Approved: June 5, 2001 by letter
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Steve Morris at 10:35 a.m. on March 26, 2001 in Room 123-S of the Capitol.

All members were present except: Senator David Adkins - Excused
Senator Christine Downey - Excused

Committee staff present:
Alan Conroy, Chief Fiscal Analyst, Kansas Legislative Research Department
Debra Hollon, Kansas Legislative Research Department
Amory Lovin, Kansas Legislative Research Department
Rae Anne Davis, Kansas Legislative Research Department
Paul West, Kansas Legislative Research Department
Michael Corrigan, Assistant Revisor, Revisor of Statutes Office
Julie Weber, Administrative Assistant to the Chairman
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Ron Hein, Legislative Counsel, National Kidney Foundation of Kansas and Western Missouri
Dr. Scott Solcher, Nephrologist, Lawrence
Bob Whitlock, Executive Director, Missouri Kidney Program
Randy Williams, CEO, National Kidney Foundation of Kansas and Western Missouri
Marlin Rein, University of Kansas
Tracy Diel, Acting Director, Kansas Racing and Gaming Commission

Others attending: See attached guest list

Chairman Morris opened the public hearing on:

HB 2059--Renal assistance program

Staff briefed the committee on the bill.

Chairman Morris welcomed the following conferees who spoke in support of **HB 2059**:

Ron Hein, Legislative Counsel, National Kidney Foundation of Kansas and Western Missouri (Attachment 1).

Dr. Scott Solcher, Nephrologist, Lawrence (Attachment 2).

Bob Whitlock, Executive Director, Missouri Kidney Program (Attachment 3).

Randy Williams, CEO, National Kidney Foundation of Kansas and Western Missouri (Attachment 4).

Marlin Rein, on behalf of the University of Kansas (Attachment 5). Mr. Rein mentioned several concerns that the University had:

- They believe there should be authority to contract for administration of the program if that appears to be the most efficient approach.;
- They remain concerned as to whether the University is the appropriate agency to administer the program.; and
- The bill is basically void of any legislative guidance as to the scope of services to be provided.

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS on March 26, 2001 in Room 123-S of the Capitol.

Additional information was distributed:

- Did you know .... regarding kidney disease (Attachment 6)
- Kansas Dialysis Patients' County of Residence (Attachment 7)
- National Kidney Foundation of Kansas and Western Missouri, Board of Directors List of Officers and Board Members, Fiscal Year 2000-2001 (Attachment 8)
- Kansas Kidney Program, Projected Budget by Level of Services Provided (Attachment 9)

Committee questions and discussion followed. The Chairman thanked the conferees for appearing before the Committee. There being no further conferees, the Chairman closed the public hearing on **HB 2059**.

Chairman Morris opened the public hearing on:

SB 337--Kansas racing and gaming commission, salary of commissioners

Staff briefed the committee on the bill.

Chairman Morris welcomed Tracy Diel, Acting Director, Kansas Racing and Gaming Commission, who spoke in favor of **SB 337** (Attachment 10).

Committee questions and discussion followed. Chairman Morris thanked Mr. Diel for his appearance before the Committee. There being no further conferees, the Chairman closed the public hearing on **SB 337**.

Bill Introduction

Senator Feleciano moved, with a second by Senator Barone, to introduce a bill (1rs1235) concerning the Kansas life and health insurance guaranty association. Motion carried by a voice vote.

The meeting was adjourned at 12:00 noon. The next meeting is scheduled for March 27, 2001.

SENATE WAYS AND MEANS COMMITTEE
GUEST LIST
DATE March 26, 2001

NAME	REPRESENTING
Marlin Rees	KU
Fred Seiler	NEPHROLOGIST
Ron Hein	NKF of Kansas / Western MO
Randy Williams	NKF of Ks. and W. Mo.
Robert W. Whitlock	Missouri Kidney Program
Julie O'Neill	National Kidney Foundation KS/Western MO
Elizabeth Witten MSW ACSW LCSW	Missouri Kidney Program
Lois J. Weeks	SRS
Michael White	Kearney Law Office
Holly Moore, RD LD	Dialysis Specialist of Topeka
Jackie Naylor	Dialysis Specialist of Topeka
Jonelle Brown, LMSW	Dialysis Specialist of Topeka
Ron McMurry	
Amy Lynn Thurn	Sen. Feleciano
Judy Kreeger	Governor's Office
TRACY DIEL	Ks Racing + Gaming Comm / State Gaming Agency

HEIN AND WEIR, CHARTERED

Attorneys at Law
5845 S.W. 29th Street, Topeka, KS 66614-2462
Telephone: (785) 273-1441
Telefax: (785) 273-9243

Ronald R. Hein
Email: rhein@hwchtd.com

Stephen P. Weir*
Email: sweir@hwchtd.com
*Admitted in Kansas & Texas

Testimony re: HB 2059
Senate Ways and Means Committee
Presented by Ronald R. Hein
on behalf of
National Kidney Foundation of Kansas and Western Missouri
March 26, 2001

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the National Kidney Foundation of Kansas and Western Missouri. NKF KS/West MO is a regional office of the National Kidney Foundation with a service area of the entire state of Kansas and the western portion of the state of Missouri. It's mission is to assist patients with kidney disease. It fulfills this mission through numerous services including raising funds for research; providing direct patient care and treatment; providing early intervention screenings; providing a camp for children with kidney disease, including kids on dialysis; increasing organ donation awareness: and operating numerous other programs for victims of kidney disease.

I serve on the Board of Directors of the NKF KS/Western MO. I have been appointed by the board to lobby for the NKF, but I want to make clear that I am not receiving any remuneration and am offering my services and the services of my firm on a *pro bono* basis.

As you know, I am also a victim of kidney disease. The source of my disease is diabetes mellitus, which I have had since I was 14 years of age. In 1978, I was advised by my physician that I had kidney disease, more technically described as end-stage renal disease (ESRD). I was lucky to have regular check-ups because of my diabetes and thus discovered my kidney disease at a very early stage. I was given the education that I needed to know how to control my diet, and to otherwise follow my medical regimen so that I could preserve my own kidneys as long as possible. As a result, I was able to sustain my own kidneys 18 years until the summer of 1996, when my kidneys failed and I went on dialysis for 2 ½ months. When I was on dialysis, I was able to do the 4 times daily dialysis treatments because it was not during the legislative session. Had my kidneys failed during the session, dialysis would have prevented me from doing my job. My wife, Julie, donated a kidney to me in September, 1996. For her to sacrifice one of her functioning kidneys to give me the gift of life was a loving and selfless act.

NKF presented a proposal to the Healthcare Reform Legislative Oversight Committee during the interim, and the committee introduced HB 2059. HB 2059 authorizes the KU Medical Center to implement a program to provide assistance for those in need of care and treatment for kidney

Senate Ways and Means
3-26-01
Attachment 1

disease. Passage of this bill will put this renal program in the Kansas Statutes, but will not mandate the appropriation of any funds for the program.

HB 2059 permits KU Medical Center to expend any monies received from appropriations, if any are made by the Legislature, and grants and other gifts for the program. When this bill was heard in the House, the KUMC raised concerns about the original bill. Their concerns included the fact that KU Med Center should not be required to operate a program out of their own funds. They also desired the ability to contract for services. The NKF agreed. In consultation with KUMC representatives, we prepared amendments that the House committee accepted that address those concerns.

The NKF wants this program to work and we are prepared to put significant expertise and effort into partnering with the state to provide services to kidney victims that will improve their medical outcomes and quality of life. We are also committed to working with KUMC to insure that any available funds are used in the most efficient, effective manner possible.

From 1970-1988, Kansas operated a program for the care and treatment of persons suffering from acute or chronic renal failure requiring dialysis. That program was funded, sporadically, from 1970 until 1984. In 1988, the legislature repealed the program.

Most patients do not have the financial wherewithal to deal with the ramifications of end stage kidney disease. Medicare provides coverage for dialysis treatment and the expense of a kidney transplant, and covers certain drugs and services for a certain period of time. However, Medicare does not cover all of the expenses that are necessary for the care and treatment of these individuals. I am fortunate that my standard of living and availability of private insurance permits me to deal with the employment and monetary ramifications of kidney disease and its treatment. But I am the exception.

If this legislation is approved, it would be our goal to have, in time, a program similar to the program in Missouri. We know funds are extremely tight. Maybe so tight that this program will not be funded at all this year. But we also know that funding for this program can greatly improve outcomes of dialysis patients and others in end-stage renal disease. Such improved outcomes can result in decreased healthcare costs, and improved health that can result in patients being more productive. By improving outcomes and keeping people productive, the state can benefit from increased taxes and decreased costs in other government programs.

HB 2059 permits the private sector and the public sector to partner to address the problems faced by a few Kansans who, through no fault of their own, are forced to deal with a devastating disease. Hopefully we hope to facilitate availability of early intervention and appropriate education and treatment to minimize the costs to government and society of kidney disease.

Dr. Scott Solcher, a nephrologist with the Cotton-O'Neil Division of Stormont-Vail Hospital, will discuss why a program such as this is needed and how it will improve patient outcomes, and ultimately societal outcomes. Randy Williams, CEO of the National Kidney Foundation of Kansas and Western Missouri, will outline the program and budget. Robert Whitlock, Missouri Kidney Program, will explain how our neighboring state's program can assist Kansas if this program is implemented. I will close with possible options for funding.

I urge you to support HB 2059. Thank you very much for permitting me to testify.

Testimony in Pursuit of a Kansas Kidney Program
Monday, March 26 2001
Scott Solcher, MD, FACP

Thank you very much for allowing me to testify in favor of a state kidney program.

I will briefly describe kidney failure and treatment with dialysis. I will also discuss issues that prevent patients from maximizing their treatment, which in turn leads to poorer health, increased hospitalizations and earlier death. I believe a Kansas kidney program can improve outcomes by facilitating patients' ability to receive predialysis education, improving awareness of renal disease, providing transportation to dialysis, supplying medicines, and providing nutritional supplementation. Improved outcomes include better health, fewer hospitalizations, and longer life.

BACKGROUND INFORMATION

Kidney Failure and Its Treatment

Kidney failure can be a slow process or a very rapid one. The symptoms may at first be subtle with loss of energy, vigor, or appetite, but progress to severe fatigue, weakness, vomiting, and profound itching. Kidney failure can be treated with either dialysis or transplantation

Hemodialysis is blood dialysis performed at a dialysis unit, typically three times weekly for four hours. Eighty-five percent of patients with end stage renal disease in the United States use this modality. With hemodialysis, the patient's blood must be transferred to the dialysis machine through a surgically placed conduit. Ideally the conduit is present in the patient's forearm several months prior to the initiation of hemodialysis. With late referral, a temporary catheter must be often be placed instead. Catheters are associated with increased rates of infection and the quality of dialysis is generally poorer.

Peritoneal dialysis is the modality that the other fifteen percent of patients use. In this procedure, patients place approximately two liters of dialysate fluid in the abdominal cavity around the stomach. Toxins diffuse into this fluid, with other beneficial chemicals diffusing from that fluid into the blood stream. This procedure must be done four to five times daily, every day.

Regardless of how patients dialyse, they have multiple other lifestyle restrictions. Included are restrictions of the amount of any fluid they drink, as well as limitations in salt, potassium, and phosphorus intake. While many of the most severe symptoms of renal failure improve with dialysis, many persist. The most prominent is fatigue.

In addition to the dialysis sessions and dietary restrictions, dialysis patients on average take nine different medicines, with many patients taking fifteen or twenty. The schedules for these medicines are very difficult for anyone to manage correctly.

Senate Ways and Means
3-26-01
Attachment 2

HOW A KANSAS KIDNEY PROGRAM WILL ASSIST DIALYSIS PATIENTS

Early Intervention and Predialysis Education

Early intervention is critical. The Kansas Foundation for Medical Care studied patient's initiation of dialysis and published their preliminary results in 1998. They compared patients who were referred early to a nephrologist versus patients who were referred late to a nephrologist. Their findings included the following.

- Patients who were late referrals were twice as likely to die within two years than early referrals.
- Patients who were late referrals were more likely to start hemodialysis than early referrals.
- Patients who were late referrals spent twice as many days in the hospital than early referrals.
- Other studies have shown that patients who were late referrals were unable to choose peritoneal dialysis over hemodialysis as often as early referrals.
- Late referrals are more likely to need a venous catheter to start dialysis, increasing the risk of infection and decreasing the quality of their dialysis.
- Finally, the initiation of dialysis in patients who were referred late has been documented to cost five times as much compared to those patients who were referred early.

Late referral also does not enable for predialysis education and treatment. Kidney disease and symptoms can often be slowed with appropriate dietary education and blood pressure control. A Kansas kidney program could increase predialysis education and facilitate early referral. In doing so, patients would feel better, live longer, and initiate dialysis less expensively.

Transportation

Transportation is a major factor in a patient's noncompliance with their dialysis schedule. Compliance to the dialysis regimen has been well studied, and patients live longer if they complete all of their thirteen or fourteen dialysis treatments each month.

- Patients who miss one or more hemodialysis session monthly are 25% more likely to die than other patients on dialysis.

- Patients who shorten three or more dialysis sessions monthly are 20% more likely to die than other patients on dialysis.

A Kansas kidney program could aid in transportation for patients. Reliable transportation would lead to better compliance to the dialysis schedule. Better compliance decreases mortality.

Medicines

I have spoken already of the number of medicines taken by the average dialysis patient. Many of these medicines must be taken up to four times daily, and costs generally range from twenty to one hundred twenty dollars per medicine monthly. For the average patient taking nine medicines daily, the costs can be staggering. Often patients simply do not have adequate income to pay for their medicines after rent and food.

Noncompliance with most medicines taken by dialysis patients leads to adverse outcomes. Common medicines include blood pressure lowering agents, phosphorus lowering medicines, blood thinners, and heart medicines. The literature is extensive and clear that lack of compliance with these medicines will lead to poorer outcomes with more strokes, heart attacks, clotted dialysis accesses, hyperparathyroidism requiring surgery, and a host of other complications. These complications lead to greater expense and early death.

It is documented that transplant patients with low incomes are twice as likely to experience a failure of the transplanted kidney and to return to dialysis after one year and after five years versus patients with adequate income.

If compliance is improved, patients' outcomes would be better with less hospital costs.

Nutritional Supplementation

Albumin, which is a blood protein, is directly correlated with survival in the dialysis population. A low blood albumin level is a powerful and independent predictor of death. Serum albumin can in turn be raised with adequate and timely nutritional supplementation with a subsequent marked reduction in risk of death. Albumin levels have also been correlated to hospital admission rates that, if reduced, could decrease costs.

IMPROVED OUTCOMES WITH IMPROVED COMPLIANCE

It is critical to point out that not only does poorer compliance lead to poorer outcomes but also that improved compliance leads to improved outcomes. Data from 1998 show increased medical compliance and increased perception of social support improved mortality. Patients were twenty percent less likely to die. A Kansas Kidney Program could replicate these findings.

SUMMARY

Kidney failure requiring dialysis is a life changing event with complicated, expensive treatment. A program that improves early referral and predialysis education, that ensures transportation will be available to dialysis, that ensures patients will be able to purchase their medicines, and that ensures adequate nutrition is available will make a difference. A program that can provide these things makes fiscal sense. There is a wonderful opportunity here to make the lives of Kansans on dialysis better, and I ask you to please help them.

Thank you very much for allowing me to speak. I would like to answer any questions at this point.

Missouri Kidney Program
University of Missouri-Columbia

112 Lewis Hall
Columbia, MO 65211-4220

LOCAL PHONE (573) 882-2506
TELEPHONE 1-(800)-733-7345
FAX (573) 882-0167

March 26, 2001

TO: Chairperson, WAYS AND MEANS COMMITTEE, Kansas State Legislature

FROM: Bob Whitlock, Director Missouri Kidney Program

SUBJECT: TESTIMONY IN FAVOR OF ESTABLISHING A KANSAS KIDNEY PROGRAM (House Bill 2059)

This is to support the efforts headed up by the National Kidney Foundation of Western Missouri and Kansas. among other groups, to establish a kidney program in the state of Kansas.

The Missouri Kidney Program, which has been in existence since the late 1960's is in full support of establishing a Kansas program and we offer our assistance and consultation in setting up such a service. We would be happy to share our manuals, processes, forms, and other supportive materials to lessen the initial task of establishing an infrastructure for the business aspects of the agency. We would also be pleased to offer consulting time in this process as well.

We encourage the establishment of a comprehensive, patient centered program. In Missouri, we are able to serve approximately 2,700 Missourians with the various costs of dialysis and transplantation; among them are providing pharmaceuticals, reimbursing transportation costs, reimbursing premium costs for commercial third party insurance, nutritional supplements, and an education program for patients and families.

Again, the Advisory Council and myself commend your Committee for its willingness to consider funding a similar kind of program in Kansas. Anything we can do to be of assistance will be provided, and we applaud your efforts at making life easier for End Stage Renal Disease patients in Kansas.

Senate Ways and Means
3-26-01
Attachment 3

National Kidney Foundation
Of Kansas & Western Missouri

1900 W. 47th Place, Suite 310 • Westwood, Kansas 66205 • (913) 262-1551 • (800) 444-8113 • FAX (913) 722-4841

Testimony re: HB 2059
Senate Ways and Means Committee
Presented by Randy K. Williams, Chief Executive Officer, National Kidney Foundation of Ks. & W. Mo.
March 26, 2001

Mr. Chairman, Members of the Committee:

My name is Randy Williams and I am the Chief Executive Officer for the National Kidney Foundation of Kansas and Western Missouri. For over forty years the National Kidney Foundation of Kansas and Western Missouri has been providing services to patients and family members having to deal with kidney disease as well as promoting organ and tissue donation. Our goals include supporting research and research training, continuing education of health care professionals, expanding patient services and community resources, educating the public, shaping health policy and raising funds to support programs and services.

There currently are an estimated 1,905 dialysis patients in 97 of 105 counties in Kansas. People with kidney disease are your neighbors and constituents. Kidney disease strikes people of both sexes, all ages, races, and income levels. Kidney disease doesn't care whether you live in an urban area within one mile of a dialysis facility or on a farm where it may be as far as 75 miles one way to access the nearest dialysis unit. Any of you could be at risk, especially if you have diabetes or hypertension, or if you are African American, Hispanic or Native American. And worst of all, you may not even know it.

Diabetes is the most common cause of kidney failure in the U.S. At least 3% of Kansas residents (67,684) have been diagnosed with diabetes. Hypertension is the second leading cause pf kidney failure in the U.S. At least 21% of Kansas residents (557,000) have hypertension. Through a nationally recognized early intervention screening program we have conducted on over 2500 people, 62% of those have signs of possible kidney disease like hypertension, high blood sugar, or proteinuria (protein in the urine). Most did not know they were at risk. Recent research indicates that proteinuria not only is an early indicator of kidney disease but possibly heart attack and stroke as well.

Why does the NKF care? Kidney disease leads to unnecessary loss of productivity because 1) Most dialysis treatments take 3-4 hours three times each week, 2) Most dialysis clinics are not open after 5 p.m. limiting patients' work hours, 3) Kidney failure complications can lead to physical disability, 4) Dialysis patients fear losing Medicaid and transplant patients fear losing Medicare coverage if they return to work, 5) Most dialysis patients are not eligible for Vocational Rehabilitation because funding has been

Senate Ways and Means
3-26-01
Attachment 4

National Kidney Foundation
Of Kansas & Western Missouri

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cut drastically so only those who can't perform most basic activities of daily living are eligible for services. The NKF wants to help more Kansans remain productive. Kidney disease is the 8th leading cause of death and the fastest growing cause of death in Kansas. Although dialysis and transplantation saves lives, too many people in Kansas die of kidney failure. People may be dying of kidney failure because 1) They don't know they have kidney disease, 2) Their primary care doctors don't offer kidney treatment or refer them to nephrologists, 3) Patients don't know about kidney disease and treatment options that can help them live quality lives or 4) They believe treatment will be too burdensome to their families or themselves. The NKF wants to ensure that more people with kidney disease understand their options for treatment, learn how to participate actively in their care, and know when and where to seek help when needed.

To determine need, we surveyed patients who were receiving treatment for kidney failure. Dialysis social workers distributed surveys so most respondents were center hemodialysis patients. An estimated 2000 surveys were mailed with 687 (34%) responding. Needs identified included: Early intervention and education, transportation costs, nutritional supplements, insurance premiums, and prescription medication costs.

The National Kidney Foundation of Kansas and Western Missouri is seeking state support for a state kidney program in Kansas. We are not asking for funds to help facilities or physicians. We want to get a program started that will help individual patient's quality of life while helping to cut long term health care costs. Based on need, and using the HHS Poverty Guidelines, we have outlined two budget options: a Basic and a Comprehensive Plan. In both Plans, support would be for those in need after Medicare, commercial insurance, Medicaid and any other source of funding support has been provided.

We understand, however, the challenges and restraints of the State's financial situation this year likely preclude this Committee from supporting a full-scale Plan, Basic or Comprehensive. We don't have all the answers yet regarding the logistics to implementing a Comprehensive Plan. We, the NKF, would like the opportunity to demonstrate how a partnership with the University of Kansas Medical Center can work. We offer an alternative that will result in a Win- Win situation for Kansans. House Bill 2059 would establish this clearly needed program. Your support of HB 2059 will allow us the opportunity to at least look for alternate sources of funding. If you *are* able to appropriate funds this year we have included in our budget materials an example of a Start-up Plan. We have three years experience in providing support for nutritional supplements. We have the eligibility requirements and the staff to administer the program already in place. We know with certainty what it will cost to provide a year's worth of service to those who requested it this past year. With your support of this bill,

National Kidney Foundation
Of Kansas & Western Missouri

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and appropriations for support of Nutritional supplements or other identified needs, we will demonstrate to you our ability to work cooperatively with the KUMC to successfully implement this program. We are willing to start slow, prove our ability to provide a quality program and work in the coming months to bring about a more comprehensive program for Kansans with kidney disease.

In summary, a Kansas Kidney Program will help people learn about risk factors for kidney disease and possibly prevent End Stage Renal Disease. It will help people learn about options for treatment to maximize productivity and quality of life. Finally, it will help people pay expensive indirect costs of treatment, improve adherence, and reduce morbidity and mortality.

Thank you for the opportunity to testify before you today. We hope that you will support HB 2059.

Testimony: House Bill 2059
Senate Ways and Means Committee
March 26, 2001

Mr. Chairman, Members of the Committee:

My name is Marlin Rein and I am here on behalf of the University of Kansas to offer comments regarding House Bill 2059.

House Bill 2059 directs the University of Kansas Medical Center to establish a program for the care and treatment of persons suffering from chronic renal disease who require lifesaving medications and treatment. The Executive Vice Chancellor of the institution is authorized to appoint needed support staff to administer the act and to develop standards for determining eligibility for care and treatment under the program. The legislation establishes within the State Treasury a renal disease fund from which all program expenditures would be financed. While the act does not specify the sources of income to the fund, one might presume that the State would provide the principal funding for this program.

Understand that the University is supportive of any initiative that extends quality healthcare to Kansans. Whether the University is the appropriate agency to be charged with administering the program is another issue. The original sponsors of this bill used the State of Missouri as a model in selecting the University as the administering agency. The University of Missouri has administered such a program since 1968. Cost of the Missouri program is $4.5 million per year with the cost of administration approximately 10-12% of that amount.

Several of the University's original concerns with the legislation were addressed by the House Committee amendments. One concern was to ensure that the program would have its own dedicated funding source. Secondly, we believe there should be authority to contract for administration of the program if that appears to be the most efficient approach. We remain concerned as to whether the University is the appropriate agency to administer the program. I would also note that the bill is basically void of any legislative guidance as to the scope of services to be provided.

With those comments, Mr. Chairman, I would stand for questions.

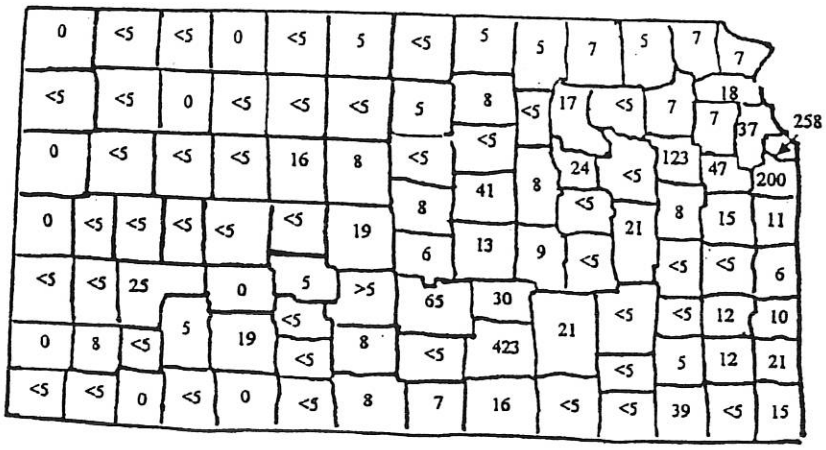
Senate Ways and Means
3-26-01
Attachment 5

Did you know...

Rank of kidney disease as cause of death in Kansas	8th
Kansas patients seen by nephrologist <1 month before treatment	17%
Diabetes as cause of kidney failure in Kansas	1st
Kansans diagnosed with diabetes of total population	3%
Hypertension as cause of kidney failure in Kansas	2nd
Kansans diagnosed with hypertension of total population	21%
Incidence of kidney failure per 1 million population, 1998	249.52
New Kansas residents starting ESRD treatment, 1998	656
Kansas residents on dialysis, 1999	1,905
Kansas counties with residents on dialysis, 1999	97
Kansas residents waiting for a transplant in Kansas, 2000	128
Kansas residents with a functioning kidney transplant, 1999	790
Kansas dialysis patients who do not live with a spouse	55%
Kansas dialysis patients who do not drive themselves	47%
Kansas dialysis patients who have missed dialysis due to transportation problems	8%
Kansas dialysis patients who have chosen not to be evaluated for transplant for financial reasons	10%
Kansas dialysis patients with Medicare	89%
Kansas dialysis patients with Medicaid	26%
Kansas dialysis patients with insurance from an employer	22%
Kansas dialysis patients with Medicare supplement	27%
Average Kansas dialysis patients pay for insurance monthly (range: 0-$1,000 monthly)	$73.40
Kansas dialysis patients with no prescription coverage	47%
Average Kansas dialysis patients pay for prescriptions monthly (range: 0-$1,400)	113.87
Average Kansas dialysis patients pay for transportation monthly (range: 0-$1,000)	$38.68
Average Kansas dialysis patients pay for nutrition supplements monthly (range: 0-$500)	$15.59
Average Kansas dialysis patients pay out of pocket for all medical care monthly (range: 0-$6,500)	$203.85
Kansas dialysis patients who are retired	33%
Kansas dialysis patients on Social Security Disability	46%
Kansas dialysis patients receiving SSI	19%
Kansas dialysis patients who would work if they could continue to get Medicaid	70%

Senate Ways and Means
3-26-01
Attachment 6

Kansas Dialysis Patients' County of Residence



This map shows where Kansas dialysis patients live. When there are 1-4 patients living in any county, this is designated by the value "<5" to protect the identity of individual patients.

Senate Ways and Means
3-26-01
Attachment 7

National Kidney Foundation
Of Kansas & Western Missouri

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BOARD OF DIRECTORS LIST
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Making Lives Better

Senate Ways and Means
3-26-01
Attachment 8

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Debra Porter-Gill · Attorney/Transplant Recipient

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Mary Ann Thies, RN · Midwest Nephrology Consultants

Bradley Warady, M.D. · Children's Mercy Hospital

Betty J. West, RN, BA · Johnson County Dialysis, Inc. · Wyandotte County Dialysis, LLC.

Kansas Kidney Program

Projected Budget by Level of Services Provided

Basic Plan	# Pts	Amt/Mo	Amt/Yr	% Poverty	Total/Category	MoKP Guideline
Dialysis Medicare premium	525	$45.50	$546	150%	$286,650	>150%
Dialysis Other Ins Premium	620	$75	$900	150%	$558,000	>150%
Transplant Medicare premium	235	$45.50	$546	150%	$128,045	>150%
Transplant Other Ins premium	264	$75	$900	150%	$237,600	>150%
Dialysis Transportation	173	$40	$480	100%	$83,040	>100%
Transplant Transportation	128	$25	$300	100%	$38,400	>100%
Education	166	$422	$422	All	$70,000	All
Nutritional Supplements	130	$50.50	$606	100%	$78,780	>100%
Subtotal					$1,480,515	
Admin @ 15%					222,077.25	
Total - Exp Basic					1,702,592.25	

Comprehensive Plan	# Pts	Amt/Mo	Amt/Yr	% Poverty	Total/Category	MoKP Guideline
Dialysis Medicare premium	525	$45.50	$546	150%	$286,650	>150%
Dialysis Other Ins Premium	620	$74	$888	150%	$550,560	>150%
Transplant Medicare premium	235	$45.50	$546	150%	$128,045	>150%
Transplant Other Ins premium	264	$75	$900	150%	$237,600	>150%
Dialysis Transportation	173	$39	$468	100%	$80,964	>100%
Transplant Transportation	128	$20	$240	100%	$30,720	>100%
Education	166	$422	$422	All	$70,000	All
Outpatient Medications	189	$114	$1,368	100%	$258,552	>100%
Transplant Medications	300	$250	$3,000	100%	$900,000	>100%
Nutrition Supplements	130	$50.50	$606	100%	$78,780	>100%
Subtotal					$2,621,871	
Admin @ 15%					$393,281	
Total - Full Service					$3,015,152	

Start-up Plan	# Pts	Amt/Mo	Amt/Yr	% Poverty	Total/Category	MoKP Guideline
Nutritional Supplements	130	$50.50	$606	100%	$78,780	>100%
Admin @ 15%					$11,817	
Total - Start-up					$90,597	

	1999
Dialysis	1905
Transplant	890

Senate Ways and Means
3-26-01
Attachment 9

KANSAS
STATE GAMING AGENCY

Racing & Gaming Commission

TO: Senate Ways and Means Committee

FROM: Tracy T. Diel, Executive Director, State Gaming Agency
Acting Executive Director, Kansas Racing and Gaming Commission

DATE: March 26, 2001

RE: Testimony on SB 337

Chairman Morris and members of the Committee. Thank you for the opportunity to testify today on SB 337.

The purpose of SB 337 is to amend K.S.A. 74-8803(j) and remove from the governor the authority to determine the level of compensation for members of the Kansas Racing and Gaming Commission (KRGC). I come before you today to speak against this amendment.

The KRGC is made up of two separate and distinct agencies. The Racing Commission and the Kansas State Gaming Agency (SGA). Each agency has separate and distinct responsibilities in regards to its areas of regulation. The Racing Commission has the responsibility of regulating the day-to-day activities at the parimutuel racetracks located in the State of Kansas. This includes licensing of all employees, vendors, horse and dog owners, kennel operators and horse trainers who are employed or operate at the racetracks. It is also responsible for licensing and regulating the racing facility owners and the charitable organizations who conduct the races and wagering at the racetracks. The KRGC through its judges, stewards, security, auditors and veterinarian staff are responsible for the integrity of the races, wagers and the health and welfare of the animals which are involved in racing. The SGA has the responsibility of monitoring and overseeing the gaming operations at the tribal casinos and enforcing the tribal-state compacts which allow them to operate.

It is KRGC's day-to-day regulatory responsibility of the parimutuel racing industry which sets the commissioners apart from other regulatory entities within the state government. It requires the commissioners to devote more time outside of the normal KRGC meeting schedule. It creates a situation where they perform duties which are similar to an employee, rather than a group which holds a meeting once a month or every quarter. In addition, this level of activity subjects them to a high level of liability. This sets them apart.

There is a perception that there is less today for the KRGC to do. This is not the case. The number of tracks which are being regulated by the KRGC has not decreased over time. It is true there has been a fluctuation. However, it has been up, not down. The number of tracks being

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Senate Ways and Means
3-26-01
Attachment 10

regulated has not dropped below the original numbers which existed when the KRGC was first organized and began its operation. Originally, two greyhound tracks and one horse track opened in the State of Kansas. The Woodlands in Kansas City, Kansas and Wichita Greyhound Park (WGP) in Wichita, Kansas. In 1995 a third greyhound track, Camptown Greyhound Park (CGP) located in Frontenac, Kansas opened. CGP went into bankruptcy and closed six months after it opened. Shortly, thereafter the Woodlands went into bankruptcy, but remained opened and operating. The Woodlands bankruptcy was resolved in December 1998 and the track was purchased by its present owner. In November 1997, WGP ownership changed. Then in early 2000, CGP was purchased by the owner of WGP and reopened in June 2000. CGP then closed again in November 2000. These issues have made the job of the KRGC very complicated and time consuming. Thus, requiring significant involvement from the commissioners. In addition, the KRGC is responsible for regulating two horse fair meets (Eureka Downs and Anthony Downs) which operate parimutuel wagering.

In addition, in July 1996 the KRGC was given the responsibility of overseeing the SGA. This involves reviewing and approving the agency's budget and personnel expansion and authorizing litigation under the tribal-state compacts. The Tribal Gaming Oversight Act requires that before the SGA can move forward with the dispute resolution process outlined under the tribal-state compacts, the KRGC must give its approval. This includes, but is not limited to, resolving disputes over the issuance of gaming licenses by the tribe, alcohol in the gaming facility, criminal jurisdiction and payment of assessments. During the last four years, I have gone to the KRGC to seek authority to go forward with the dispute resolution procedures for approximately two dozen issues.

Finally, I have had the opportunity to deal with the gaming industry on a daily basis for over four years as executive director of the SGA. I have seen first-hand how regulation of gambling should work and what the pitfalls are when it is not done correctly. In September 2000, I was asked to be the acting executive director of the KRGC. This gave me the opportunity to see up close and personal how the parimutuel racing industry interacts with itself and the regulatory body which oversees it. My experiences with the SGA and the KRGC have led me to believe that in order to effectively regulate the gambling industry at any level, there needs to be a high level of insulation between the gaming industry and the regulatory body which oversees it. This amendment could have a detrimental effect in this area.

If you have any questions, I would be happy to answer them.