 1992

Pharmacist's vigilance turns her toothache into headache

By Robert Short
The Wichita Eagle

Kathy Talbert says all she wanted was relief for a toothache. Pharmacist Thomas Bailey says he was merely doing his job. #8957

Talbert stopped by the Reliable Drug outlet at 501 E. Pawnee about noon Tuesday with two prescriptions in hand, one for a painkiller, another for an antibiotic.

"I was just standing there in the store, trying to get out of everybody's way, and the next thing I knew, here come these two police officers," she said. "They said, 'Please take your hands out of your pockets.' I was like, 'What did I do?' "

The officers told Talbert that the pharmacist suspected her of presenting a forged prescription for the painkiller. After searching her purse and checking with her dentist, the officers found that the prescription was legitimate.

"I had a toothache. Give me a break. The pharmacist never did apologize."

Kathy Talbert

But Talbert, 35, is still upset.

See **PHARMACY,** *Page* **2D**

Fernando Salazar/*The Wichita Eagle*

Kathy Talbert's prescriptions raised the suspicions of a pharmacist because they were written with different colors of ink.

PHARMACY

From Page 1D

"I didn't know whether to get mad or get upset or cry," she said. "I know he was doing his job, but I am sitting here and turning white and red and green, and I am going 'Oh my God.'

"I had a toothache. Give me a break," Talbert said. "The pharmacist never did apologize."

Bailey said most pharmacists in Wichita are sensitive to the growing problem of forged prescriptions, especially for Lortab, the painkiller Talbert wanted.

"The pharmacists are getting really leery," Bailey said. "With modern photocopy machines, you can make a real good copy. The problem is, they can take the prescription, have it photocopied, and then get it filled at several different places."

Bailey said he was suspicious of Talbert's prescriptions because they were written with two different colors of ink: The antibiotic prescription was in blue; the prescription for painkiller was in black.

He finally filled Talbert's prescription for the painkiller. Talbert, who is awaiting a root canal, said she would return when she had the money for the antibiotic.

"I didn't apologize to her," Bailey said. "I probably should have said I was sorry I caused her the embarrassment."

Talbert said Tuesday night that her pain was gone but not her embarrassment.

12-3

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director
February 27, 1992

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563

To: Chairman Ehrlich and Members, Senate Public Health Committee

From: Harold E. Riehm, Executive Director, The Kansas Association of Osteopathic Medicine

Subject: Testimony in Support of S.B. 673

I appear today in support of S.B. 673.

There has been considerable discussion in recent years, of physicians being "duped" by persons seeking access to certain prescription drugs. The extent of such activity is little known, but there are documented instances of it taking place.

This has prompted programs by KAOM and other professional associations aimed at educating doctors of "approaches" used by such persons and how physicians should respond. This has been part of our "risk management" continuing education for physicians.

Though the Board of Healing Arts, Kansas, licensed physicians have been subject to investigation and penalty for misprescribing or, in this specific case, prescribing without proper cause. But, Kansas law has been silent on any penalties for persons attempting to obtain a prescribed drug under false pretenses or fraud.

S.B. 673 would remedy this by making it a violation of Kansas law to provide false information to a practitioner for the purpose of obtaining a prescription-only drug. It would also preclude use of physician-patient confidentiality as a defense against providing false information to a physician.

We urge your support of S.B. 673. Thank you for this opportunity to present our views.

Senate P H & W
Attachment #13
2-27-92

State of Kansas

235 S Topeka Blvd
Topeka, KS 66603

913 296 7413
FAX 913 296 0852

Board of Healing Arts

MEMORANDUM

TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr., Executive Director LTB

DATE: February 27, 1992

RE: **TESTIMONY ON SENATE BILL 673**

Mister Chairman and members of the Committee, thank you for the opportunity to appear before you and, on behalf of the State Board of Healing Arts, express the Board's strong support for Senate Bill 673. This bill would make it a crime for a person to provide false information to a physician in order to obtain a prescription drug, whether by prescription order or through dispensing or administration. At present, a person who obtains a drug by fraudulent, deceptive and false methods is guilty of no criminal conduct.

Each year, millions of unit dosages of controlled drugs are illegally diverted from the health care industry for non-medical or "street" use. The federal government's Drug Abuse Warning Network (DAWN) data, from selected hospital and medical examiners consistently indicates that more overdose deaths and hospital admissions are attributed to prescription drugs than to illegal drugs.

Senate P.H.&W.
Attachment #14
2-27-92

The American Medical Association has categorized physicians who misprescribe drugs into four categories: dishonest, dated, disabled and deceived or duped. This Legislature has provided the State Board of Healing Arts and law enforcement authorities with adequate laws to address the first three categories. However, with the deceived or duped doctor, that individual is guilty of nothing more than an honest attempt to do what he has spent years learning to do - alleviate pain and suffering. It is the doctor shopper, professional patient or con artist that is guilty of the misconduct. Yet, there is no statutory provision that allows for any punishment for such deception and fraud. Examples of just a few of the scams utilized by these doctor shoppers are illustrated in the attached portions of a publication entitled The Second Scam of the Month Initiative printed by the Missouri Department of Health. In the item entitled A Con Artist's Year, prescriptions obtained by one individual in a one year period are illustrated. In that particular case, the individual obtained prescriptions from 25 physicians, six of whom were in Kansas.

As the attached illustrations reflect, the duped or deceived physicians are those who get conned by people who are adept at scams and it is not only the grossly naive who get conned. Due to the skill of the con artists, any physician can be taken since these people prey on the natural compassion and strong desire of physicians to provide help to individuals who appear in need.

In conclusion, the State Board of Healing Arts strongly supports Senate Bill 673 and the amendments to K.S.A. 21-4214 which would punish the true offender who obtains drugs by the use of false information.

Thank you very much for the opportunity to appear before you and I would be happy to answer any questions.

THE SECOND

Scam of the Month

INITIATIVE

A project to alert Missouri health-care professionals and law-enforcement officials to common techniques used to improperly secure abuseable prescription drugs. Scam reports may be used for publications or other communications directed to:

Physicians	Sheriffs	Health Care Centers
Dentists	Prosecutors	Nursing Homes
Nurses	Judges	Pharmaceutical Firms
Veterinarians	Hospitals	CEU Programs
Pharmacists	Clinics	Police Departments

Missouri Task Force on Misuse Abuse and Diversion of Prescription Drugs

Printed by the Missouri Department of Health

A Con Artist's Year

The following chart depicts a 12-month account of a clever professional patient who was able to obtain prescriptions for 4,873 tablets of 4 mg Dilaudid and other drugs, from 25 unwary physicians. Given prevailing street prices, it can be estimated that one year's effort produced a net profit of $194,920.

This information, provided by the Missouri Bureau of Narcotics and Dangerous Drugs (BNDD), is based on a true account, however, the names of the prescribers have been replaced by numerical code.

All told, this con artist approached an average of one physician every 4 days. His trail covered 25 individual physicians in 30 towns and 12 states. He was arrested in Jefferson City, Missouri, on October 10, 1985.

DATE	LOCATION	DRUG	QUANTITY	PHYSICIAN	
1984					
10/05	Liberty, MO	Dilaudid, 4 mg.	40	1	
10/10	Columbia, MO	"	100	2	
10/23	Sedalia, MO	"	48	3	
11/13	Independence, MO	"	100	4	
12/05	Sedalia, MO	"	100	5	
12/07	Jefferson City, MO	"	100	6	
12/11	Independence, MO	"	40	4	(2)
12/12	Liberty, MO	"	40	1	(2)
12/18	Raytown, MO	"	100	7	
12/20	Sedalia, MO	"	50	5	(2)
1985					
1/07	Jefferson City, MO	"	50	6	(2)
1/25	Liberty, MO	"	40	1	(3)
1/28	Garfield Heights, OH	"	30	7	(2)
1/31	Chagrin Falls, OH	"	30	8	
2/11	Jefferson City, MO	"	75	6	(3)
2/26	Lansing, MI	"	50	9	
3/08	Clarks Summit, PA	"	75	10	
3/09	Binghampton, NY	Percodan 24	11		
3/09	Johnson City, NY	Dilaudid, 4mg	50	11	(2)
3/12	Parma, OH	"	10	12	
3/29	Mishawaka, IN	"	100	13	
4/04	Olathe, KS	"	50	14	
4/10	Clarks Summit, PA	"	40	15	
4/24	Shreveport, LA	"	50	16	
5/03	St. Joseph, MO	"	50	17	
5/07	Battle Creek, MI	"	30	18	
5/08	Clarks Summit, PA	"	75	10	(2)
5/17	Lansing, MO	"	50	9	(2)
5/23	Overland Park, KS	"	50	10	
5/26	Corning, AR	"	50	11	
5/28	Memphis, TN	"	20	12	(2)
5/28	Jonesboro, AR	"	30	13	
5/30	Walnut Ridge, AR	"	100	14	
6/04	Memphis, TN	"	6	15	

		"	50	16	
6/05	West Plains, MO	"	50	6	(7)
6/05	Jefferson City, MO	Dilaudid, mg	30	17	
6/14	Las Vegas, NV	"	50	18	
6/14	Las Vegas, NV	"	50	9	(3)
6/19	Lansing, MI	"	100	13	(2)
6/20	Mishawaka, IN	"	50	17	(2)
6/25	St. Joseph, MO	"	50	10	(2)
6/27	Overland Park, KS	"	20	18	
6/28	Pocahontas, AR	"	20	12	(3)
7/01	Jonesboro, AR	"	50	16	(2)
7/03	West Plains, MO	"	100	6	(5)
7/03	Jefferson City, MO	"	100	14	(2)
7/06	Walnut Ridge, AR	"	100	19	
7/09	Wyoming, MI	"	100	14	(3)
7/16	Jonesboro, AR	Dolophine 6	20		
7/17	West Memphis, AR	Dilaudid, 4 mg	30	12	(4)
7/17	Jonesboro, AR	"	50	10	(3)
7/19	Overland Park, KS	"	50	1	(4)
7/19	Liberty, MO	"	100	19	(2)
7/25	Grand Rapids, MI	"	100	9	(4)
7/29	Lansing, MI	"	50	9	(5)
8/06	Lansing, MI	"	50	1	(5)
8/09	Liberty, MO	"	100	14	(4)
8/12	Walnut Ridge, AR	"	75	16	(3)
8/14	West Plains, MO	"	100	6	(6)
8/15	Jefferson City, MO	"	100	19	(3)
8/19	Wyoming, MI	"	40	18	(2)
8/20	Battle Creek, MI	"	100	9	(6)
8/21	Lansing, MI	"	100	19	(4)
8/23	Grand Rapids, MI	"	100	9	(7)
8/26	Lansing, MI	"	40	10	(4)
8/29	Overland Park, KS	"	40	1	(6)
8/30	Liberty, MO	"	100	19	(5)
9/04	Wyoming, MI	"	50	12	(5)
9/09	Lansing, MI	"	100	19	(6)
9/12	Grand Rapids, MI	"	50	21	(2)
9/17	Lansing, MI	Valium, 5 mg	40	22	
9/20	Lansing, MI	Dilaudid, 4 mg	30	22	(2)
9/20	Lansing, MI	"	100	6	(7)
9/23	Jefferson City, MO	"	40	10	(5)
9/15	Olathe, KS	"	20	23	
9/28	Davenport, IA	"	123	19	(7)
9/29	Wyoming, MI	"	150	19	(8)
9/30	Hastings, MI	"	50	21	(3)
10/07	Lansing, MI	Percodan 24	23		
10/07	Lansing, MI	Dilaudid, 4 mg	10	24	
10/15	Hastings, MI	"	50	25	
10/18	Michigan City, IN				

NOTES: *Parenthesis following prescriber code indicates number of times that particular doctor was approached during the 12-month period reported. 1984 dates are for Missouri only. In a few cases, where prescription information was incomplete, estimates have been made.*

(The first 22 scams appeared in the First Edition)
Scam of the Month #23

The Aggravated Stump Scam

An expensive van, transporting a driver and four elderly passengers (each of whom has a missing leg) pulls into town. The van stops at the first available outside telephone. The youthful driver begins to randomly contact local doctors, requesting appointments for his passengers. Moved by the urgency of the medical condition described ("My grandmother's from out of town and she has an artificial leg. Her stump is very sore, I think it's infected. She's really in pain."), most of the doctors contacted agree to an immediate appointment. After numerous visits are scheduled, the driver carefully charts the most efficient route to deliver his charges.

As each wheelchair borne amputee arrives at the doctor's office, the driver makes individual inspections. If the stump being checked doesn't appear sufficiently aggravated, sandpaper is used to produce the desired effect. A convincing, well practiced, story is told why the grandmother can't use any pain medication except Dilaudid. The sympathetic physician usually issues the requested prescription, normally for a large quantity ("Grandmother won't be able to see her regular doctor for at least two weeks.")

After the Dilaudid prescriptions are filled (one per pharmacy), the drugs are immediately sold to local drug dealers and the con artists are on their way to another town. The street price for a single 4 mg Dilaudid tablet ranges from $55 to $60. Daily profits from such operations run as high as $5,000.

*****

Physicians are cautioned to be alert to patients who are unknown to them, demonstrate behavior associated with drug abuse, have insufficient identification, or who otherwise behave suspiciously. A request for positive identification and/or a telephone call or two can be an effective deterrent.

Pharmacists should verify all Dilaudid prescriptions with the physician involved. The identity of the person presenting the prescriptions should be verified by recording license numbers, Social Security numbers, etc. on the prescriptions.

14-7

Paraplegic Scam

Physicians and pharmacists should be alert to the use of paraplegic patients in a drug scam. The Missouri Bureau of Narcotic and Dangerous Drugs has reported cases of such impaired persons scheduling multiple physician appointments on regular schedules throughout the state.

Four such individuals are known to have become paraplegic due to gun battles with other drug dealers or with law enforcement officials. It's also known that some of these persons do not suffer pain requiring Dilaudid, but simply use their condition to solicit sympathy from unwary health care professionals.

One of the paraplegic gang members was seeing 14 physicians in Kansas City and had obtained prescriptions for Ritalin, Talwin NX, Valium, Tylenol, Fiorinal #3 and #4, as well as Dilaudid and non-controlled drugs. Another gang member was rotating through 12 St. Louis area physicians with much the same results. Fifteen southeast Missouri physicians have been bilked by still another paraplegic gang member. Percodan, Demerol, Tylox and Percocet are often on the shopping list of these unscrupulous con artists.

*****

Physicians are cautioned to be alert to patients who are unknown to them, demonstrate behavior associated with drug abuse, have insufficient identification, or who otherwise behave suspiciously. Always request positive identification from the patient and the person(s) assisting the patient. The identification of the vehicle used to transport the patient and the license number of that vehicle can be vital to law enforcement officials.

Pharmacists should verify all Dilaudid prescriptions with the physician involved. The identity of the person presenting the prescription should be checked against the name on the prescription. Verification of identification numbers such as driver's license number, Social Security number, Medicaid number, etc., should be made before any controlled prescription is filled.