Approved: January 25, 2007
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on January 23, 2007 in Room 231-N of the Capitol.

All members were present.

Committee staff present:
Emalene Correll, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jim Wilson, Office of Revisor of Statutes
Nabuko Folmsbee, Office of Revisor of Statutes
Morgan Dreyer, Committee Secretary

Conferees appearing before the committee:
Pam Scott, Executive Director, Kansas Funeral Directors Association
Diane Glynn, J.D., R.N., Practice Specialist with The Kansas Board of Nursing
Ellen Carson, PH.D., A.R.N.P., B.C., President, Kansas State Nurses Association
Deborah Stern, Vice President Clinical Services/Legal Counsel, Kansas Hospital Association
Linda Kenney, Director, Bureau for Children, Youth and Families, Kansas Department of Health and Environment

Others attending:
See attached list.

Upon calling the meeting to order, Chairman Barnett asked that the Committee review the Minutes for January 17, 2007 and January 18, 2007 for approval at the end of the meeting.

The Chair also asked that the Committee view a packet of the 3 studies that The Kansas Health Policy Authority submitted to the legislature since the end of the 2006 Session. The three studies are:

- Prescription Drug Generic Rebate and Dispensing Cost Study
- Potential Impact of a Medicaid Photo Identification Requirement
- Early Results from the Presumptive Eligibility Pilot Program

A copy of these studies are (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

Introduction of Bills

Chairman Barnett called upon Pam Scott, Executive Director, Kansas Funeral Directors Association, who proposed a bill which would amend Kansas statutes relating to the licensing of assistant funeral directors. A copy of the draft is (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

The motion was made by Senator Gilstrap to adopt the introduced bill. It was seconded by Senator Schmidt and the motion carried.

The Chair introduced a bill for Ernie Kutzley, Advocacy Director for AARP Kansas. The proposed legislation would reflect the New Hampshire # 1346 "Prescription Confidentiality Act" and the possibility that passage of a similar law in Kansas would help reduce health care costs and help protect the privacy of physicians. A draft of the bill was not provided. A copy of his requested proposal is (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

The motion was made by Senator Schmidt to adopt the introduced bill. It was seconded by Senator Jordan and the motion carried.

The Chair asked for Jim Wilson give a brief reading and to explain **SB 107.** The Chair then announced the next order of business would be to open a hearing on **SB 107.**

Hearing on SB 107 – An act concerning the board of nursing; fingerprinting and criminal history records checks; creating the criminal background and fingerprinting fund.

The Fiscal Note for **SB 107** was available for the Committee to view. A copy of the fiscal note is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

Chairman Barnett called upon his first proponent conferee, Diane Glynn, Practice Specialist, Kansas Board of Nursing who stated that the bill will allow the Board of Nursing to ask an applicant for licensure to be fingerprinted and submit to a state and national criminal history record check. A copy of her testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

Questions came from Senators Palmer, Wagle, Schmidt, Barnett, and Journey regarding increase for renewals, intent, other states recognizing the Kansas License, language of the legislation, original and new application, other agencies doing background checks, implementation for all or only new employees, data referencing the Boards, awareness, employee validated to take fingerprints, and Federal employee licenses.

The Chair then called upon opponent conferee Ellen Carson, PH.D., A.R.N.P., B.C., Kansas State Nurses Association who stated that KSNA would accept the legislation if the Committee uses the amendments listed in their testimony. A copy of her testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

No questions came from the Committee.

Chairman Barnett called upon his last proponent conferee, Deborah Stern, Vice President Clinical Services/ Legal Counsel, Kansas Hospital Association who stated their support for **SB 107** because it would assists Kansas hospitals by requiring both a state and a federal criminal background check for all registered nurses. A copy of her testimony is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

With no more conferees and no questions from the Committee, Chairman Barnett closed the hearing on **SB 107.**

Then Chair then called upon Nabuko Folmsbee to give a brief reading and explain **SB 116.** The Chair then announced the next order of business would be to open a hearing on **SB 116.**

Hearing on SB 116 – An act concerning school; health programs

The Fiscal Note for **SB 116** was available for the Committee to view. A copy of the fiscal note is (Attachment 8) attached hereto and incorporated into the Minutes as referenced.

The Chair then called upon neutral conferee, Linda Kenney, Director Bureau for Children, Youth and Families, Kansas Department of Health and Environment who stated her thanks to the Committee for the opportunity to provide the department's comments relating to this bill that amends the requirements for child health assessments for new Kansas school entrants age 8 and under. A copy of her testimony is (Attachment 9) attached hereto and incorporated into the Minutes as referenced.

No questions came from the Committee.

Chairman Barnett announced to the Committee that there was written testimony provided for the Committee in opposition to **SB 116** from Cindy Galemore, Director of Health Services for Olathe District Schools. A copy of her testimony is (Attachment 10) attached hereto and incorporated into the Minutes as referenced.

With no more conferees and no more questions from the Committee, the Chair closed the hearing on **SB 116.**

Chairman Barnett announced that the final item on the agenda was for the Minutes to be approved for the Senate Public Health and Welfare Committee for January 18, 2007.

The motion was made by Senator Journey to approve the Minutes. It was seconded by Senator Jordan and the motion carried.

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

MINUTES OF THE Senate Public Health and Welfare Committee at 1:30 P.M. on January 23, 2007 in Room 231-N of the Capitol.

Adjournment

As there was no further business, the meeting was adjourned at 2:30 p.m.

The next meeting is scheduled for Thursday, January 25, 2007.

Jan. 23, 2007

Senate Public Health and Welfare Committee

Please Sign In

Name	Organization
Linda Kenney	
Carolyn Middendorf	Ks St Ns Assn
Christy Caldwell	Little Gov't relations
Jeffrey J. Hammelberg	
John C. Peterson	Glaxo
Derek Hein	Hein Law Firm
Dan Murray	Federico Consulting
MARK P. MARTZ	VIA CHRISTI HEALTH SYSTEM
Karl Wenger	Kearney + Associates
LORNE A. PHILLIPS	KDHE
Mary Blubaugh	KSBN
MARK KNIGHT	KSBN
DEBORAH STERN	KHA
LARRY BUENING	BD OF HEALING ARTS
Ellen Carson	KSNA
Terri Roberts	KSNA
Mary Sloan	KAHSA
Barb Conant	KDOA

Kansas Health Policy Authority

MARCIA J.NIELSEN, PhD, MPH
Executive Director

ANDREW ALLISON, PhD
Deputy Director

Report on:
Early Results from the Presumptive Eligibility Pilot Program

presented to:
House Appropriations Committee and Senate Ways and Means Committee

January 8, 2007

For additional information contact:
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Senate Public Health and Welfare Committee
Attachment #1
January 23, 2007

Early Results from the Presumptive Eligibility Pilot Program

The 2006 Kansas Legislature, as outlined in proviso, directed the Kansas Health Policy Authority (KHPA) to prepare a report about the Presumptive Eligibility (PE) program. The proviso specified the following items be addressed in the report: "...to prepare a report to be presented on or before the first day of the 2007 regular session of the legislature to the house committee on appropriations and the senate committee on ways and means regarding the implementation of presumptive eligibility for the Title XIX and XXI programs: *Provided*, That the report shall include a detailed description of the plan for implementation at both the state and provider level, as well as the anticipated number of children served and the cost of providing services under this program."

Executive Summary:
Early Results from the Presumptive Eligibility Pilot Program

The policy objective of implementing presumptive eligibility through local hospitals and clinics across Kansas is for uninsured children to gain access to ongoing preventive health care services. There are an estimated 40,000 Kansas children who are uninsured and potentially eligible for Kansas Medicaid - Title XIX or the State Children's Health Insurance Program - Title XXI health insurance programs (HealthWave). Presumptive eligibility allows each health care provider who cares for a presumptively eligible child to be reimbursed for medical services provided at the Medicaid reimbursement rate, instead of having to provide uncompensated care. Based on the past six months of pilot activities for the presumptive eligibility program in Kansas, KHPA has learned the following:

- Through November 30, 2006, 651 children had enrolled as presumptively eligible, resulting in about $50,000 in medical services per month in the three pilot sites combined. The primary service costs for those presumptively enrolled are from in-patient hospital services, followed by physician and pharmacy services.
- Through an early quality review process, KHPA estimates that 38% of families whose children are determined presumptively eligible successfully complete the formal eligibility process and enroll their child in ongoing coverage in HealthWave for their children. This rate of successful enrollment is below that of other states with more mature presumptive eligibility programs.
- The primary reason that children who apply for presumptive eligibility do not go on to full enrollment is the failure to provide information on the HealthWave application in order to complete a formal eligibility determination.
- KHPA has identified some problems with the pilot sites completing the determination tools accurately, and is actively working to correct these problems and revise the tools and our training process as necessary. Expanded use of an electronic eligibility tool is viewed as a key to improvement, and the enrollment process would be streamlined through the use of a proposed web-based tool.
- The earliest results from the presumptive eligibility pilot sites indicate the need for additional training, monitoring, and program improvement before the program is expanded. As KHPA determines the need for additional outreach, and as program performance and staff levels allow, new sites will be recruited and prepared for implementation of presumptive eligibility.

Background

There are an estimated 40,000 Kansas children who are uninsured and potentially eligible for Kansas Medicaid - Title XIX or the State Children's Health Insurance Program - Title XXI health insurance programs. Together, these programs are referred to as HealthWave. The policy objective of implementing presumptive eligibility through local hospitals and clinics across Kansas is for uninsured children to gain subsequent access to ongoing preventive health care services. Additionally, presumptive eligibility allows each health care provider who cares for a presumptively eligible child to be reimbursed for medical services provided at the Medicaid reimbursement rate, instead of having to provide uncompensated care. The goal of presumptive eligibility is to enroll children who are eligible for Title XIX or XXI, but who have not applied and, therefore, are uninsured, and to ensure proper payment to providers for services rendered.

Presumptive Eligibility Pilot

Test sites. In order to prepare for statewide implementation of the program, a pilot presumptive eligibility process was initiated in three selected sites. A State Plan Amendment (SPA) was submitted to, and approved by, the Centers for Medicare and Medicaid Services (CMS) to allow Kansas to perform presumptive eligibility determinations. The state is required to select and provide training to designated entities that are authorized to determine presumptive eligibility. The KHPA chose two counties in which to test presumptive eligibility. The two locations chosen were Children's Mercy Hospital in Kansas City and Via Christi Medical Center in Wichita. Working in cooperation with Via Christi Medical Center, Grace Medical Evergreen Clinic is participating as a health clinic pilot site.

Training and eligibility tools. On site training was provided to staff from each facility about the program. KHPA staff specifically developed both electronic and paper eligibility tools that can be used by designated entities to determine presumptive eligibility. The electronic eligibility tool automatically calculates portions of the application, helping the staff correctly determine the child's eligibility, and can be sent electronically to an e-mail address at the Kansas Family Medical Clearinghouse. The paper application is manually completed and then may be faxed to the Clearinghouse. KHPA has discovered that pilot sites are only using the paper application tool; as a result, there have been some problems with accuracy in determining presumptive eligibility. In order to make the electronic tool widely available, we have determined that the tool should be converted into a web-based application. As a web-based tool, information on the application could be sent directly to the eligibility system at the Kansas Family Medical Clearinghouse, improving accuracy rates. A policy option to expand eligibility and health and wellness outreach efforts for Medicaid was approved by the KHPA Board and forwarded to the Governor for review for FY 2008. The option includes $350,000 to design an on-line application and screening tool for potential beneficiaries. In the meantime, KHPA will continue to work with pilot sites to increase accuracy using existing tools.

Number and costs of children served. Staff at the designated pilot sites were trained in June and July of 2006. The first child was presumptively enrolled in Kansas on July 3, 2006. The following data were collected from July through November 2006:

- 651 children have successfully applied for health insurance coverage through PE
- 531 (82%) were determined presumptively eligible for Medicaid - Title XIX coverage
- 120 (18%) were determined presumptively eligible for State Children's Health Insurance Program (SCHIP) - Title XXI coverage

- In total, of the 651 children who successfully applied for presumptive eligibility, 163 children (38%) were successfully determined eligible for ongoing health insurance coverage in the HealthWave program.

The designated entities send the presumptive eligibility applications of children who are approved to the Clearinghouse. They do not send presumptive eligibility applications that are denied. The numbers reflected above are children who have successfully entered presumptive eligibility, and do not include every child or family that completed an application.

Quality Review. A thorough quality review of 100% of PE applications submitted from June through August was conducted. Based on the quality review, KHPA found that in these first months of the program, 62% of families with presumptively enrolled children are not completing the HealthWave application process. The number one reason PE cases are closed without continued coverage is failure to obtain the necessary information required to complete the formal HealthWave application. Further study is necessary to ascertain what barriers prevent families from supplying application information. KHPA provided additional training to the pilot facilities in December 2006 to address the high percentage of the very first group of presumptive eligibility families that failed to follow through with the formal application process after a presumptive determination. The majority of designated entities are using the paper determination tool, rather than the electronic determination tool. While the primary focus will be on methods to increase follow up to obtain missing application information, KHPA staff will also discuss emphasis on using the electronic determination tool to increase the accuracy of determinations.

Pilot Program Expenditures. The average monthly cost to provide health care coverage to children during their period of presumptive eligibility from July 1 through November 30, 2006 is as follows:

- Medicaid - Title XIX $41,471 (All Funds)
- SCHIP - Title XXI $9,166
- Average cost per child per month $ 323

Just fewer than 50% of all PE expenditures are related to a small number of high cost claims; specifically inpatient hospital claims, large pharmacy claims, and physician fees. This is because children who enter the program through hospitals are sometimes quite ill and in need of intensive acute care services. KHPA reviewed the inpatient services Diagnosis Related Groups (DRGs) for children who received those services while presumptively eligible from July through October. The review shows the top 4 DRGs for which children were treated and the total accumulated costs associated with each DRG through October:

- Chemotherapy $35,062
- Major cardiovascular procedures $26,741
- Hip and Femur procedures $19,006
- Immune System Disorders $15,504

Absent the PE program, these costs may have resulted in uncompensated care at Via Christi and Children's Mercy Hospitals, or Grace Medical Clinic, especially for children who meet presumptive eligibility guidelines for the SCHIP (Title XXI) program. For presumptively enrolled children who meet the Medicaid (Title XIX) guidelines, claims may be filed and reimbursement given for services provided up to three months prior to a child's application for full Medicaid eligibility – if they follow through with the enrollment process.

For FY 2007, it is estimated that 950 children will be enrolled as a result of presumptive eligibility. The estimated cost for these children in FY 2007 is expected to be between $650,000 and $1,300,000 All Funds. For FY 2008, as additional counties are added to presumptive eligibility, it is estimated that 1,200 children will be enrolled as a result of presumptive eligibility. The estimated cost for these children in FY 2008 is expected to be between $1,000,000 and $2,000,000 All Funds.

Implementing an ongoing presumptive eligibility program

Provider enrollment. Although this process is not yet completed for the pilot sites, a Memorandum of Understanding (MOU) with KHPA will, as a normal course of business, be signed by each designated entity prior to participation in the program. The MOU will outline KHPA's expectations of the participating designated entity, and what the designated entity can expect from KHPA. KHPA staff provide training to the staff at the facilities chosen as designated entities. KHPA staff at the Clearinghouse monitor enrollment outcomes of each entity. On-going technical support and training are also provided to designated entities based on observed outcomes. KHPA has developed training materials that were tested on the designated entities participating in the pilot program. The program's policies, procedures, and communications processes may also be revised on the basis of information gleaned from the pilot.

The presumptive process. Trained staff members at each designated entity complete a brief eligibility determination to ascertain if a child is likely to qualify for medical services in the Title XIX or XXI programs. When approved, the determination is forwarded to the Kansas Family Medical Clearinghouse, and the child is eligible for services until the regular HealthWave application is processed. Staff at the pilot sites simultaneously assist the family in completing the HealthWave medical services application. The HealthWave application must be received no later than the last day of the month following the PE determination. When the child is determined eligible for HealthWave through Title XIX Medicaid or Title XXI SCHIP, presumptive eligibility ends. The child is then enrolled in the appropriate HealthWave program, and remains insured for the next twelve months. If the child fails to meet eligibility requirements for Title XIX or Title XXI, their presumptive eligibility ends. Providers are reimbursed for services rendered during the child's period of presumptive eligibility whether or not the child is ultimately enrolled in Medicaid or SCHIP. Children may only be designated presumptively eligible once each twelve month period. However, families may apply for HealthWave coverage at any time. Because family circumstances frequently change, the child that was not eligible one month could qualify for eligibility in a following month.

Evaluation of the pilot program. After additional training is provided to the designated entities in December, KHPA staff will conduct a survey of each designated entity. The survey is designed to determine:

- Why designated entities use the paper determination tool rather than the electronic determination tool
- The amount of time required to complete the PE process by staff at each designated entity
- Steps to improve the PE process prior to statewide implementation
- Additional training needs identified by designated entity staff
- Further identification of the barriers that prevent families from completing the formal determination process
- The benefits that designated entities have identified due to the PE program.

In addition to the survey, KHPA will continue to analyze administrative data to monitor the number of children

who are determined presumptively eligible and the number of families who successfully complete the enrollment process. This will help KHPA better predict future utilization and inform the caseload estimating process. KHPA will monitor which program, either Medicaid - Title XIX or SCHIP – Title XXI, children are assigned to. Claims data will be analyzed to monitor the costs of medical services incurred by children during their period of presumptive eligibility. Analysis of this data will help target gaps in the process and identify any barriers families may experience in accessing services for which their children are eligible.

Possible expansion to new sites. The earliest results from the presumptive eligibility pilot sites indicate the need for additional training, monitoring, and program improvement before the program is expanded. Expanded implementation will occur if program outcomes increase, and if the capacity for KHPA staff to support this outreach tool is sufficient. The KHPA will work in cooperation with the Kansas Association for the Medically Underserved (KAMU) and the Kansas Hospital Association (KHA) to determine a timeline for training and implementation. As KHPA determines the need for additional outreach, and as program performance and staff levels allow, new sites will be recruited and prepared for implementation of presumptive eligibility. KHPA has identified an initial list of up to 33 Medicaid providers, consisting of major acute care centers and health care clinics that could serve as designated entities (see attached chart).

Conclusion

The presumptive eligibility pilot provided increased access to health services for several hundred children during its first few months in operation, enabling participating providers to recoup tens of thousands of dollars in otherwise un-reimbursable costs. This level of participation is suggestive of the potential for the program to have a significant impact as an outreach and enrollment tool for the HealthWave program. However, the earliest experiences from the three pilot sites indicate the need for program improvement, ongoing monitoring and training at the pilot sites, and a measured approach to expansion. KHPA will continue to look for ways to increase the percentage of presumptively eligible children who successfully enroll for full-fledged eligibility. KHPA will plan to expand to additional sites only as these outcomes improve, capacity for KHPA staff support allows, and specific outreach needs are identified.

Kansas Health
olicy Authority

Presumptive Eligibility for Children

1-7

Participating Pilot Entity

Medicaid Enrolled Hospital

Safety Net Health Clinic

CHEYENNE RAWLINS DECATUR NORTON PHILLIPS SMITH JEWELL REPUBLIC WASHINGTON MARSHALL NEMAHA BROWN DONIPHAN

SHERMAN THOMAS SHERIDAN GRAHAM ROOKS OSBORNE MITCHELL CLOUD CLAY RILEY POTTAWATOMIE JACKSON ATCHISON LEAVENWORTH JEFFERSON WYANDOTTE

WALLACE LOGAN GOVE TREGO ELLIS RUSSELL LINCOLN OTTAWA GEARY WABAUNSEE SHAWNEE DOUGLAS JOHNSON

GREELEY WICHITA SCOTT LANE NESS RUSH BARTON ELLSWORTH SALINE DICKINSON MORRIS OSAGE FRANKLIN MIAMI

HAMILTON KEARNY FINNEY HODGEMAN PAWNEE RICE MCPHERSON MARION CHASE LYON COFFEY ANDERSON LINN

STANTON GRANT HASKELL GRAY FORD EDWARDS STAFFORD RENO HARVEY GREENWOOD WOODSON ALLEN BOURBON

KIOWA PRATT KINGMAN SEDGWICK BUTLER ELK WILSON NEOSHO CRAWFORD

MORTON STEVENS SEWARD MEADE CLARK COMANCHE BARBER HARPER SUMNER COWLEY CHATAUQUA MONTGOMERY LABETTE CHEROKEE

MARCIA J.NIELSEN, PhD, MPH
Executive Director

ANDREW ALLISON, PhD
Deputy Director

Report on:
Potential Impact of a Medicaid Photo Identification Requirement

presented to:
2007 Kansas Legislature

January 1, 2007

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Study on the Potential Impact of a Medicaid Photo Identification Requirement

The 2006 Kansas Legislature directed the Kansas Health Policy Authority (KHPA) to study the impact of requiring Medicaid beneficiaries to present photo-identification (i.e. a current Kansas driver's license, a state-issued identification card, or a federally-issued passport) each time Medicaid services are received. The proviso specified the following issues be studied:

> ". . . (2) the development of rules and regulations to address the need for third parties to access services for consumers under the state Medicaid plan, (3) the development of hardship criteria and a process for paying for a driver's license or state-issued identification card for hardship-qualifying Medicaid consumers with state funds that are matched at the highest allowable federal rate, and (4) the feasibility of implementing a plastic card with photo identification to access benefits under the state Medicaid plan. . ."

Executive Summary
To examine and research the potential impact of a photo identification (ID) requirement, KHPA commissioned a statewide feasibility survey, conducted a national survey of Medicaid programs, evaluated photo IDs in light of historical experiences with similar requirements, and enumerated a variety of other potential implications.

Based on this review of beneficiary, provider, and operational concerns, we conclude that requiring Medicaid beneficiaries to show a photo ID before receiving services would pose a significant barrier to the appropriate use of medically necessary care. For this reason, the Board would not support such a policy without significant modification.

A photo ID requirement could have a particularly severe impact on the provision of care to certain populations, including:

- applicants who currently lack a picture ID and would be unable to transport their family to a Medicaid picture ID station;
- individuals in need of emergency services;
- children who lack an existing (approved) photo ID;
- individuals with certain disabilities; and
- those residing in institutional settings.

The requirement could also lead to an increase in missed appointments as beneficiaries present without photo ID, adding costs to both providers and beneficiaries.

To avoid such harmful impacts, a workable photo ID requirement would need to address each special population and circumstance, possibly through targeted exemptions, hardship criteria, or alternative requirements.

Statewide Survey

To examine the implementation issues associated with requiring Medicaid consumers to present state approved photo identification before receiving Medicaid services, KHPA contracted with the Docking Institute at Fort Hays State University (FHSU) to conduct a survey assessing the feasibility of such a requirement. The survey was designed to assess the potential impact of this requirement on Medicaid beneficiaries and to gain input and perceptions about the requirement from Medicaid providers. Areas studied were:

- What percentage of Medicaid beneficiaries do not currently have state-approved photo identification (i.e., driver's license, state ID, or federal passport)?
- What are the financial costs of acquiring state-approved photo identification?
- What steps would a Medicaid beneficiary without approved photo identification need to take to obtain one?
- What do Medicaid beneficiaries perceive as barriers to obtaining approved identification (e.g., financial costs and transportation to obtain the ID)?
- What are the perceptions and opinions of medical service providers, specifically office managers, regarding a photo ID requirement to receive services among medically eligible individuals?
- What are the perceptions and opinions of SRS Medicaid Liaisons regarding a photo ID requirement?

The overall results of the FHSU study are summarized below:

Survey of Medicaid Beneficiaries

- Only about a third (38%) of Medicaid beneficiaries responding to the survey who would need to obtain an ID "strongly agree" with the statement that "requiring Medicaid beneficiaries to show a photo ID is a good idea." More than 20% do "not agree" with the statement.
- Only about two-thirds (64%) of the Medicaid beneficiaries surveyed expressed a willingness to purchase one of the three state-approved forms of identification.
- Slightly more than 85% of the beneficiaries needing a new ID "strongly agree," "mostly agree," or "somewhat agree" with a statement suggesting that they would experience financial hardship if required to purchase a photo ID.
    - An average of 1.8 IDs would need to be purchased per household.
    - A Kansas Driver's License and State ID cost between $16 and $22. A passport costs between $82 and $97.
    - Medicaid beneficiaries estimate that they can spend between $5 and $8 for one ID.
- Three-quarters (76%) of respondents "strongly agree," "mostly agree," or "somewhat agree" that they would need financial assistance to purchase an ID.
- Respondents in households needing more new photo IDs are more likely (than those in households needing fewer new photo IDs) to anticipate financial hardship, the need for financial assistance, and problems with childcare when traveling to purchase an ID.
- Respondents in households needing more new photo IDs are less likely to express the opinion that a new photo ID requirement is a "good idea."
- Respondents in poorer households are more likely to anticipate financial hardship, the need for financial assistance, and transportation problems when traveling to get a new photo ID.
- Older respondents are more likely to express difficulty with transportation when attempting to obtain a new photo ID, while younger respondents express concerns about childcare issues.

Survey of Physician Office Managers

- The physicians' offices surveyed estimate that about 22% of their patients are Medicaid beneficiaries.
- Less than 14% of the office managers perceive even a "moderate amount" of Medicaid card "borrowing" among their patients.
- When asked if the proposed photo ID requirement would reduce the incidence of Medicaid card borrowing, 23% suggest that it would "greatly reduce" borrowing, and 48% suggest that it would "moderately reduce" borrowing.
- Office managers were evenly divided in their assessment of the impact of a Photo ID requirement on operations. About a quarter (23%) of the office managers surveyed anticipate a new photo ID requirement as having a negative influence on daily office operations, half (50%) anticipate that an ID requirement would have no influence on operations, while another quarter (27%) perceived a positive influence on operations.
- About half (52%) of the office managers "strongly agree" with the statement that "requiring Medicaid beneficiaries to show a photo ID at office visits is a good idea." About one in ten (11%) disagree with the statement.
- More than two-fifths (44%) of the office managers interviewed suggest that Medicaid beneficiaries should receive some sort of financial help with purchasing a new ID.

Survey of Supervisors and Case Managers

A handful of SRS supervisors or case managers were surveyed. Their perceptions were that:

- The typical Medicaid beneficiary will experience financial hardship if required to purchase a new photo ID.
- The typical Medicaid beneficiary will have difficulty traveling to obtain a new photo ID because of transportation problems and/or childcare issues.

National Survey

In addition to the FHSU statewide survey, KHPA conducted a national survey to determine if other states require Medicaid beneficiaries to present authenticating identification (e.g., a current resident driver's license, a state-issued identification card, a federally-issued passport, etc.) at the time medical services are received. Survey questions included:

- Does your state require, or plan to require, Medicaid beneficiaries authenticate who they are at the time they receive services by presenting some form of self-identification?
- If yes, what form of identification does your state require, or plan to require?
- Did your Medicaid agency conduct, or does it plan to conduct, any studies on the potential impact?
- If yes, did the study include research regarding the feasibility of implementing a plastic card with photo ID to access benefits under the state plan?
- If yes, did the study conclude this arrangement would be feasible?
- Is there a summary of the overall results of the study that KHPA might access through the internet?
- If implementing (or planning to implement) an identification requirement, has your state developed rules and regulations addressing the need for third parties to access services for consumers under the state plan (e.g., as might happen with a person who has severe cognitive disabilities)?
- If yes, could your state send a copy of the rules and regulations that were developed to KHPA?

Sixteen states responded to the survey. Fifteen of the sixteen states do not require photo identification. Results are listed below.

State	Photo ID Required at Time of Service
Alaska	No
Connecticut	No
Idaho	No
Illinois	No
Iowa	No
Louisiana	No
Mississippi	Yes (alternatives accepted)
Missouri	No
Nebraska	No
Nevada	No
New York	No (some IDs have a photo)
South Carolina	No
Utah	No
Virginia	No
Wisconsin	No
Wyoming	No

Summary of Mississippi's Photo Identification Requirements

Information included on Mississippi's Medicaid identification card includes:

- The 12 digit number consisting of the beneficiary's ID number and a three digit card control suffix;
- beneficiary name;
- card issue date; and an
- encoded magnetic strip.

Photo identification, or other authenticating documentation, is not included on the card but must be presented in separate form. The provider is responsible for confirming that the person presenting the card is the person whom the card is issued to by:

- requesting a picture ID (e.g., a driver's license, school ID card, etc.); or
- verifying the Social Security number; and/or
- date of birth

While the preference is for providers to verify the identity of the person presenting for service with a picture ID when possible, some flexibility is provided as noted above. Mississippi did not conduct any studies to determine impact or feasibility. Rules and regulations regarding the need for third party access to services for consumers were not developed. We do not know how often or in what proportion providers accept alternative identification lacking a photograph, the relative impact of the requirement on adults and children, nor the overall impact on access to care.

Summary of New York's Photo Identification Card
New York does not require a photo ID in addition to the beneficiary's Medicaid card, although for many adults, the Medicaid card contains a photo. There are numerous exceptions, however, to the inclusion of the photo ID on the Medicaid card.

Beneficiaries whose card does not include a photo ID are:

- Persons residing in health care facilities
- Persons residing in developmental centers operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD)
- Persons residing in psychiatric centers operated by the Office of Mental Health (OMH)
- Persons residing in residential treatment facilities certified by the OMH
- All Social Security Income (SSI) recipients
- All children under 21 living with a responsible relative, as well as foster care children
- At local option, districts may require photo identification of persons between the ages of 18 and 21, who are not living with a responsible relative
- All persons applying at sites other than local social services offices until next client contact or recertification
- Homebound persons including those receiving personal care, home health care, or long term care
- Persons residing in living arrangements operated by OMH, or residing in living arrangements certified or operated by the OMRDD
- Persons enrolled in the OMRDD Home and Community Based Services Waiver (HCBS)

As indicated by this list, the inclusion of a photo on the Medicaid card is inconsistent across beneficiaries in New York. Supporting documentation in addition to or instead of a photo on the Medicaid card (e.g., current driver's license) is not required by New York rules.

Relationship to DRA Citizenship and Identity Verification
To further investigate effects of the proposed requirement, KHPA reviewed the procedural and enrollment impact on Kansas Medicaid beneficiaries of the new federal citizenship and identity verification requirements, as defined in the Deficit Reduction Act of 2005 (DRA). While the DRA requires documentary proof of citizenship and identity to determine eligibility, the Legislature requested a study of requiring photographic proof of identity at the time services are received. The documentation requirements for each of these processes are very similar. Examples of the common forms of acceptable documentation for proof of citizenship and identity at the time of application include:

Any one of these as a single primary document:

- U.S. Passport
- Certificate of Naturalization
- Certificate of U.S. Citizenship, or

Any two of these secondary documents in combination:

- U.S. Birth Certificate
- Certification of Birth Abroad
- U.S. Citizen Identification Card

- Consular Report of Birth
- Final adoption decree, plus
- Driver's license or state ID card
- School ID card with photo
- U.S. Military Card
- Native American Tribal document[1]

The requirements for obtaining a valid Kansas driver's license or state identification card are very similar (e.g., certified birth certificate, U.S. passport, U.S. military I.D., DD 214, Bureaus of Indian Affairs Tribal Identification Card, certified order of adoption, certificate of naturalization with intact photo, photo DL issued by a U.S. state, photo ID issued by a U.S. state).

Since implementation of the citizenship verification requirements went into effect on July 1, 2006, KHPA has documented significant impact on Kansas applicants and beneficiaries as well as on enrollment operations at the Kansas Family Medical Clearinghouse.[2] These impacts, including a drop in caseload of approximately 18,000-20,000 and a potential increase in administrative costs of more than $1 million, illustrate how additional administrative requirements can pose enrollment barriers to eligible Kansans. While the nature of the DRA documentation requirements at the time of application, and a photo ID requirement at the time of service, are different, it is important to note the potential for administrative requirements to impact access to care. In particular, the administrative process of creating Medicaid picture IDs would fundamentally alter the existing mail-in application process. Approximately 85% of applications from families and children are processed at the Family Medical Clearinghouse in Topeka. Adding a photograph to this process would have significant cost implications for the state and would make it more difficult to enroll in the program, e.g., with the added burden of driving to a central location (such as a local SRS office) to get an official Medicaid picture.

KHPA's experience with the identity verification requirement shows that beneficiaries struggle with producing identification documents for an annual enrollment process. There are significant costs to acquiring the documents, and accessing the original documents for enrollment purposes has prevented several thousand people from becoming eligible. Imposing a requirement to show identification at each appointment would have similar discouraging impacts on beneficiaries' access to routine care or emergency care.

Potential Impact to People with Disabilities

The citizenship requirement in the DRA included "all U.S. citizens and nationals applying for or renewing their Medicaid coverage to provide documentation of their citizenship status." [3] As a result of this requirement, Community Supports and Services (CSS), a unit within the Health Care Policy Division of Social Rehabilitation Services (SRS), began planning how to support people with disabilities in obtaining the necessary documentation. Although subsequent legislation and Federal regulation has since been issued exempting Medicare beneficiaries and most individuals receiving Supplemental Security Income (SSI) and Disability Income (SSDI) from the citizenship documentation requirements, issues with relevance to a potential photo ID requirement that were initially taken into consideration by CSS in reviewing the citizenship requirements included the following:

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1 Families USA. "Citizenship Update: Administration Creates Additional Barriers to Medicaid Enrollment." June 2006. http://www.familiesusa.org/assets/pdfs/DRA-Citizenship-Update.pdf.

2 http://www.khpa.ks.gov/PressReleases/Releases/12-1-06Citizenship%20Fact%20Sheet%20_3.pdf

3 Kaiser Commission on Medicaid and the Uninsured. "New Requirements for Citizenship Documentation in Medicaid." July 2006. www.KFF.ORG/KCMU.

- Individuals enrolled in Medicaid are less likely than the general population to have access to a passport or birth certificate.[4]
- Based on ongoing experience, many of the people served by CSS do not have driver's licenses or access to their birth certificates.
- Families or guardians of these beneficiaries are often times not readily available to help (i.e., many live out-of state or are located a significant distance away).
- For some beneficiaries, especially those with cognitive disabilities, staff will need to take responsibility for maintaining and presenting the photo ID to the provider. Given the already hectic schedule many staff members are required to maintain, remembering to bring the photo ID to each appointment may be difficult. If the requirement were implemented, forgetting the ID could result in denial of services.
- Elderly beneficiaries may have been born outside of hospitals making the documentation requirements even more difficult to achieve.
- For children, decisions about how often the ID would need to be updated to account for rapid changes in appearance, and how to assist parents in obtaining the IDs, would need to be made.
- Similarly, decisions regarding how to pay for the costs of the IDs, staff research time to locate the needed documentation to obtain the IDs, and transportation costs to the designated entities where the IDs can be obtained would need to be made.

Rules and Regulations regarding Third Parties to Access Services

Many Medicaid beneficiaries, especially individuals with cognitive disabilities, children, and the elderly, are dependent upon third parties to assist in the enrollment process and to access services. Any requirement to provide photo ID or documentation at the point of service would need to accommodate these groups of people and others with special needs, which may potentially lead to a series of exempted populations or services. Related questions include:

- Within the context of institutional settings (e.g., ICFMRs, state institutions, etc.) does the proposed requirement mean that presentation of the photo ID would be necessary each time institutional staff provide services?
- Would IDs be required for each Medicaid service provided to a child in a school setting?
- Would foster-care children be required to obtain and show photo ID?
- Are there special concerns for the provision and delivery of the Durable Medical Equipment Program (e.g., oxygen deliveries, etc.)?
- How will this requirement affect the provision of services for recipients in private insurance plans, i.e., managed care organizations?
- How would the requirement apply to self-directed care within Home and Community Based Services (HCBS)?

Development of Hardship Criteria

While some populations might have a difficult time presenting a photo ID at the time of service, some populations would (also) have an especially difficult time obtaining a photo ID. The state could develop hardship criteria to exempt these populations from the requirement, or could make an effort to ease the costs and difficulties. The need to do this would depend in part on the method used to pay for beneficiary acquisition of the state-approved photo identification. To address these costs, the state could pay the costs of the ID (whether

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4 Families USA. "Citizenship Update: Administration Creates Additional Barriers to Medicaid Enrollment." June 2006. http://www.familiesusa.org/assets/pdfs/DRA-Citizenship-Update.pdf.

it be a Medicaid ID or an alternative), and could also pay for associated costs of obtaining the ID, such as the transportation costs to the nearest photo ID station. It is possible that a 50/50 Medicaid administrative match could be used.

Conformity with Emerging Standard for Health Plan ID Cards

In addition to feasibility and overall beneficiary impact, consideration should also be given to the standards for advanced technology health plan ID cards being developed by the Governor's Health Care Cost Containment Commission (H4C). The H4C was established in 2004 as part of the Healthy Kansas initiative and was charged with improving quality of health care and increasing the acceptance of health care information technology in the state of Kansas. In order to identify regional administrative issues and best practices, the Commission conducted community forums throughout the state and worked with key stakeholders, in both public and private sectors, to achieve their goals of improving quality of care and reducing the cost of health care. [5]

In April, 2006, the H4C initiated an advanced technology ID card project to explore eligibility and claims payment problems at the point of service and to identify best practice guidelines for health plan patient/member identification cards. Recently, the H4C endorsed the Mid-America Coalition on Health Care (MACHC) best practice guidelines for health plan patient/member identification cards. Below is a partial list of data elements the MACHC considers essential or optional to include on the identification card.

- Patient Name
- Patient Identification Number
- Health Plan or Payor Name and Logo
- Health Plan or Payor Phone Number
- Product or Plan Type
- Primary Care Physician (PCP) Name
- PCP Phone Number (optional)
- Employer Group Name or ID Number
- Provider Network Name or Logo
- Effective or Issue Date

A photograph is not included in the essential or optional data elements identified by MACHC.

The best practice standards established by the MACHC are aligned with the guidelines developed by the Workgroup for Electronic Data Interchange (WEDI). WEDI is an organization dedicated to identifying "best practices" for implementation of health care standards. In December, 2005, WEDI developed draft implementation guidelines specific to the American National Standard, *Identification Cards-Health Care Identification Cards.*[6] The standard is an application of international card standards to health care applications in the United States.[7] The stated purpose of the guideline is "to standardize present practice, to bring uniformity to information, appearance, and technology of over 100 million cards now issued by health care providers, health plan or payers, government programs, and others." [8] WEDI reports that the "potential benefits (of the standardization of health identification cards) to the health care – to patients, health care providers, and health

5 Office of the Governor. "Sebelius Administration Takes More Steps for Affordable Health Care." 15 Dec. 2004. http://www.ksgovernor.org.

6 Workgroup for Electronic Data Interchange. "Health Identification Card Implementation Guide." 2 Dec. 2005.

7 Ibid.

8 Workgroup for Electronic Data Interchange. "Health Identification Card Implementation Guide." 2 Dec. 2005.

plans or payers - are very significant, especially from uniformity, efficiency, automation, and error reduction."[9] It is worthwhile to note that the implementation guide "permits, but does not require, inclusion of a portrait" on the identification card.[10]

The H4C has invested in the development of a uniform health plan ID card and may move ahead with guidelines that do not include photographs on the card. The H4C expects to complete its recommendations by the end of December 2007.

The Legislature may want to examine the H4C's progress in advancing uniform statewide ID card standards before moving ahead with a separate plan for Medicaid cards. Questions include:

- Does the state want to establish one ID card for Medicaid populations and a separate and distinguishable card for private pay populations?
- What are the specific concerns that entail a photo ID requirement for populations insured through Medicaid that private plans – using current market practice and the H4C's recommendations as a guide – have determined are unnecessary or unwanted?

Summary of Potential Implications

This review has identified a number of concerns related to requiring photo identification for Medicaid beneficiaries at the point of service. Factors that need to be taken into consideration in the decision to require a photo ID include:

- The potential financial costs to beneficiaries, providers and the state due to the introduction of a photo ID requirement.
- The attitude of compliance, modest support, and serious questions reflected in the results of the FHSU survey of beneficiaries and providers.
- The lessons learned from the addition of citizenship and identity verification requirements to the Medicaid enrollment process, including a negative impact on access to care.
- Questions about the application of newly-developed national and state standards for health plan cards (that do not include a photograph) and the unclear rationale for – and implications of – treating Medicaid beneficiaries differently.
- The differential impact a photo ID requirement would have on certain populations, primarily children, people with disabilities, and the elderly, and the potential for accentuating disparities in treatment and care.

KHPA Board Recommendation

Medicaid beneficiaries are currently experiencing delays in receiving health care services due to the implementation of new Federally-mandated citizenship and identity verification requirements as specified in the Deficit Reduction Act. The proposed photo ID requirement would likely have a similar impact and could compound the situation for many beneficiaries. A uniform photo ID requirement would also impact a much wider group of Medicaid beneficiaries, including the disabled, elderly, and institutionalized populations. It is the consensus of the KHPA Board, gained during the December 12, 2006 Board meeting, that the impact of this proposed photo ID requirement would cause potential harm to individuals needing health care services, and that they would not support such a proposal without significant modification to address these concerns.

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9 Ibid.

10 Workgroup for Electronic Data Interchange. "Health Identification Card Implementation Guide." 2 Dec. 2005.

Kansas Health Policy Authority

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Report on:
Prescription Drug Generic Rebate and Dispensing Cost Study

presented to:
Joint Committee on Health Policy Oversight

November 30, 2006

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Prescription Drug Generic Rebate and Dispensing Cost Study

Executive Summary: Generic Rebate and Dispensing Cost Studies

Increasing the State's purchasing power was a key factor in creating the Kansas Health Policy Authority by combining health care purchasing under its purview. This includes pharmaceutical purchasing in the Medicaid program. After reviewing rebates for Kansas Medicaid, analyzing available dispensing cost surveys, and a thoughtful review of current pharmacy reimbursement practices both nationally and locally, the agency recommends no changes to the current system at this time. However, the KHPA recommends the following for the Kansas Medicaid program:

- Monitor rebate levels for brand-name and generic drugs to ensure compliance with Federal law.
- Monitor the impact of Part D on supplemental rebates.
- Track savings and rebates on recently available high volume/high cost generic medications and study the potential of supplemental rebates on those drugs.
- Determine impact of Federal pricing changes on Medicaid reimbursement.
- Determine impact of national changes to published prescription drug pricing, including but not limited to AWP and AMP.
- Monitor impact of Medication Therapy Management Services (MTMS) programs on quality of care in both Medicare and Medicaid programs for potential changes to Kansas Medicaid.
- Pilot MTMS in Kansas Medicaid, funded by Centers for Medicare & Medicaid Services (CMS) transformation grant. If not funded by CMS transformation grant, consider funding through Kansas Medicaid with federal matching funds.
- Bring together pharmacy stakeholders to gather information and evaluate the impact of pharmacy pricing changes on reimbursement methodologies and access, especially in rural counties.
- Study the impact of e-prescribing on dispensing costs and quality of care and the feasibility of implementing e-prescribing in Kansas Medicaid.
- Pilot e-prescribing in Kansas Medicaid, funded by CMS transformation grant. If not funded by CMS transformation grant, investigate integrating into the MMIS and obtaining 90 percent federal match rate to develop.

Introduction:

The Kansas Health Policy Authority (KHPA) is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. By statute, health insurance purchasing by the State is now combined under the Authority, including publicly funded programs such as Medicaid, State Children's Health Insurance Program, MediKan, and the State Employee Health Benefits Plan (SEHBP).

Purchasing power is critical to the vitality of the agency and its overall mission of improving quality and accessibility of health care to Kansans. By consolidating health purchasing under the Authority's purview, the purchasing power of the State and KHPA can be maximized and benefit Kansans.

As outlined in proviso, the 2006 Kansas Legislature requested the agency to study generic drug rebates and the cost of dispensing medication. Specifically, the proviso requested the KHPA:

"...study rebates for the state pharmaceutical purchasing plan, including the possibility of increasing rebates for generic products, in light of the consolidation of state purchasing under the Kansas health policy authority: *Provided*, That the Kansas health policy authority shall conduct a survey of Kansas retail community pharmacies or utilize a recently conducted national survey of a statistically relevant sample of pharmacies, to determine the cost of dispensing pharmaceutical products and services within the Kansas medicaid program: *Provided further*, That such study shall be conducted on or before September 30, 2006: *And provided further*, That the Kansas health policy authority shall present the cost of dispensing survey, analysis and recommendations of the Kansas health policy authority to the joint committee on health policy oversight on or before November 30, 2006."

For the past several months, the Kansas Health Policy Authority has examined its current pharmaceutical purchasing plan for Kansas, prescription drug reimbursement issues at the national level, and the direction for the future. Although the KHPA recommends the Medicaid prescription drug purchasing plan to remain unchanged for now, it is important that we continue to closely monitor rebate levels for both brand name and generic prescriptions; monitor the impact of Medicare Part D on rebates and pharmacy reimbursement; track savings and rebates on high volume/high cost generic medications; and evaluate the impact of e-prescribing and MTMS on quality care and expenditures. These recommendations are based on an analysis of Kansas Medicaid pharmacy rebates; regional and national dispensing cost surveys; current pharmacy reimbursement practices; and Kansas Medicaid and HealthConnect current pharmacy reimbursement methodology.

Pharmacy Rebate Study

State Medicaid programs are required by Federal law to cover medications that are rebated by the pharmaceutical manufacturer, with the exception of a few drug categories (for example, OTCs, weight-loss drugs, cosmetic drugs, benzodiazepines). Rebates differ for brand-name and generic drugs. Manufacturers of brand-name drugs are required to provide a minimum rebate of 15.1 percent of average manufacturer's price (AMP). Generic manufacturers are required to provide a rebate of 11 percent rebate of AMP.

Kansas Medicaid spent $251,543,689 in fiscal year 2006 on prescription drugs. During that time period, the program recouped over $74 million in rebates. The following table illustrates the amount of volume and expenditures that brand-name and generic medications account for.

Kansas Medicaid Fiscal Year 2006 Pharmacy Expenditures

	Volume	Expenditures	Avg Cost/Rx	Rebates	Avg Rx Cost Net Rebate
Brand-Name	1,766,326	$206,722,264	$117.04	$73,069,420	$75.67
Generic	2,605,675	$44,821,425	$17.20	$1,325,052	$16.69
TOTAL	4,372,001	$251,543,689	$57.54	$74,394,472	$40.52

An analysis of rebates showed that Kansas is recouping, on average, 29.5 percent of total expenditures in prescription rebates. A more detailed study of generic rebates showed that Kansas Medicaid is recouping 3 percent of average prescription cost on generic pharmaceutical, and more than 35 percent of average cost on

brand-name pharmaceuticals, but the cost difference between brand-name and generics is almost ten-fold.

In addition to the rebate amount required by Federal law, Kansas Medicaid obtains supplemental rebates from manufacturers for inclusion on the preferred drug list (PDL) as long as the drugs in that category have been determined to be clinically equivalent by the PDL panel of physicians and pharmacists. To date, Kansas Medicaid obtained a very small amount of supplemental rebates from generic manufacturers. Generics with multiple manufacturers generally cost much less than their brand-name counterparts, as seen in the previous table ($117.04 brand-name vs. $17.20 generics). Typically, generic drug companies have a much smaller profit margin than brand name drug manufacturers. However, in the past year, a number of "blockbuster" drugs with very high utilization have become available generically, including Zocor and Zoloft. It may be useful for the KHPA to investigate the potential of obtaining supplemental rebates on these drugs. This should be undertaken cautiously, and the impact on market competition should be evaluated.

The Medicare Part D program has resulted in a drop of approximately 40 percent in prescription volume and expenditures paid for through Medicaid. A corresponding drop in rebates has occurred as well. FY 2007 will be the first full fiscal year without prescription drug expenditures for Medicare-eligible individuals.

Generic Rebate Policy Recommendations

- Monitor rebate levels for brand-name and generic drugs to ensure compliance with Federal law.
- Monitor the impact of Part D on supplemental rebates.
- Track savings and rebates on recently available high volume/high cost generic medications and study the potential of supplemental rebates on those drugs.

Dispensing Cost Study

Reimbursement of prescription drugs consists of two components: 1) average wholesale price (AWP) less a percentage and 2) dispensing fee. It is well known in the industry that AWP is not reflective of actual pharmaceutical costs, thus the practice of reimbursing an amount discounted from AWP. This methodology is unique to pharmacy, is consistent across all payers, both public and private, and has been in place for many decades.

Kansas Medicaid currently reimburses pharmacy providers AWP – 13% for brand-name drugs, and AWP – 27%, the Federal Upper Limit (FUL) or State Maximum Allowable Cost (MAC) for generics, plus a $3.40 dispensing fee per prescription.

In order to determine the cost of dispensing pharmaceutical products and services in the Medicaid program, KHPA staff obtained several recently-conducted state and national dispensing surveys, and conducted an informal polling of local Kansas pharmacies. Those surveys are summarized below.

State-Level Dispensing Cost Surveys

- Oklahoma- the University of Oklahoma College of Pharmacy conducted a survey on behalf of the Oklahoma Health Care Authority using 2002 prescription claims and pharmacy operational cost data. Dispensing costs were calculated using pharmacy overhead and labor costs only. The survey concluded that the average dispensing cost in Oklahoma was $8.01 per prescription.

- Indiana- Myers and Stauffer, a Topeka, Kansas, based firm, conducted a dispensing survey for the Indiana Office of Medicaid Policy and Planning using prescription claims paid between July 1, 2003,

and June 30, 2004, and comparative data from other state Medicaid agencies. Myers and Stauffer evaluated operational, professional services, overhead and profit data relating to the costs of pharmacy operations. The survey concluded that Indiana's statewide average cost of dispensing was $7.95 per prescription.

National Dispensing Cost Surveys

- The Center for Pharmacoeconomic Studies, University of Texas at Austin, conducted a survey of fifty (50) national and regional chain pharmacies to estimate costs of dispensing a prescription. The survey included an evaluation of pharmacy financial and operational data. Calculated dispensing costs ranged from $8.85 to $10.39 per prescription with a mean of $9.61 per prescription. The study conclusion indicates more widespread studies are needed and clarifies that the sampling method for this study was not random, and the estimates of cost to dispense were not exclusive to Medicaid prescriptions.

- The National Community Pharmacists Association (NCPA), using 2005 Pfizer Digest Data, determined dispensing costs range from $7.84 to $9.24. NCPA also estimated dispensing costs by geographic region. The West Central region, which included Kansas, was determined to have a dispensing cost of $9.05.

- The National Association of Chain Drug Stores (NACDS) is currently conducting a dispensing cost survey. Publication is slated for late November / early December 2006.

While this proviso referred only to dispensing fee costs, it is important to consider total prescription drug reimbursement and impending changes at the national level that will impact pharmacy reimbursement by all plans, including Medicaid. There are two major changes related to published pricing that have been imposed to address the long-standing problem of AWP not being representative of actual cost.

The first are changes made at the federal level regarding prescription drug price setting for generics. The second has to do with a drug pricing publisher widely used to set pricing.

The Federal Deficit Reduction Act (DRA) of 2005 changes how federal upper limit (FUL) pricing is calculated for generic drugs. The DRA changes FUL pricing from 150 percent of the lowest published AWP price to 250 percent of Average Manufacturer Price (AMP). This will lower generic reimbursement to pharmacies and will significantly increase the number of generics subject to FUL reimbursement. Beginning July 2006, the DRA also required that CMS provide State Medicaid agencies with the AMP of all rebated pharmaceuticals. States have been instructed by CMS to not use the AMP data to set reimbursement. AMP has historically been reported to CMS by pharmaceutical manufacturers and is not transparent to consumers.

The second major change is in regard to pricing published by a major drug data provider. Recently, First Databank (FDB), one of two major providers of drug information and cost data, was sued for using practices that resulted in inflating AWP. FDB settled the lawsuit in October 2006, and agreed that two years after the settlement, they would no longer publish AWP.

The pharmacy community is concerned that the lower AMP will eventually become the benchmark price payers will use to set their reimbursement rates (as opposed to AWP) and that it too will not be reflective of actual costs.

Another major issue affecting reimbursement is the recent change enabled by the Part D legislation that allows

Medicare prescription drug plans to reimburse clinicians, including pharmacists, for medication therapy management services (MTMS). This is a welcome change to the pharmacy community, who for years has advocated the influence of pharmacists' professional services on improving quality of care for their patients. Many Medicaid programs are beginning to follow suit and reimburse pharmacists for MTMS. Kansas Medicaid recently applied for a CMS transformation grant to pilot a MTMS program.

Lastly, e-prescribing is gaining adoption throughout the country as a means to reduce medication errors, improve quality of care, and reduce administrative inefficiencies in handling prescriptions. The impact of e-prescribing on dispensing costs should be measured before changes to reimbursement are made. Kansas Medicaid applied for two e-prescribing grants through the CMS transformation grant program. CMS has announced that awards will be made in December 2006.

Due to the confluence of events surrounding pharmacy reimbursement at the national level and the impact of e-prescribing and MTMS on quality of care and dispensing costs, it is recommended that the impact of these changes be thoroughly studied and the implications to total pharmacy reimbursement, quality of care, and access to services be considered.

Dispensing Cost Policy Recommendations:

- Determine impact of Federal pricing changes on Medicaid reimbursement.
- Determine impact of national changes to published prescription drug pricing, including but not limited to AWP and AMP.
- Monitor impact of MTMS programs on quality of care in both Medicare and Medicaid programs for potential changes to Kansas Medicaid.
- Pilot MTMS in Kansas Medicaid, funded by CMS transformation grant. If not funded by CMS transformation grant, consider funding through Kansas Medicaid (with federal matching funds).
- Bring together pharmacy stakeholders to gather information and evaluate the impact of pharmacy pricing changes on reimbursement methodologies and access, especially in rural counties.
- Study the impact of e-prescribing on dispensing costs and quality of care and the feasibility of implementing e-prescribing in Kansas Medicaid.
- Pilot e-prescribing in Kansas Medicaid, funded by CMS transformation grant. If not funded by CMS transformation grant, investigate integrating into the MMIS and obtaining 90 percent federal match rate to develop.

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PAM SCOTT
Topeka

January 22, 2007

To: Senate Public Health and Welfare Committee

From: Pam Scott, Executive Director
Kansas Funeral Directors Association

Re: Bill Introduction

Chairman Barnett and members of the Committee, on behalf of the Kansas Funeral Directors and Embalmers Association I would like to request introduction of a bill which would amend Kansas statutes relating to the licensing of assistant funeral directors.

The attached proposed amendments to K.S.A. 65-1717 and 65-1727 would require applicants for an assistant funeral directors license to have graduated from high school or have attained the equivalent thereto. The amendments would also require an applicant to take and pass a written examination, the manner and form to be determined by the Kansas State Board of Mortuary Arts.

Thank you for your consideration. I would be happy to address any questions the committee may have.

Senate Public Health and Welfare Committee
Attachment #2
January 23, 2007

65-1717. Assistant funeral director's license; qualifications; fees; application; registration; suspension or revocation of license; procedure; biennial renewal; rules and regulations.

(a)The term "assistant funeral director" as herein used means a person who assists a duly Kansas licensed funeral director in one or more of the principal functions of funeral directing, and is actively engaged in such work. An assistant funeral director must be an employee of the funeral director under whom the employee is registered, and shall be a person to whom the funeral director delegates the responsibility of conducting funeral services and making interments.

(b)The state board of mortuary arts may, in its discretion, license assistant funeral directors to each Kansas licensed funeral director. Licensure as an assistant funeral director shall be separate and distinct from registration as an apprentice embalmer. The board may issue an assistant funeral director license with ~~or without~~ examination, the manner and form of which to be determined by the Board, upon the payment of the application fee which shall include the license fee for the current year or portion thereof, and such application and license fee shall be in the amount fixed by the board in accordance with the provisions of K.S.A. 65-1727 and amendments thereto. The renewal fee shall be in the amount fixed by the board in accordance with the provisions of K.S.A. 65-1727 and amendments thereto. Before issuing a license to an applicant for an assistant funeral director's license, the board shall require satisfactory proof that the applicant is capable and trustworthy to act as such and that the applicant is a person of good moral character and temperate habits, has a good standing in the community and is qualified to engage in the business. In determining the moral character of any such applicant, the board shall take into consideration any felony conviction of such person, but such conviction shall not automatically operate as a bar to licensure. Each person applying for an assistant funeral director's license shall make application and be recommended in writing on forms provided by the board~~, and shall be~~ . The application shall show that the applicant is at least 17 years of age and has graduated from an accredited high school or has obtained the equivalent of a high school education as determined by the state department of education before such license can be issued to the applicant. Upon issuing a license to an assistant funeral director, as herein provided, the board shall cause the licensee to be registered in the office of the secretary of the board under the supervision of the Kansas licensed funeral director by whom such licensee is employed and under whom such licensee is registered. The funeral director under whom the assistant funeral director has been registered must immediately notify the secretary of the board when the licensee has left the director's employ. Upon the reemployment of the licensee by any other funeral director, such licensee shall be reinstated by the board and receive credit on their apprenticeship for the period of time the licensee had theretofore served as an

apprentice. The work of an assistant funeral director shall at all times be under the supervision and control of the Kansas licensed funeral director under whom the licensee is registered. Licenses of assistant funeral directors may be suspended or revoked, or the board may refuse to issue or renew the same, for any of the reasons and in the manner stated herein for funeral directors' licenses. Any such license suspension or revocation action shall be in accordance with the provisions of the Kansas administrative procedure act.

(c) The expiration date of each license shall be established by rules and regulations of the board. Subject to the provisions of this section, each license shall be renewable on a biennial basis upon the filing of a renewal application prior to the expiration date of the license and upon payment of the renewal fee established pursuant to K.S.A. 65-1727 and amendments thereto. To provide for a system of biennial renewal of licenses, the board may provide by rules and regulations that licenses issued or renewed may expire less than two years from the date of issuance or renewal. In each case in which a license is issued or renewed for a period of time less than two years, the board shall prorate to the nearest whole month the license or renewal fee established pursuant to K.S.A. 65-1727 and amendments thereto.

(d) The examination requirements set forth section (b) above shall not apply to any person holding a valid assistant funeral director's license as of December 31, 2007 or to registered apprentice funeral directors.

This act shall take effect and be in force on January 1, 2008.

Chapter 65.--PUBLIC HEALTH
Article 17.--REGULATION OF EMBALMERS AND FUNERAL DIRECTORS; FUNERAL ESTABLISHMENTS

65-1727. Fees; fixed by rules and regulations; notice to licensee; licensure by endorsement. (a) On or before October 15 of each year, the state board of mortuary arts shall determine the amount of funds that will be required during the next ensuing two years to properly administer the laws which the board is directed to enforce and administer under the provisions of article 17 of chapter 65 of the Kansas Statutes Annotated, and acts amendatory of the provisions thereof and supplemental thereto, and by rules and regulations shall fix fees in such reasonable sums as may be necessary for such purposes within the following limitations:

Embalmers examination fee, not more than................$300

Embalmers endorsement application fee, not more than................400

Embalmers reciprocity application fee, not more than................400

Funeral directors examination fee, not more than................300

Funeral directors reciprocity application fee, not more than................400

Embalmers/funeral directors reciprocity application fee, not more than................400

Assistant funeral directors application fee, not more than................200

<u>Assistant funeral directors examination fee, not more than............200</u>

Embalmers license and renewal fee, not more than................250

Funeral directors license and renewal fee, not more than................350

Assistant funeral directors license and renewal fee, not more than................300

Apprentice embalmers registration fee, not more than................150

Funeral establishment license fee, not more than................800

Branch establishment license fee, not more than................800

Crematory license fee, not more than................800

Crematory renewal fee, not more than................800

Funeral establishment/crematory license fee, not more than................1000

Funeral establishment/crematory renewal fee, not more than................1000

Branch establishment/crematory license fee, not more than................1000

Branch establishment/crematory renewal fee, not more than................1000

Duplicate licenses................20

Rulebooks................20

Continuing education program sponsor applications................25

Continuing education program licensee applications................25

At least 30 days prior to the expiration date of any license issued by the board, the board shall notify the licensee of the applicable renewal fee therefor.

(b) The fees established by the board under this section immediately prior to the effective date of this act shall continue in effect until such fees are fixed by the board by rules and regulations as provided in this section. An owner of a licensed funeral establishment or licensed branch establishment and a licensed crematory may be charged by the board a combined funeral establishment/crematory license or renewal fee or branch establishment/crematory license or renewal fee under this section in lieu of a separate license or renewal fee for each facility.

(c) The state board of mortuary arts may license embalmers via endorsement from another state: (1) if the individual has been licensed for at least five years and has completed at least five consecutive years of active practice in embalming; (2) has passed the national examination written by the international conference of funeral service examining boards; and (3) has not had any adverse action taken against such licensee by the state board in which licensure is held. The original fee for such endorsement license and the renewal fee shall be in the amounts fixed by the board in accordance with the provisions of this section.

(d) Fees paid to the board are not refundable.

History: L. 1964, ch. 27, § 8 (Budget Session); L. 1973, ch. 251, § 1; L. 1979, ch. 188, § 11; L. 1981, ch. 300, § 4; L. 1982, ch. 264, § 4; L. 1985, ch. 215, § 15; L. 1986, ch. 238, § 3; L. 1991, ch. 190, § 6; L. 1995, ch. 86, § 5; L. 2001, ch. 183, § 11; Jan. 1, 2002.

January 18, 2007

Senator Jim Barnett
Chair, Senate Public Health and Welfare Committee
Kansas Senate

Greetings Senator Barnett:

Thank you for taking time out of your very busy schedule to meet with me this morning concerning the recently passed New Hampshire Bill #1346 "Prescription Confidentiality Act" and the possibility that passage of a similar law in Kansas would help reduce health care costs and help protect the privacy of physicians.

AARP is promoting legislation similar to the New Hampshire "Prescription Confidentiality Act" in several states as part of our national campaign to provide comprehensive health care reform that provides access to and affordable quality health care. As you can see from the attached position paper, RX affordability and health care quality and reform are major issues of AARP Kansas.

We know from working with you in the past on the Evidence Based Research Video that these are concerns that you have also. Therefore, we respectfully request your sponsorship for a Kansas-specific Prescription Confidentiality Act during the 2007 legislature.

Since this is a nationwide issue, we will work closely with experts from our national office and across the states who are willing to provide a global view to Kansas of any issue or concerns related to health care quality and reform.

AARP Kansas staff, volunteers and members look forward to working with you on this issue.
We would greatly appreciate your assistance.

Please contact me if you have any questions or concerns about this proposed legislation or if you would like our assistance on other issues.

Again, we thank you for your support and for your consideration of this request. We look forward to working with you during the 2007 legislative session.

Respectfully,

Ernie Kutzley
Advocacy Director
(785)221-2827 cell
ekutzley@aarp.org

555 S. Kansas Avenue, Suite 201 | Topeka, KS 66603 | toll-free 866-448-3619 | 785-232-8259 fax | toll-free 877-434-7598 TTY
Erik Olsen, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ks

Senate Public Health and Welfare Committee
Attachment #3
January 23, 2007

DIVISION OF THE BUDGET

Kathleen Sebelius, Governor
Duane A. Goossen, Director

http://budget.ks.gov

January 23, 2007

The Honorable Jim Barnett, Chairperson
Senate Committee on Public Health and Welfare
Statehouse, Room 120-S
Topeka, Kansas 66612

Dear Senator Barnett:

SUBJECT: Fiscal Note for SB 107 by Senate Committee on Public Health and Welfare

In accordance with KSA 75-3715a, the following fiscal note concerning SB 107 is respectfully submitted to your committee.

SB 107 would require an applicant for licensure as a professional nurse, practical nurse, or mental heath technician to be fingerprinted for a state and national criminal history check. The Kansas Board of Nursing would use the resources of the Kansas Bureau of Investigation to assist with the fingerprinting process and the background check.

Estimated State Fiscal Effect				
	FY 2007 SGF	FY 2007 All Funds	FY 2008 SGF	FY 2008 All Funds
Revenue	--	--	--	$241,866
Expenditure	--	--	--	$241,866
FTE Pos.	--	--	--	--

The Kansas Board of Nursing would plan to fingerprint all new applicants beginning in FY 2008. The estimated total cost would be $241,866 from all funding sources. This amount represents 4,479 applicants at $54.00 per licensee. The number of applicants is based on FY 2006 actual figures. The cost per application is the estimated expense to complete fingerprinting and background checks, which would be paid by the licensee. All fees collected under SB 107 would be deposited into a newly created Criminal Background and Fingerprinting Fund, which would be administered by the Board of Nursing. The money in this fund would be used to

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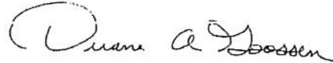
e-mail: duane.goossen@budget.ks.gov

Senate Public Health and Welfare Committee
Attachment #4
January 23, 2007

The Honorable Jim Barnett, Chairperson
January 23, 2007
Page 2—107

reimburse the Kansas Bureau of Investigation for processing the fingerprints and conducting the background checks. Any fiscal effect resulting from this bill would be in addition to the amounts included in *The FY 2008 Governor's Budget Report*.

Sincerely,



Duane A. Goossen
Director of the Budget

cc: Mary Blubaugh, Board of Nursing
Linda Durand, KBI

Public Health and Welfare Committee
January 23, 2007

Testimony in Support of Senate Bill 107

Diane Glynn, J.D., R.N.
Practice Specialist

Good Afternoon Chairman Barnett and Members of the Committee on Public Health and Welfare. My name is Diane Glynn, Practice Specialist for the Kansas State Board of Nursing. I am providing testimony on behalf of the Board Members to provide support of SB 107 which will allow the Board of Nursing to ask an applicant for licensure to be fingerprinted and submit to a state and national criminal history record check.

The mission of the Board of Nursing is to assure the citizens of Kansas safe and competent practice by trustworthy nurses and mental health technicians.

The citizens of Kansas are dependent upon the Board of Nursing to conduct appropriate screening of applicants. Boards of Nursing have the responsibility of regulating nursing and a duty to exclude individuals who pose a risk to the public health and safety. One means of predicting future behavior is to look at past behavior. In 1998 only five boards of nursing were authorized to use criminal background checks and in 2005 a National Council of State Boards of Nursing survey revealed the number had increased to 18 boards and that number increased in 2006 to 20.

Teachers, banking and financial positions, and in some states physicians require criminal background checks. The Kansas judicial system received authority to require fingerprint and criminal back ground checks on attorneys in 2005 and the system has been implemented. Three states (Massachusetts, Missouri, and Oregon) require criminal background checks for most, if not all professional licensure applicants. Although most states ask questions about criminal convictions on licensure applications, applicants may not be motivated to be truthful. Criminal background checks provide validation of the information reported or not reported on applications. The board asks applicants to self-report but the board has no way to know if applicants have fully disclosed arrests and convictions in other states.

Review of information from State Boards of Nursing who have implemented fingerprints

Senate Public Health and Welfare Committee
Attachment #5
January 23, 2007

and criminal background checks reveal that the rate of positive returns is 6-7% for RNs and 10-12% for LPNs.

On September 30, 2003 the Board of Nursing was notified by a Registered Nurse in New Mexico that he had received information from the Internal Revenue Service (IRS) that he had worked in Kansas and had not paid taxes on that income. The nurse from New Mexico had never worked in Kansas. KSBN investigated the allegations and collaborated with the FBI who arrested the imposter on November 18, 2003. The imposter was originally licensed in Missouri in 1985 and in Kansas in 1998. At least one agency that had employed the imposter had run a security check and it produced a "clean" record. Had fingerprints been required on application, this imposter would not have been granted a license. The imposter was a convicted felon. The nurse who was the victim of identify theft was in the Army Reserve. Fingerprints for both of these individuals were on file, and the imposter would have been exposed.

Criminal convictions are permissive grounds for discipline or denial of licensure for all boards of nursing, with the one exception for Kansas, the person-felony bar. Kansas law requires for the board to weigh and balance the conviction with mitigating factors. Not all applicants with a criminal history are or should be denied a license, most are granted a license. Each applicant receives individual analysis. K.S.A. 65-1120 (f) currently authorizes the Board of Nursing to receive (from the KBI) criminal history record information relating to arrests and criminal convictions as necessary for the purpose of determining initial and continuing qualifications of licensees of applicant. This bill will broaden current authority to the national level.

In August 2005, National Council of State Boards of Nursing passed a **model** process for fingerprints and background checks. The model is a baseline for states to use and build on. Kansas currently conducts KBI background checks which include arrests, convictions, and expungements.

On December 4, 2005 the Council of State Governments Health Policy Task Force signed a resolution on supporting criminal background checks for nurses applying for state licenses. A copy of the resolution is attached to this testimony.

Legislative Post Audit Committee recommended in October 2006 that the Board of Healing Arts request statutory authority which would require applicants to be fingerprinted that would be submitted to KBI and FBI for a background check.

We ask for favorable action on this legislation. Thank you for your time and consideration and I will stand for questions.

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Ellen Carson, Ph.D., A.R.N.P., B.C.
President

The Voice And Vision Of Nursing In Kansas

Terri Roberts, J.D., R.N.
Executive Director

For More Information Contact:
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January 23, 2007

S.B. 107 Fingerprinting and Background Checks for Professional, Practical Nurses and Licensed Mental Health Technicians

Senator Barnett and members of the Senate Public Health and Welfare Committee, my name is Ellen Carson Ph.D., ARNP, and I am the President of the KANSAS STATE NURSES ASSOCIATION. KSNA is the professional organization for registered nurses in Kansas.

KSNA has been very active in monitoring and dialoguing with the Kansas State Board of Nursing Investigative Committee since they started holding "policy discussions" in an open meeting during each of the regularly scheduled Board meetings. Both members of the KSNA Council on Practice and Council on Economic and General Welfare have made presentations to the investigative committee on various aspects of the "investigative and disciplinary process" as well as requesting information about practice patterns that the Board has identified as inappropriate or unsafe by licensed nurses.

KSNA has a rich history of supporting the Board of Nursing in their role of "protection of the public". Licensees are required to self-report felonies and misdemeanors on their initial and every two year renewal forms. In 1997 KSNA introduced and lobbied for a statutory change in the Nurse Practice Act that was passed and prohibits individuals with *Article 34, Chapter 21 Felony Convictions* from being licensed as nurses in Kansas. This followed a highly publicized conviction of a PSU senior nursing student, with a previous felony conviction that murdered a PSU female student. At the time the legislature passed this absolute prohibition Kansas was only the second state to add such a restriction for licensure. It reads as follows and is in K.S.A. 65-1120;

> ***no license, certificate of qualification or authorization to practice nursing as a licensed professional nurse, as a licensed practical nurse, as an advanced registered nurse practitioner or registered nurse anesthetist shall be granted to a person with a felony conviction for a crime against persons as specified in article 34 of chapter 21 of the Kansas Statutes Annotated and acts amendatory thereof or supplemental thereto;***

See the attachment labeled Felony Restrictions on RN Licensure in Kansas. We print this list regularly in **The Kansas Nurse** to insure that educators and others are aware of this statutory prohibition.

In addition to supporting the role of the Board in protecting the public, we have an obligation to insure that the Board is following the statutes and is consistent and fair in matters related to licensure, discipline and affording licensees their legal rights.

Senate Public Health and Welfare Committee
Attachment # 6
January 23, 2007

For the past seven years KSNA has requested, provided information and participated in dialogue with the BON Investigative Committee towards the establishment of a decision making model that would be used by the agency when reviewing matters involving licensure restrictions and discipline disposition. To date the Board has not yet adopted a model, although immediately before and since the Kansas Legislative Post Audit they have adopted several policies that guide and document the "process" that they use in reviewing complaints and disciplinary cases. These have been helpful, in providing some level of assurances that disciplinary matters are considered according to the same process, however, they fail to insure that similar cases from year to year are treated equally with commensurate disposition. This includes disposition of licensure applications with self-reported criminal histories.

S.B. 107 contains new language that would authorize the Kansas Board of Nursing to obtain not only criminal convictions, but arrests, expungements and juvenile records from the Kansas Bureau of Investigation (KBI) and the Federal Bureau of Investigation (FBI) for all licensees and applicants. **KSNA has no objection to the agency receiving criminal conviction data**, or using **fingerprints for proper identification**.

The Nurse Practice Act statute provides in K.S.A. 65-1120 that the Board of Nursing may "revoke, limit, or suspend" a license if a licensee is found:

> **"to have been guilty of a felony or to have been guilty of a misdemeanor involving an illegal drug offense unless the applicant or licensee establishes sufficient rehabilitation to warrant the public trust"**.

We do however, have concerns about the Board obtaining juvenile, expunged and arrest records. Their current statute includes language that authorizes them to receive "arrest" information pursuant to KSA 65-1120 (f)

> ***"(f) Criminal justice information. The board upon request shall receive from the Kansas Bureau of Investigation such criminal history record information relating to arrests and criminal convictions as necessary for the purpose of determining initial and continuing qualifications of licensees of and applicants for licensure by the board."***

KSNA cannot support even this access to *arrest records* because it must be assumed that they will be construed as prejudicial in determining whether a licensee should be granted or retain a license. Licensees and/or applicants would be forced to defend an "arrest" that might be aged, a false accusation and in most cases certainly a challenge to defend, if no prosecution ensued and an opportunity under the law to defend the allegation. We cannot support that licensees/applicants are considered guilty and have to defend themselves under these circumstances. Only criminal convictions should be obtained and used by the agency.

Juvenile records are currently protected under separate statute which prohibits their release unless the entity has statutory authority. We have not heard a compelling argument by the Board of Nursing in any of their discussions about fingerprinting and background checks why juvenile records should be considered by the Board in awarding licensure.

Expungements are slightly different. There is a laundry list in K.S.A. 21-4619 the Expungement Statute of those entities that are entitled to receive expungement information, and there appear to be no categories of licensed health professionals currently in that list and this may be the first to be added.

Expungements generally require:

- 3-5 years of no criminal conviction,
- going to court to ask for the expungement,

and heinous felonious crimes cannot ever be expunged. Again, we have heard no compelling argument for obtaining these records.

In addition to these comments about the proposed language in S.B. 107 we ask that the committee review another area of the Kansas Nurse Practice Act that is germane to the rights of licensees and applicants of the Board in matters relating to discipline and licensure. This is an area of the Nurse Practice Act that several lawyers representing licensees in disciplinary matters have brought to our attention, as well as employers and licensees. K.S.A. 65-1135 currently by statute prohibits the Board from disclosing matters in a pending investigation except in three circumstances:

> **65-1135. Complaint or information relating to complaint confidential; exceptions.**
> (a) Any complaint or report, record or other information relating to the investigation of a complaint about a person licensed by the board which is received, obtained or maintained by the board is confidential and shall not be disclosed by the board or its employees in a manner which identified or enables identification of the person who is the subject or source of such information except:
>
> (1) In a disciplinary proceeding conducted by the board pursuant to law or in an appeal of the order of the board entered in such proceeding, or to any party to such proceeding or appeal or such party's attorney;
>
> (2 to the proper licensing or disciplinary authority of another jurisdiction, if any disciplinary action authorized by K.S.A. 65-1120 and amendments thereto has at any time been taken against the licensee or the board has at any time denied a license certificate or authorization to the person; or
>
> (3) to the person who is the subject of the information, but the board may require disclosure in such a manner as to prevent identification of any other person who is the subject or source of the information.
>
> (b) This section shall be part of and supplemental to the Kansas nurse practice act.
> **History:** (L. 1994, ch. 218, § 1; L. 2000, ch. 113, § 3; L. 2001, ch. 161, § 7; July 1.)

Licensees and lawyers, for a number of years have expressed concern about the Boards disclosure outside the boundaries of this statute. This statute has been interpreted by the Board *that they may release information to potential employers (faculty) information* related to pending investigations. We and attorney's representing licensees have viewed this as a violation of statute. The inappropriate disclosure of information by the Board of a pending investigation was the topic of a KSNA complaint letter filed with the Attorney Generals Office in June of 2005. The letter was accompanied with documentation that information was shared in violation of the statute. The AG's office (which provides an Assistant AG to represent and advise the agency) sent a response in December of 2005 indicating that the AG's office had no jurisdiction and that the only recourse for licensees it to go to District Court. We believe that the legislature should make this statute more clear to avoid licensees having to seek judicial review in order to have their rights upheld by the licensing agency.

KSNA respectfully requests that this committee amend S.B. 107 by:

1. **Deleting from the new proposed language in S.B. 107 on lines 19, 22, 23,31,32, and 41 the references to arrests, juvenile and expungement records.** See attached Ballon.

2. Adding KSA 65-1120, another statute in the Kansas Nurse Practice Act, to this bill **with amended language in (f) deleting the words "arrests and"** so that **only** criminal convictions would be obtained by the Board of Nursing from the KBI for consideration of fitness for licensure.
   Current Statute:
   "(f) Criminal justice information. The board upon request shall receive from the Kansas bureau of investigation such criminal history record information relating to arrests and criminal convictions as necessary for the purpose of determining initial and continuing qualifications of licensees of and applicants for licensure by the board."

3. **Clarify K.S.A. 65-1135 that the Board** can only release investigative information to the licensee and in a formal disciplinary hearing and **is strictly prohibited from releasing to anyone, anything but final orders of the Board on matters of discipline.** We believe that these protections on behalf of the licensee must be clarified in the nurse practice act.

Thank you for your consideration.

Session of 2007

SENATE BILL No. 107

By Committee on Public Health and Welfare

1-17

January 23, 2007

9 AN ACT concerning the board of nursing; concerning fingerprinting and
10 criminal history records checks; creating the criminal background and
11 fingerprinting fund.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 Section 1. (a) The board of nursing may require an applicant for
15 licensure as a professional nurse, practical nurse or mental health tech-
16 nician to be fingerprinted and submit to a state and national criminal
17 history record check. The fingerprints shall be used to identify the ap-
18 plicant and to determine whether the applicant has a record of criminal
19 ~~history~~ in this state or other jurisdictions. The board of nursing is au- — convictions
20 thorized to submit the fingerprints to the Kansas bureau of investigation
21 and the federal bureau of investigation for a state and national criminal — convictions
22 ~~history~~ record check. The board of nursing may use the information ob- — convictions
23 tained from fingerprinting and the applicant's criminal ~~history~~ for pur-
24 poses of verifying the identification of any applicant and in the official
25 determination of character and fitness of the applicant for any licensure
26 to practice professional or practical nursing or mental health technology
27 in this state.
28 (b) Local and state law enforcement officers and agencies shall assist
29 the board of nursing in taking and processing of fingerprints of applicants
30 to practice professional or practical nursing or mental health technology — delete "and juvenile"
31 in this state and shall release all records of adult ~~and juvenile~~ convictions, — delete "adjudications, expungements and non-convictions"
32 ~~adjudications, expungements and non-convictions~~ to the board of nursing.
33 (c) The board shall fix a fee for fingerprinting of applicants or licens-
34 ees, or both, as may be required by the board in an amount necessary to
35 reimburse the board for the cost of the fingerprinting. Fees collected
36 under this subsection shall be deposited in the criminal background and
37 fingerprinting fund.
38 (d) There is hereby created in the state treasury the criminal back-
39 ground and fingerprinting fund. All moneys credited to the fund shall be
40 used to pay the Kansas bureau of investigation for the processing of fin-
41 gerprints and criminal ~~history background~~ checks for the board of nurs- — conviction
42 ing. The fund shall be administered by the board of nursing. All expend-
43 itures from the fund shall be made in accordance with appropriation acts

Felony Restrictions on RN Licensure in Kansas

The Kansas Nurse Practice Act was amended in 1997 to prohibit licensure of RNs, LPNs or LMHTs who have a criminal conviction of felony crimes against persons. This is the list of felonies referenced in KSA 65-1120 which reads as follows:

65-1120.

(a) *Grounds for disciplinary actions.* The board may deny, revoke, limit or suspend any license, certificate of qualification or authorization to practice nursing as a registered professional nurse, as a licensed practical nurse, as an advanced registered nurse practitioner or as a registered nurse anesthetist that is issued by the board or applied for under this act or may publicly or privately censure a licensee or holder of a certificate of qualification or authorization, if the applicant, licensee or holder of a certificate of qualification or authorization is found after hearing:

(2) to have been guilty of a felony or to have been guilty of a misdemeanor involving an illegal drug offense unless the applicant or licensee establishes sufficient rehabilitation to warrant the public trust, except that notwithstanding K.S.A. 74-120 *no license, certificate of qualification or authorization to practice nursing as a licensed professional nurse, as a licensed practical nurse, as an advanced registered nurse practitioner or registered nurse anesthetist shall be granted to a person with a felony conviction for a crime against persons as specified in article 34 of chapter 21 of the Kansas Statutes Annotated and acts amendatory thereof or supplemental thereto;*

Article 34, Chapter 21 Felony Crimes Sorted Numerically by Statute Number

REFERENCE	DESCRIPTION
21-3401	Murder in the First Degree
21-3401	Murder in the First Degree: Attempt (K.S.A. 21-3301)
21-3401	Murder in the First Degree: Conspiracy (K.S.A. 21-3302)
21-3401	Murder in the First Degree: Solicitation (K.S.A. 21-3303)
21-3402(a)	Murder in the Second Degree (intentional)
21-3402(b)	Murder in the Second Degree (reckless)
21-3403	Voluntary Manslaughter
21-3404	Involuntary Manslaughter
21-3406(a)(1)	Assisting Suicide (force or duress)
21-3406(a)(2)	Assisting Suicide
21-3410	Aggravated Assault
21-3411	Aggravated Assault on LEO
21-3412a	Domestic Battery: third or subsequent conviction w/in last 5 years (b)(3)
21-3413(a)(2)	Battery Against a Correctional Officer
21-3413(a)(3)	Battery Against a Juvenile Correctional Facility Officer
21-3413(a)(4)	Battery Against a Juvenile Detention Facility Officer
21-3413(a)(5)	Battery Against a City/County Correctional Officer/Employee
21-3414(a)(1)(A)	Aggravated Battery – intentional, great bodily harm
21-3414(a)(1)(B)	Aggravated Battery – intentional, bodily harm
21-3414(a)(1)(C)	Aggravated Battery – intentional, physical contact
21-3414(a)(2)(A)	Aggravated Battery – reckless, great bodily harm
21-3414(a)(2)(B)	Aggravated Battery – reckless, bodily harm
21-3415(a)(1) or (3)	Aggravated Battery on LEO – intentional, great bodily harm or w/motor vehicle
21-3415(a)(2)	Aggravated Battery on LEO – bodily harm or physical contact; deadly weapon
21-3419(a)(1)	Criminal Threat
21-3419(a)(2)	Criminal Threat *(adulterate or contaminate any food, raw agricultural commodity, beverage, drug, animal feed, plant or public water supply)*
21-3419a	Aggravated Criminal Threat: < $500 loss of productivity
21-3419a	Aggravated Criminal Threat: > $500 but < $25,000 loss of productivity
21-3419a	Aggravated Criminal Threat: e" $25,000 loss of productivity
21-3420	Kidnapping
21-3421	Aggravated Kidnapping
21-3422(c)(2)	Interference With Parental Custody in all other cases
21-3422(a)(b)	Aggravated Interference With Parental Custody
21-3426	Robbery
21-3427	Aggravated Robbery
21-3428	Blackmail
21-3435(1)(2) or (3)	Exposing Another to a Life Threatening Communicable Disease
21-3437(a)(1)	Mistreatment of a Dependant Adult - physical
21-3437(a)(2)*	Mistreatment of a Dependant Adult – aggregate amount $25,000 or more
21-3437(a)(2)*	Mistreatment of a Dependant Adult – aggregate amount at least $500 but < $25,000
21-3437(a)(2)*	Mistreatment of a Dependant Adult – aggregate amount is < $500 and committed by a person convicted w/5 years of this crime two or more times
21-3438(a)	Stalking
21-3438(b)	Stalking *when the victim has an order pursuant to the protection from stalking act,* a Temporary Restraining Order or an Injunction in effect against the offender
21-3438(c)	Stalking when the offender has a previous conviction w/in 7 years for stalking the same victim
21-3439	Capital Murder
21-3440(a)	Injury to a Pregnant Woman in the Commission of a Felony
21-3440(c)	Injury to a Pregnant Woman in the commission of KSA 21-3412 (battery), or KSA 21-3413(a)(1) (battery on LEO), or KSA 21-3412a(b)(1) or (b)(2) (domestic battery statute), or KSA 21-3517 (sexual battery)
21-3441(c)(1)	Injury to a Pregnant Woman by Vehicle-committing a violation of 8-1567
21-3442	Involuntary Manslaughter in the Commission of a DUI

6-5

KANSAS STATE NURSES ASSOCIATION
Board of Directors Meeting
February 25, 2006
Agenda Item # **2.3**

STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

PHILL KLINE
ATTORNEY GENERAL

120 SW 10TH AVE., 2ND FLOOR
TOPEKA, KS 66612-1597
(785) 296-2215 • FAX (785) 296-6296
WWW.KSAG.ORG

December 8, 2005

Janice Jones, R.M., M.N., C.N.S., President
Kansas State Nurses Association
1208 SW Tyler
Topeka, Kansas 66612-1735

Re: Complaint and Request for Investigation - KSBN

Dear Ms. Jones,

I am writing in response to your June 28, 2005, letter of complaint and request for an investigation into the Kansas State Board of Nursing (KSBN) staff's interpretation and implementation of K.S.A. 65-1135. I regret to inform you that we cannot provide the assistance you requested.

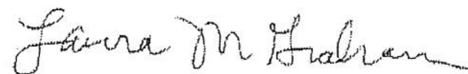
While the Attorney General's office does have investigatory authority into certain record-related issues – pursuant to the Kansas Open Records Act, K.S.A. 45-215 *et seq.* – the office does not have carte blanche jurisdiction to oversee or enforce how specific state agencies, boards or commissions apply or interpret record-related laws pertaining exclusively to them. Rather, that authority rests with the specific agency, board or commission to which the pertinent record-related laws apply. Essentially, how a specific agency, board or commission interprets such provisions is a matter of policy; accordingly, such interpretations may be subject to challenge pursuant to the act for judicial review and civil enforcement of agency actions, K.S.A. 77-601 *et seq.*

In terms of the KSBN staff's interpretation of K.S.A. 65-1135, therefore, and whether the statute allows the board to disclose that an investigation is pending – even before a formal proceeding has been initiated - the Attorney General's office has no basis to investigate or instruct KSBN on how the statute should be applied or interpreted. Furthermore, it would seem that the appropriate recourse for a nurse who believes the KSBN staff wrongly disclosed that an investigation was pending against the nurse would be to bring a private cause of action against KSBN.

I hope this information is helpful. If you have any questions or concerns or wish to discuss this matter further, please feel free to contact our office.

Sincerely,

OFFICE OF THE ATTORNEY GENERAL
PHILL KLINE



Laura M. Graham
Assistant Attorney General

LMG:jm
cc: Mary Blubaugh, KSBN Executive Administrator
Judith Hiner, KSBN President

KANSAS STATE NURSES ASSOCIATION

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THE VOICE AND VISION OF NURSING IN KANSAS

JANICE JONES, R.N., M.N., C.N.S.
PRESIDENT

TERRI ROBERTS J.D., R.N.
EXECUTIVE DIRECTOR

June 28, 2005

Laura Graham, Assistant Attorney General
Attorney General's Office, Memorial Hall
120 SW 10th Street, 2nd Floor
Topeka KS 66612

Dear Ms. Graham,

In March of 2005, officials of the KANSAS STATE NURSES ASSOCIATION, in conversation with Kansas State Board of Nursing staff and an official, expressed concerns about the KSBN staff's interpretation and implementation of KSA 65-1135. The KSNA Board of Directors recently reviewed correspondence shared with our office that appears to defend conduct by the Kansas State Board of Nursing staff that may violate this statute.

KSNA files this letter as a formal complaint of KSBN staff violating KSA 65-1135. Our interpretation of the statute is that all matters, including the fact that an investigation is pending, are confidential

- until a formal proceeding is initiated (KSA 65-1135(a)(1));
- final action is taken by the agency authorizing the sharing of agency action on the license (KSA 65-1135(a)(2)); or
- at any time to the licensee being investigated (KSA 65-1135(a)(3)),

and that these are the only criteria and thresholds for release of confidential information related to a complaint or investigation. These exceptions reflect elements of fundamental fairness that is important for licensees, and maintains the integrity of due process afforded to licensees in the investigative phase of a potential disciplinary proceeding.

Statistics from the Board of Nursing indicate that, after the investigation phase, in 2003, 160 cases (32%) were inactivated; in 2004, 157 cases (32%) were inactivated, and to date, 58 of 2005 cases (51%) have been inactivated. With one third of all case files inactivated, it is very important that all protections afforded by statute be upheld.

Here is the circumstance (documented) that we believe to be in violation:

The Director of a Kansas community college received a telephone call early this spring from a KSBN Education Specialist, that a RN licensee, a newly-hired part-time faculty member, was "under investigation by the KSBN for possible drug impairment and other allegations." KSBN staff made this call following receipt of a "Faculty Qualification Form," required of all schools when a potential new faculty member is hired.

After hearing and confirming that this conversation had taken place, the licensee affected contacted her attorney and requested that he send a letter to the KSBN, requesting compliance with KSA 65-1135 in the future.

KSNA elected and appointed officials have received several anecdotal stories and complaints about just such conduct by KSBN staff privy to confidential investigative files and information; however, because information was shared verbally by the KSBN staff with certain individuals (employers, licensees, co-workers, other states' licensing boards), KSNA never had legitimate evidence that the statute was being violated. The licensees in receipt of the phone calls and disclosed information, for the most part, are hesitant to call the KSBN action into question because of their regulatory role and retaliatory reputation. These individuals have, however, called and reported what they knew or suspected about such disclosures to KSNA elected officials and staff.

In the past couple of months, the interpretation of KSA 65-1135 by the KSBN has been questioned by attorneys representing RN licensees and RN's themselves. We believe this matter to be very important to licensees of the Kansas State Board of Nursing. The KSBN staff clearly differ from KSNA in their interpretation and implementation of this statute.

We respectfully request a full and complete investigation into this matter by your office. This may include the licensee's case mentioned previously, interviews with Kansas School of Nursing Deans/Directors who have received phone calls in the past from KSBN staff disclosing confidential investigative information, and Boards of Nursing staff in other states.

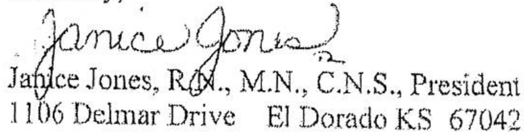
We would add that a legislator had a bill introduced in the 2005 session (House Bill 2149) to add a new (a)(4) to KSA 65-1135, which would read:

> "Section 1. K.S.A. 65-1135 is hereby amended to read as follows: 65-1135.
> (a) Any complaint or report, record or other information relating to the investigation of a complaint about a person licensed by the board which is received, obtained or maintained by the board is confidential and shall not be disclosed by the board or its employees in a manner which identified or enables identification of the person who is the subject or source of such information except: ...
>
> *(4) to a prospective employer of the person who is the subject of the information. The board may require such prospective employer to submit documentation verifying that the person is seeking employment which such employer or a release to disclose such information from the person who is the subject of the information.*"

It is clear that a legislator (and the Revisor) didn't believe sharing now-confidential investigative information with prospective employers was permitted, hence the bill aimed at expanding the conditions in which it could be disclosed.

KSNA officials' discussions and dialogue on HB 2149, the public policy involved, and protecting the rights of licensees, has heightened our awareness of this statute. It is imperative that the profession and regulators be in concert on this statute's meaning, interpretation, and implementation. Unfortunately, this is not the case, and we seek clarity and compliance. Thank you for your attention to this matter.

Sincerely,



Janice Jones, R.N., M.N., C.N.S., President
1106 Delmar Drive El Dorado KS 67042

cc: Mary Blubaugh, Executive Administrator, KSBN
Judith Hiner, President, KSBN
KSBN Board Members
KSNA Board of Directors and Council on Practice

enclosures: List of licensee/parties referenced
Letter from Larry Michel (Redacted)
Letter from Betty Wright (Redacted)
Investigative Committee Disposition of Cases (by calendar year)

LAW OFFICES

KENNEDY BERKLEY YARNEVICH & WILLIAMSON

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TELEPHONE (785) 825-4674

FAX (785) 825-5936

April 13, 2005

Betty Wright
Kansas State Board of Nursing
900 S.W. Jackson, Suite 1051
Topeka, KS 66612-1230

Re: [redacted]
[redacted]

Dear Betty:

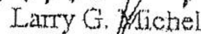
I am writing this letter to address a concern in connection with the above matter. We have previously discussed this case and you are aware that I represent [redacted]

[redacted] has recently learned that [redacted] of the State Board told [redacted] Community College that [redacted] was being investigated for possible drug impairment. First, it is not my understanding that the Board of Nursing is investigating [redacted] for possible impairment. Second, we do not believe that it is appropriate for this information to be revealed. It is my understanding that the Nurse Practice Act requires that investigative files be kept confidential until such time as they become a public record. Accordingly, I would ask that you check into this situation and advise your client to cease disclosing confidential information to third parties.

Please let me know if you have any questions. Otherwise, we appreciate your prompt attention to this matter.

Sincerely,

KENNEDY BERKLEY YARNEVICH
& WILLIAMSON, CHARTERED

By: 
Larry G. Michel
lmichel@kenberk.com

LGM:wl

KANSAS STATE BOARD OF NURSING
MARY BLUBAUGH MSN, RN, EXECUTIVE ADMINISTRATOR

KATHLEEN SEBELIUS, GOVERNOR

COPY

April 26, 2005

Larry Michel
KENNEDY BERKLEY YARNEVICH
& WILLIAMSON, CHARTERED
119 West Iron Ave, Suite 710
PO Box 2567
Salina, KS 67402-2567

Re: your client [redacted]

Dear Mr. Michel:

Thank you for your letter written April 13, 2005 regarding your client [redacted]. The letter stated that "[redacted] of the State Board told [redacted] Community College that [redacted] was being investigated for possible drug impairment."

The facts are that [redacted] is required to reveal pending investigations to nursing schools who inquire about this information if the nurse is applying for a position on the faculty of a nursing school. She always relays that an investigation is pending, what the brief description of the case is, and then states that the school should contact the potential faculty member.

The information that the board has a pending investigation would be released, along with the type of case being investigated. [redacted] would have also indicated that the case or cases are pending and her license is unencumbered.

The contents of the investigative case file are confidential, unless requested by other licensing boards, see K.S.A. 65-1135, however, the fact that there is an investigation is not confidential.

If you have questions, Il can be reached at 785-296-7047.

Sincerely,

Betty Wright
Assistant Attorney General
Kansas Board of Nursing

LANDON STATE OFFICE BUILDING, 900 SW JACKSON ST., STE 1051, TOPEKA, KS 66612-1230
Voice 785-296-4929 Fax 785-296-3929 www.ksbn.org

Thomas L. Bell
President

TO: Senate Committee on Public Health and Welfare

FROM: Deborah Stern, RN, JD
Vice President Clinical Services/ Legal Counsel

RE: Senate Bill 107

DATE: January 23, 2007

The Kansas Hospital Association (KHA) appreciates the opportunity to speak in favor of Senate Bill 107 which would require nursing licensees to be fingerprinted and submit to both state and national criminal history record checks. This information would then be made available to the Kansas State Board of Nursing for use in determining the suitability of the applicant for licensure.

KHA supports this legislation as it assists Kansas hospitals by requiring both a state *and* federal criminal background check for all registered nurses, licensed practical nurses and licensed mental health technicians seeking a license to practice in Kansas. In this transient society in which we live, obtaining both state and federal criminal background information is a necessity.

Screening potentially dangerous applicants for licensure before they become employed greatly assists Kansas health care facilities in providing a safer environment for patients, co-workers and the community. Applicants could easily meet these new requirements by going to their local or state law enforcement agency to have their fingerprints taken. The proposed legislation calls for the fee for these background checks (approximately $54) to be paid by the applicant.

For the reasons cited above, KHA recommends that you support SB 107.

Kansas Hospital Association
215 SE 8th Ave. • PO Box 2308 • Topeka, KS 66601-2308 • (785) 233-7436 • FAX: (785) 233-6955 • www.kha-net.org

Senate Public Health and Welfare Committee
Attachment #7
January 23, 2007

Kathleen Sebelius, Governor
Duane A. Goossen, Director

http://budget.ks.gov

January 23, 2007

The Honorable Jim Barnett, Chairperson
Senate Committee on Public Health and Welfare
Statehouse, Room 120-S
Topeka, Kansas 66612

Dear Senator Barnett:

SUBJECT: Fiscal Note for SB 116 by Senate Committee on Public Health and Welfare

In accordance with KSA 75-3715a, the following fiscal note concerning SB 116 is respectfully submitted to your committee.

SB 116 would require elementary and secondary student health assessments to include screening tests to determine predisposition for asthma. Current law does not require such testing.

Enactment of SB 116 would not affect operating costs of the Department of Education.

Sincerely,

Duane A. Goossen
Director of the Budget

cc: Dale Dennis, Education

900 S.W. Jackson Street, Room 504-N, Topeka, KS 66612 • (785) 296-2436 • Fax: (785) 296-0231
e-mail: duane.goossen@budget.ks.gov

Senate Public Health and Welfare Committee
Attachment # 8
January 23, 2007

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on
Senate Bill 116
Senate Public Health and Welfare Committee

Presented by: Linda Kenney, Director
Bureau for Children, Youth & Families
January 23, 2007

Chairperson Barnett and Members of the Committee, thank you for the opportunity to provide the department's comments relating to this bill that amends the requirements for child health assessments for new Kansas school entrants age 8 and under.

The proposed amendment expands the screening requirements from "hearing, vision, nutrition adequacy, and appropriate growth and development" to add "predisposition for asthma" but it does not define predisposition for asthma. We assume this means genetic predisposition (asthma and allergies in student or immediate family) or other predisposition exacerbated by environmental triggers. If this is the case, such predisposition is already assessed through the recommended screening tool on our website a copy of which is attached.

While asthma is a very important chronic health condition for school age children, the screening purpose may be better served by a broader focus. The focus on a single-health condition appears to exclude screening for equally important chronic health conditions such as cancer, diabetes, epilepsy, heart disease, overweight, neurological disorders, and others. The department along with the National Association of School Nurses recommends that legislation, policy making and protocol utilize a comprehensive model focusing on the broader chronic health condition approach rather than a single-disease approach.

We agree with the objective of the bill to assure effective screening of children. Our conclusion is that the existing statute meets this objective. Thank you for the opportunity to appear before this Committee. I will be happy to respond to any questions.

Senate Public Health and Welfare Committee
Attachment # 9
January 23, 2007

BUREAU FOR CHILDREN, YOUTH AND FAMILIES
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 220, TOPEKA, KS 66612-1274
Voice 785-291-3368 Fax 785-296-6553

From: <galemorec@comcast.net>
To: <barnett@senate.state.ks.us>
Date: 1/23/2007 8:18 AM
Subject: Sb 116

To: Sen. Jim Barnett, Chair, Public Health & Welfare Committee
From: Cindy Galemore RN, MSEd, NCSN
Subject: Written Testimony Related to Sb116
Date: January 22, 2007

Last Friday, January 19, 2007, I received notice that proposed additional language was being considered that would amend the current law regarding the required physical for entry into school. Specifically, the phrase ôpredisposition for asthmaö is to be added to the items that must be covered in the required physical for entrance into Kansas schools.

Currently I am employed as the Director of Health Services for Olathe District Schools. Additionally, I have just completed a four year term as the Kansas Director to the National Association of School Nurses (NASN). In the recent past, we have seen a surge of single disease legislation. While not opposed to legislation that would improve the detection, treatment, and management of conditions specific to children, I remain cautious with legislation that emphasizes a particular disease rather than recognizing the multitude of diseases that are prevalent in our children and youth. A recent review of available research by NASN did indeed identify asthma as one of the most prevalent of chronic conditions in children (13%). Other prevalent chronic conditions identified include vision deficiencies (24% of all students by the age of 17), food allergies (5%), seizure disorder (5% experience at least a single seizure with 1% developing epilepsy), attention deficit disorder (5 to 10%),
etc. (NASN, Issue Brief, SCHOOL NURSING MANAGEMENT OF STUDENTS WITH CHRONIC HEALTH CONDITIONS, http://www.nasn.org/Default.aspx? tabid=348)

Further, a standard among the medical and nursing professions in conducting physicals includes a thorough history that would identify the presence of the most common chronic conditions including asthma. Vision and hearing screening merit specific recognition (as is the current case) due to their high impact on learning. Instead, of including this additional language specific to asthma, I would welcome the screening tool being further explored with school nurses in Kansas with potential consideration of incorporating an asthma symptom checklist as a routine screening in schools (as occurs with vision and hearing). The research behind the screening tool would be an important part of this exploration. Therefore, I am opposed to the amending of this regulation at this time.

I would be happy to answer any questions. I may be reached at work (913-780-7002) or home (913-829-0392). Thank you again for your interest and commitment to the health of Kansas children.

Senate Public Health and Welfare Committee
Attachment #10
January 23, 2007