Approved: March 10, 1994
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on March 7, 1994 in Room 423-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Representative Glasscock
Nancy Zogleman, Chair of Kansas Pharmaceutical Manufacturers Assn. Task Force
Chip Wheelen, Kansas Medical Society
Harold Riehm, Kansas Association of Osteopathic Medicine
Bob Williams, Kansas Pharmacy Association
Commissioner Robert Epps, Department of SRS

Others attending: See attached list

Chair called the meeting to order welcoming all visitors, and a special welcome given to Emalene Correll who returned to Committee after being ill with pneumonia. Ms. Correll thanked Committee for the flowers on her desk and noted they made her feel optimistic about Spring being near.

Chair drew attention to **SB 410**, and requested a staff briefing.

Mr. Furse detailed the language in **SB 410,** and noted this is carry-over legislation that affects current law, K.S.A. 1992 Supp. 39-7,118. The change in current law would spell out what the Committee of health care providers is, would name the Committee, and the Drug Utilization Review Board, (DUR). He detailed the duties, authority, functions, and composition of the Board, appointment to and length of time of service of Board members. He noted the change that was amended into **SB 410** in Senate Public Health and Welfare Committee, i.e., the DUR would be subject to open meetings, but could recess for closed or executive meetings. He indicated page 4, sub 9, provides language for allowing such a recess for discussions. He drew attention to several references in the bill related to "licensed pharmacists and licensed physicians". He noted, ordinarily, language used would be "persons licensed to practice medicine and surgery". He noted the Committee may wish to consider bringing this language into conformity with that customarily used.

HEARINGS BEGAN ON **SB 410.**

Rep. Glasscock spoke in support of **SB 410**, that would require meetings of the DUR be conducted as open meetings after July 1, 1994. (See Attachment No. 1). He strongly believes in the concept of openness of government. He cited specifics related to the attendance of Appropriations Sub-Committee meetings in which input from the public attending has ultimately allowed the state to recommend cuts resulting in great savings. He feels the interest and ideas from the public have been beneficial, and he urged passage for **SB 410** for that reason.

Nancy Zogleman, Chair, Kansas Pharmaceutical Manufacturers Association, (Attachment No.2), stated the Department of SRS has operated a DUR Committee for many years, however, there is no statutory language providing specifically to its membership or under what rules the Committee should operate. She noted **SB 410** was proposed last year, to clear up confusion as to whether the meetings of the DUR should be considered public meetings under the "Kansas Open Meetings Act. When SRS questioned an Attorney General's opinion, the Legislature added a proviso to last year's omnibus bill which attached language to the SRS appropriation related to "open meetings", in essence, providing a trial period to let the sunshine in on the DUR Committee. It has been determined, the openness of meetings does no harm, and actually enables people to better understand the Medicaid Drug Program. Ms. Zogleman urged support for **SB 410** which codifies the federal requirements and provides for a balanced membership. She answered numerous questions, i.e., the Committee is a contract with the Kansas Pharmacy Foundation, not set up by the Department of SRS. It was noted, HICFA has not taken any exception to our current structure.

Chip Wheelen, Kansas Medical Society, drew attention to a proposed amendment, see (Attachment No. 3). He detailed the amendment proposed for **SB 410** in the balloon provided, i.e., page 3, line 9, add new Sec. 3. He explained, the Board would be given the necessary power and authority to bring some of the functions of the Committee out into the public arena. He noted, there will no longer be restricted formulary, but instead there is prior authorization. It is much easier to form legislation correctly the first time, he noted, than to try and correct it later. He noted **SB 410** in its current form doesn't really do a lot except to conform with the federal law. If Committee does adopt the amendment he proposes, it will give the DUR Board the opportunity to review regulations before they are published. Those regulations would set out the medications that are to be included in a restricted formulary, or subject to a prior approval requirement, allowing a time period for the public to have an opportunity to provide input. He answered numerous questions, i.e., proposed amendment would completely change the legislative process in that the public would have an opportunity to give in-put in a set period of time while regulations are still being considered.

It was determined, public input would need to be provided very early on in the process, since the procedure is fairly well structured. Discussion held regarding the phrasing, "public notice" and "publishing". It was noted that when Committee discusses this for possible action, the language could be clarified at that time.

Harold Riehm, (Attachment No.4) stated he was the only conferee that spoke in support of **SB 410** in the Senate hearings. The Kansas Association of Osteopathic Medicine (KAOM) consistently opposes the limitation of the formulary, as well as prior authorization. He had not had time to examine the amendment proposed by Mr. Wheelen today, but indicated from comments made by Mr. Wheelen, the amendment could be supported conceptually by the KAOM, since it does allow greater involvement of the DUR influencing the policy decisions coming out of the Department of SRS. He read language coming out of the Senate Sub-Committee, i.e., recommending that the agency cease the prior authorization for anti-depressant medication which began in January , 1994, based on the small level of projected savings and recommendations of the DUR Committee. He stated approval of the composition of the Board. He drew attention to another hand-out (see Attachment No. 5), that detailed a specific case of a patient's intolerance for an anti-depressant drug, and the inability of the nursing facility, where he was a resident, to obtain a medication that he could tolerate, and the consequences suffered by that patient.

Bob Williams, Executive Director, Kansas Pharmacists Association detailed the history of the Medicaid DUR Board. He drew attention to **SB 410**, see (Attachment No. 6), and suggested an amendment, i.e., paragraph (b), new section 2, changed in regard to the composition of the Board, nominations to be provided by the Kansas Medical Society, Kansas Pharmacists Association, Kansas Osteopathic Association, as well as any other organization who may now or in the future be represented on the DUR Board. He explained. He then further recommended, i.e., lines 13-42 on page 2, the language be stricken, therefore changing paragraph (e) and (f) on page 3 to (c) and (d) respectively. These changes would allow the DUR to maintain flexibility in membership, and by placing the DUR in Kansas Statute, will provide for permanence of this Board. He drew attention to the federal law indicated in his attachment. Noted, if this particular Committee is placed in statute, then certain ethics laws that are applied to other organizations, should be also be used in reference to the DUR Committee as well. He answered numerous questions. It was noted by Mr. Williams, the intent here is, that those appointments would have to be made from the nominations provided by the organizations.

Commissioner Robert Epps, Kansas Department of SRS offered hand-out (see Attachment No. 7). He stated continued opposition for **SB 410**. The Department views **SB 410** as unnecessarily duplicating the federal statute, i.e., Omnibus Budget Reconciliation Act, (OBRA), of 1990. This legislation also adds inappropriately requirements to the federal statute, changes the structure of the longstanding successful Kansas Medicaid DUR Committee. He noted the Kansas Medicaid program has contracted with the Kansas Pharmacy Foundation to provide the DUR Committee.

Commissioner Epps continued. This is a clinical Committee that discusses sometimes sensitive confidential and volatile issues surrounding prescription drug coverage, prescribing dispensing and usage of these drugs. The meetings held are intended to make unbiased and objective medical/pharmaceutical recommendations. He answered questions, i.e., there has been a long standing policy those persons who wish to attend meetings and make presentations may do so by contacting the Committee. He noted since the meetings have been opened up, the Department of SRS feels it has all gone quite well. There is no real problem with continuing in that manner. However, he does continue to oppose **SB 410** because the Department feels legislation is not required for the DUR Committee to continue to function well. Basically, the Department feels this is unnecessary legislation. Yes, the Department does wish to preserve as much as possible, the authority of the Secretary. One large factor used in the Departments decisions is money. The DUR Committee would be looked to to provide high quality, unbiased, ethical, and clinical advice which could then be put into the decision making process. Rep. Epps noted there are numerous (about 20) drugs on prior authorization, it is just the 3 anti-depressant drugs that seem to have caused the most attention and concern.

It was brought out by some members, there is need for more input regarding prior-authorization by those persons offering amendments, since some clarification is needed.

Commissioner Epps stated he would clarify that the DUR process must be under the control of the state, whether or not that is in OBRA 90. Her indicated that the prospective DUR is handled in conjunction with regulation by the Kansas Board of Pharmacy, which requires practicing pharmacists to initiate patient counseling. When asked, Commissioner Epps noted that there had long been a feeling by the professionals on the Committee that they would be subject to additional marketing pressures if the Committee was opened up. However, since the Committee has held open meetings, he is unaware of any such marketing pressure. It was noted, prior utilization in an emergency setting might be a possibility, but Commissioner Epps was unaware of any situation of that kind. He could check into the matter he stated.

HEARINGS CLOSED ON **SB 410.**

Chair drew attention to **SB 550,** and requested Mr. Furse bring members up to date on this legislation.

Mr. Furse indicated proposed changes, noting in **SB 550,** page 1, lines 24-28, in addition to a physician who could certify the birth, the person in charge of the institution where the birth takes place, could also certify, and also, that person's representative.

It was noted **SB 550** when discussed at an earlier meeting this year, it was recommended the Committee minutes be provided so that the Committee action could be reviewed on **HB 2407** , i.e., legislation from 1993 that is identical to **SB 550.** These minutes were not immediately available, so Committee members continued their discussion while the secretary located the minutes from February 23, 1993, (Attachment No. 8), see pages 2-4. The Committee secretary read the minutes that reflected action on **HB 2407,** and this action indicated, i.e., unfavorable consideration, with motions being made by Rep. Sader and Rep. Swall respectively.

During the discussion, it was the view of some members that only the physician should be authorized to sign the document certifying to the birth; physicians are more traceable than hospital staff. It was noted until the birth certificate is filed, errors can be corrected, but once this document is filed, only corrections can be made through a court order. It was noted there was no opposition in the Senate to **SB 550.**

At this point, Rep. Neufeld moved to pass **SB 550** out of Committee favorably and place it on the consent calendar, motion seconded by Rep. Rutledge.

Discussion ensued. Some members still feeling strongly, the document needs to be signed by the physician, not a designee. At this point, Rep. Neufeld and Rep. Rutledge withdrew the part of the motion that would place **SB 550** on the consent calendar.

Discussion continued regarding liability; differences between the document verifying the birth of the baby, and the vital statistic record that is considered the birth certificated. If the certificate isn't signed within the 5 day period, there is a separate procedure for a delayed birth certificate.

Chair asked if there was further discussion. There was none. Chair noted, a vote on the motion was in order. Vote taken, motion carried.

Chair adjourned the meeting at 3:14 p.m. The next meeting is scheduled for March 8, 1994.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 7, 1994

NAME	ORGANIZATION	ADDRESS
Chip Wheelen	KS Med Soc	Topeka
MARGOT GENDREAU	Boehringer Ingelheim	COLUMBIA MO
Brad Smoot	Pfizer Inc	Topeka
HAROLD RIEHM	KAOM	TOPEKA
Nancy Zagleman	Pfizer	KC
John Peterson	Glaxo	Topeka
[illegible]	SRS	Topeka
Sandra Nye	State Farm	Topeka
Gene Stephens	SRS	Topeka
David Tidd	Zeneca	Dallas
Tom Hitchcock	Bd. of Pharmacy	Topeka
Bob Williams	KS Pharmacists Assoc	Topeka

TESTIMONY ON SENATE BILL 410
HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
REPRESENTATIVE KENT GLASSCOCK
March 7, 1994

Madam Chair and members of the Committee, I am appearing today in support of SB 410 which would require that the SRS Drug Utilization Review Committee operate in compliance with the Kansas open meetings law. Actually such a requirement was imposed last year by a proviso attached to the SRS appropriation bill. However since a proviso only operates for one fiscal year, it is necessary to enact SB 410 for those meetings to continue to be open after July 1st of this year.

I support this measure first because I firmly believe in the concept of openness in government.

Furthermore during the past month, as a member of the Appropriations Subcommittee handling the SRS budget, I have learned of the importance of the public being able to attend these meetings. Our Subcommittee was able to recommend cuts of $1,240,000 based on information from the DUR Committee. We learned about these possible savings, not from the agency, but from observers who had attended the DUR Committee meetings.

P Hall
3-7-94
attm #1

Other recommendations of the DUR Committee came to our attention not from SRS staff but from parties attending those meetings, whereupon our subcommittee contacted the Chair of the DUR Committee for direct confirmation of their recommendations.

These meetings being open has benefited our Subcommittee in obtaining facts in order to formulate recommendations. I would urge your support for Senate Bill 410.

PHCW
3-7-94
Attm #1-2
~~Of 2~~ 2

STATEMENT OF THE
PHARMACEUTICAL MANUFACTURERS ASSOCIATION
BEFORE THE
HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
SENATE BILL 410

March 7, 1994

Madam Chair and members of the Committee. My name is Nancy Zogleman and I am appearing before you today as Chair of the Kansas Pharmaceutical Manufacturers Association (PMA) Task Force. I would like to thank you for this opportunity to testify before you today in support of SB 410.

SB 410 deals with drug utilization review under the Kansas Medicaid program. Under the federal Omnibus Budget Reconciliation Act (OBRA 90) passed in 1990 and the federal regulations that followed, each state must have in place a drug utilization board to assist the state by providing educational information on drug usage and by conducting prospective and retrospective utilization review.

The Department of SRS has operated a DUR Committee for many years. However, there is no statutory language providing specifically for its membership or under what rules the committee should operate. Currently, the DUR Committee is operating under a paid contract ($75,000 per year) with the Kansas Pharmacy Foundation. SB 410 would simply codify the membership and authority of the DUR Committee to ensure that it is consistent with the federal requirements of OBRA 90 and also guarantee public access to its meetings.

This bill was proposed last year to clear up some confusion as to whether the meetings of the DUR Committee should be considered public meetings under K.S.A. 75-4317 et. seq., the "Kansas Open Meetings Act". For many years, the DUR Committee meetings have been closed and the public has been denied access. While the committee is merely

HHW
3-7-94
Attm #2

advisory, SRS relies on the expertise of the committee in determining patient and provider access to the multi-million dollar Medicaid pharmacy program.

The Kansas Attorney General has long held that such advisory bodies are subject to the Kansas Open Meetings Act, and last year, he issued an opinion specifying that the DUR Committee must meet in public. (See Kan. Atty. Gen. Op. No. 93-41) SRS questioned the Attorney General's opinion and so the Legislature added a proviso to last year's omnibus appropriations bill which attached the following language to the SRS appropriation:

> "No expenditure may be made by the Secretary of the Department of Social and Rehabilitation Services pursuant to this or any other appropriations act of the 1993 Legislature for or on behalf of the SRS Drug Utilization Review Committee authorized pursuant to K.S.A. 39-7,118 and amendments thereto unless such contract provides that the review committee operate in compliance with the Kansas Open Meetings Act, except that such review committee is hereby authorized to recess for closed or executive meeting in accordance with subsection (a) of K.S.A. 75-4319 and amendments thereto when the review committee is considering matters relating to identifiable patients or provider."

In essence, this proviso provided a trial period to let the sunshine in on the DUR Committee. During this trial period, many interested parties, including representatives of PMA member companies, attended to observe the DUR Committee meetings. Observers do not participate in the committee's discussions and at no time during this period, did any interested party interfere with the committee's deliberations.

As far as we can tell, openness does not harm the DUR Committee but rather enables interested persons to better understand the Medicaid Drug Program and any changes to that program made by SRS. SB 410 would extend an "open" DUR Committee indefinitely without requiring annual provisos in SRS appropriation bills.

PHCW 3-7-94 Attm #2

Section 2 of SB 410 sets out the membership. Currently, the members are appointed by the Kansas Pharmacy Foundation and approved by SRS. Under this current

arrangement, there are no statutory requirements for membership. I urge the committee to adopt the language included in SB 410 which codifies the federal requirements and provides for a professionally balanced membership. Similar membership language was recommended by the Council of State Governments (CSG) in its annual volume of model legislation.

Once again, I appreciate this opportunity to offer testimony and would urge your support of SB 410.

PHW
3-7-94
Attm 2-3
SB 373

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

(f) The board shall not be subject to ~~K.S.A. 75-4317~~ *et seq.* and amendments thereto *in accordance with K.S.A. 75-4319 and amendments thereto may recess for a closed or executive meeting* when it is considering matters relating to identifiable patients or providers.

~~See. 3.~~ *K.S.A. 1992 Supp. 75-4319 is hereby amended to read as follows: 75-4319. (a) Upon formal motion made, seconded and carried, all bodies and agencies subject to this act may recess, but not adjourn, open meetings for closed or executive meetings. Any motion to recess for a closed or executive meeting shall include a statement of (1) the justification for closing the meeting, (2) the subjects to be discussed during the closed or executive meeting and (3) the time and place at which the open meeting shall resume. Such motion, including the required statement, shall be recorded in the minutes of the meeting and shall be maintained as a part of the permanent records of the body or agency. Discussion during the closed or executive meeting shall be limited to those subjects stated in the motion.*

(b) No subjects shall be discussed at any closed or executive meeting, except the following:

(1) Personnel matters of nonelected personnel;

(2) consultation with an attorney for the body or agency which would be deemed privileged in the attorney-client relationship;

(3) matters relating to employer-employee negotiations whether or not in consultation with the representative or representatives of the body or agency;

(4) confidential data relating to financial affairs or trade secrets of corporations, partnerships, trusts, and individual proprietorships;

(5) matters relating to actions adversely or favorably affecting a person as a student, patient or resident of a public institution, except that any such person shall have the right to a public hearing if requested by the person;

(6) preliminary discussions relating to the acquisition of real property;

(7) matters permitted to be discussed in a closed or executive meeting pursuant to K.S.A. 74-8804 and amendments thereto; and

(8) matters permitted to be discussed in a closed or executive meeting pursuant to subsection ~~(j)~~ (a)(2)(J) of K.S.A. 38-1507 and amendments thereto or subsection (f) of K.S.A. 38-1508 and amendments thereto; and

PHW
3-7-94
Attm #3

New Sec. 3. The secretary of social and rehabilitation services may adopt rules and regulations requiring prior approval of prescriptions for certain drugs that may be dispensed to a patient receiving medical assistance or may adopt rules and regulations establishing a restrictive formulary of drugs that may be dispensed to patients receiving medical assistance. Prior to publishing any such proposed rules and regulations, the secretary shall obtain the approval of the medicaid drug utilization review board established under section 2 of this act.

and renumber ensuing sections

amendment drafted by Chip Wheelen
Kansas Medical Society

PHW
3-7-94
Attm #3

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

March 7, 1994

To: Chairperson Flower and Members, House Public Health Committee

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

TESTIMONY ON S.B. 410

Thank you for this opportunity to testify in support of S.B. 410. KAOM thinks this Bill clarifies and make more specific the responsibilities of the drug review program as it impacts upon the Medicaid program, and the Review Board specifically structured in this Bill to carry out those responsibilities.

In Section 1 (a) of the Bill, we think any study of drug utilization, be it over or under utilization, would reach conclusions on both. Though prior authorization is not specifically addressed, we see nothing in the enumerated responsibilities of the Program/Review Board to preclude this as a topic of analysis. It is, in fact, instructed to do so by an Appropriations Subcommittee Report for prospective and retrospective drug utilization review, as specified by OPRA 1990.

In New Sec. 2 we agree with the change in composition of the DUR, offering greater balance between the physician and the pharmacist communities. The impact of such programs as prior authorization, we think, effects most directly the prescribing practices of physicians vis-a-vis the medicaid patients they serve.

We also support the structuring of membership on the Drug Utilization Review Board provided for in New Sec. 2 of the Bill. While there may be some interest in increasing consumer representation on the Board, we think the provided balance between prescribing providers and representatives of pharmacy of practicing and academic has merit. We particularly applaud the specific provision that there be an osteopathic physician on the Board. While there currently is a D.O. on the DUR, this has not always been the case.

Finally, we support Sec. 3 of the Bill which we interpret to be a "sunshine" provisions. Except for the exceptions noted, this will require that meetings of the Board be open meetings in which interested parties may observe the deliberation and process. This Board will be making decisions critical to not only physicians who prescribe drugs for Medicaid Patients but also to many Medicaid consumers. We see little reason why a Board that makes decisions critical to the conduct of a major public policy program should operate outside the provisions of open meetings.

Thank you. I will be pleased to respond to questions.

3-7-94
Attm # 4.

PHILLIPS COUNTY MEDICAL CLINIC
250 W. State 913-543-5211
Phillipsburg, KS 67661-0547

Mark Barber, D.O.
Daryl Callahan, D.O.
Cameron Knackstedt, D.O.
Joseph Roncskevitz, D.O.
Gene Wyse, D.O.
Genny Robben-Rahjes, ARNP

STOCKTON MEDICAL CLINIC
623 S. 2nd 913-425-6791
Stockton, KS 67669

Daryl Callahan, D.O.
Richard Perry, D.O.
Genny Robben-Rahjes, ARNP

October 25, 1993

Harold Riehm
Kansas Association of Osteopathic Medicine
1260 S. W. Topeka Boulevard
Topeka, Kansas 66612

RE: MEDICAID PRIOR AUTHORIZATION FOR ANTI-DEPRESSANT MEDICATIONS

Dear Mr. Riehm:

I have recently had a most unusual exchange with Kansas Medicaid Prior Authorization Authorities in Topeka, Kansas via there phone number 1-800-285-4978. I do not clearly understand which legislative authority oversees the Prior Authorization Department of Medicaid, but I trust that you will.

A patient of mine, Q.N. Medicaid Number 001003402271, was admitted to a local nursing home, September 14, 1993 after an acute care of hospital stay. One of his diagnosis was cerebral vascular accident (stroke) and post stroke depression, confusion, and combativeness. An interesting part of his history is that his acute care hospital stay originated due to a side effect of anti-psychotic medication (Mellaril) causing heart block. This medication had been started for his combative behavior, confusion, and clearly he could not tolerate it. Since this patient had this intolerance to this medication, I chose to place him on a newer anti-depressant (Paxil) which has limited side effects when compared to the older anti-depressants.

Apparently, the Prior Authorization authorities would not allow approval of this anti-depressant pursuant to a new anti-depressant regulation. Since they would not pay for it the medicine was not supplied by the pharmacy to the patient and he subsequently began having increased confusion, combativeness, and depression. When he is in this state he is extremely difficult to manage in the nursing home setting and will frequently try to flee the facility.

I was notified by Witmer Rexall Pharmacy (Steve Schick, RPh) that he had tried unsuccessfully to get approval for Paxil for this patient. He had discussed it with the Prior Authorization authority and had informed them of the patient's previous history and side effects to Mellaril. They told him it would not be allowed. However, if I wanted to continue the patient on this medication that I would have to call the Prior Authorization office in Topeka.

PH&W
3-7-94
Attm #5

On October 19, 1993, 3:20 p.m. I called 1-800-285-4978 and was promptly placed on hold and listened to Topeka radio music for 19 minutes awaiting my call to be taken in turn. I was subsequently cut off and had to re-dial 1-800-285-4978 and was placed on the line for another 10 minutes before my call was received by Jimmie Patty, RN. I discussed the case with her in detail and she informed me that there was no procedure to allow for this patient to be placed on Paxil inspite of his prior history to side effects from other anti-psychotic medication and his clear behavior problems when removed from the drug.

I questioned her at length and in detail as to what procedure could be taken to get this patient placed back on Paxil on an emergency basis, but I was informed that my only recourse was to call Gene Stephens, Director of Pharmacy Prior Authorization (913) 296-3981. I expresed my discontent with the phone delays and the impersonal decision making regarding this patient. Ms. Patty informed me that this was an on-going problem at Prior Authorization and that Mr. Stephens was aware of it and that I should express it to him.

I promptly called Gene Stephens and discussed this case with him. He told me that he thought they had "everything worked out," and he agreed it was unacceptable to have had to hold for 40 minutes before talking with someone from Prior Authorization and that there are emergency procedures available to place patients on anti-depressants. He then told me that he would get back with me. At 5:00 p.m. the same day Mr. Stephens did return my call and relayed to me that mistakes have been made in dealing with this case and the patient would be placed back on Paxil.

Since this whole debacle occured during my busiest part of the day I had to stay at the clinic until nearly 7:00 p.m. to finish seeing patients. If this is the route that we can expect to see on all Medicaid prescriptions, especially medications that have clear advantages (the newer anti-depressants), then prior authorization should directly inform a physician before they remove a patient from a drug. Also, they should have a twenty-hour hotline that will be answered promptly and a staff that is educated on the regulations.

If we practiced medicine like they authorize pharmaceuticals we would have state regulators all over us.

I appreciate your assistance in relaying this to the proper legislative authority so that future regulations will take into account patients needs.

Respectfully,

Daryl J. Callahan, D.O.

DJC/ag

PAW
3-7-94
Attn # 5-2

THE KANSAS PHARMACISTS ASSOCIATION
1308 SW 10TH STREET
TOPEKA, KANSAS 66604
PHONE (913) 232-0439
FAX (913) 232-3764

ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
SB 410

Monday, March 7, 1994

My name is Bob Williams; I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee regarding Senate Bill 410. Senate Bill 410 establishes a Medicaid Drug Utilization Review Board. The State of Kansas has had a Medicaid Drug Utilization Review Board for the past 15 years. As a matter of fact, the State of Kansas was the first state to establish such a program. As a result of the so-called "OBRA 90" legislation passed by Congress, all state medicaid programs are now required by federal law to have drug utilization review programs. The current DUR Committee is more extensive than the recommendation of SB 410 in that there are nine members. The DUR Committee consists of two physicians, one osteopath, one clinical pharmacist, one pharmacologist, three practicing pharmacists and one registered nurse. The DUR Committee is charged with the responsibility of monitoring all clinically appropriate prescribing/dispensing of covered out-patient drugs, as well as drug use review, evaluation and intervention. The DUR Director files an Annual Report with SRS and publishes four newsletters a year which are sent to all prescribers and dispensers in the state.

-over-

PH&W
3-7-94
Attm #6

However, we do suggest the following amendment to SB 410:

Paragraph (b) in new section 2 be changed to read "composition of the Board shall comply with the specifications outlined in the Federal Omnibus Reconciliation Act of 1990 (Public Law 101-508). Nominations for the board will be provided by the Kansas Medical Society, Kansas Pharmacists Association, the Kansas Osteopathic Association as well as any other organization who may now or in the future be represented on the drug utilization and review board."

Lines 13 through 43 on page 2 would be struck changing paragraph (e) and paragraph (f) on page 3 to paragraphs (c) and (d) respectively.

These changes will allow the Drug Utilization Review Board to maintain flexibility in membership. By by placing the Drug Utilization Review Board in Kansas Statute, will provide for permanence of the board.

Thank you.

Attm #6-2
3-9-94

drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

"(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this title by pharmacists which includes at least the following:

"(I) The pharmacist must offer to discuss with each individual receiving benefits under this title or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

"(aa) The name and description of the medication.

"(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

"(cc) Special directions and precautions for preparation, administration and use by the patient.

"(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

"(ee) Techniques for self-monitoring drug therapy.

"(ff) Proper storage.

"(gg) Prescription refill information.

"(hh) Action to be taken in the event of a missed dose.

"(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this title:

"(aa) Name, address, telephone number, date of birth (or age) and gender.

"(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

"(cc) Pharmacist comments relevant to the individuals drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.

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"(B) RETROSPECTIVE DRUG USE REVIEW.—The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1903(r)) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this title, or associated with specific drugs or groups of drugs.

"(C) APPLICATION OF STANDARDS.—The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

"(D) EDUCATIONAL PROGRAM.—The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

"(3) STATE DRUG USE REVIEW BOARD.—

"(A) ESTABLISHMENT.—Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the 'DUR Board') either directly or through a contract with a private organization.

"(B) MEMBERSHIP.—The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

"(i) The clinically appropriate prescribing of covered outpatient drugs.

"(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

"(iii) Drug use review, evaluation, and intervention.

"(iv) Medical quality assurance.

The membership of the DUR Board shall be made up at least ⅓ but no more than 51 percent licensed and actively practicing physicians and at least ⅓ * * * licensed and actively practicing pharmacists.

"(C) ACTIVITIES.—The activities of the DUR Board shall include but not be limited to the following:

"(i) Retrospective DUR as defined in section (2)(B).

"(ii) Application of standards as defined in section (2)(C).

"(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

"(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

"(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

"(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

"(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

"(D) ANNUAL REPORT.—Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

"(h) ELECTRONIC CLAIMS MANAGEMENT.—

"(1) IN GENERAL.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system, for the purpose of performing online, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

"(2) ENCOURAGEMENT.—In order to carry out paragraph (1)—

"(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1903(a)(3)(A)(i) (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

"(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

"(i) ANNUAL REPORT.—

"(1) IN GENERAL.—Not later than May 1 of each year the Secretary shall transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives a report on the operation of this section in the preceding fiscal year.

"(2) DETAILS.—Each report shall include information on—

"(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;

"(B) the total value of rebates received and number of manufacturers providing such rebates;

"(C) how the size of such rebates compare with the size or rebates offered to other purchasers of covered outpatient drugs;

"(D) the effect of inflation on the value of rebates required under this section;

"(E) trends in prices paid under this title for covered outpatient drugs; and

"(F) Federal and State administrative costs associated with compliance with the provisions of this title.

"(j) EXEMPTION OF ORGANIZED HEALTH CARE SETTINGS.—(1) Covered outpatient drugs dispensed by *** Health Maintenance Organizations, including those organizations that contract under section 1903(m), are not subject to the requirements of this section.

"(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

"(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions

described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

"(k) DEFINITIONS.—In this section—

"(1) AVERAGE MANUFACTURER PRICE.—The term 'average manufacturer price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade.

"(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term 'covered outpatient drug' means—

"(A) of those drugs which are treated as prescribed drugs for purposes of section 1905(a)(12), a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

"(B) a biological product, other than a vaccine which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product; and

"(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3) LIMITING DEFINITION.—The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

"(A) Inpatient hospital services.

"(B) Hospice services.

"(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

"(D) Physicians' services.

"(E) Outpatient hospital services * * * *emergency room visits.

"(F) Nursing facility sevices.

"(G) Other laboratory and x-ray services.

"(H) Renal dialysis.

Such term also does not include any such drug or product which is used for a medical indication which is not a medically accepted indication.

"(4) NONPRESCRIPTION DRUGS.—If a State plan for medical assistance under this title includes coverage of prescribed drugs as described in section 1905(a)(12) and permits coverage of drugs which may be sold without a prescription (commonly referred to as 'over-the-counter' drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

"(5) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in—

"(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

"(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

"(6) MEDICALLY ACCEPTED INDICATION.—The term 'medically accepted indication' means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

"(7) MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.—

"(A) DEFINED.—

"(i) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, with respect to a calendar quarter a covered outpatient drug (not including any drug de-

scribed in paragraph (5)) for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'),

"(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed in the State during the period.

"(ii) INNOVATOR MULTIPLE SOURCE DRUG.—The term 'innovator multiple source drug' means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

"(iii) NONINNOVATOR MULTIPLE SOURCE DRUG.—The term 'noninnovator multiple source drug' means a multiple source drug that is not an innovator multiple source drug.

"(iv) SINGLE SOURCE DRUG.—The term 'single source drug' means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributers operating under the new drug application.

"(B) EXCEPTION.—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

"(C) DEFINITIONS.—For purposes of this paragraph—

"(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

"(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

"(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

"(8) STATE AGENCY.—The term 'State agency' means the agency designated under section 1902(a)(5) to administer or supervise the administration of the State plan for medical assistance.".

(b) FUNDING.—

(1) DRUG USE REVIEW PROGRAMS.—Section 1903(a)(3) (42 U.S.C. 1936b(a)(3)) is amended—

(A) by striking "plus" at the end of subparagraph (C) and inserting "and", and

(B) by adding at the end the following new subparagraph:

"(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g); plus".

(2) TEMPORARY INCREASE IN FEDERAL MATCH FOR ADMINISTRATIVE COSTS.—The per centum to be applied under section 1903(a)(7) of the Social Security Act for amounts expended during calendar quarters in fiscal year 1991 which are attributable to administrative activities necessary to carry out section 1927 (other than subsection (g)) of such Act shall be 75 percent, rather than 50 percent; after fiscal year 1991, the match shall revert back to 50 percent.

(c) DEMONSTRATION PROJECTS.—

(1) PROSPECTIVE DRUG UTILIZATION REVIEW.—

(A) The Secretary of Health and Human Services shall provide, through competitive procurement by not later than January 1, 1992, for the establishment of at least 10 statewide demonstration projects to evaluate the efficiency and cost-effectiveness of prospective drug utilization review (as a component of on-line, real-time electronic point-of-sales claims management) in fulfilling patient counseling and in reducing costs for prescription drugs.

(B) Each of such projects shall establish a central electronic repository for capturing, storing, and updating prospective drug utilization review data and for providing access to such data by participating pharmacists (and other authorized participants).

(C) Under each project, the pharmacist or other authorized participant shall assess the active drug regimens of recipients in terms of duplicate drug therapy, therapeutic overlap, allergy and cross-sensitivity reactions, drug interactions, age precautions, drug regiment compliance, prescribing limits, and other appropriate elements.

(D) Not later than January 1, 1994, the Secretary shall submit to Congress a report on the demonstration projects conducted under this paragraph.

(2) DEMONSTRATION PROJECT ON COST-EFFECTIVENESS OF REIMBURSEMENT FOR PHARMACISTS' COGNITIVE SERVICES.—

(A) The Secretary of Health and Human Services shall conduct a demonstration project to evaluate the impact on quality of care and cost-effectiveness of paying pharmacists under title XIX of the Social Security Act, whether or not a drug is dispensed, for drug use review services. For this purpose, the Secretary shall provide for no fewer than 5 dem-

onstration sites in different States and the participation of a significant number of pharmacists.

(B) Not later than January 1, 1995, the Secretary shall submit a report to the Congress on the results of the demonstration project conducted under subparagraph (A).

(d) STUDIES.—

(1) STUDY OF DRUG PURCHASING AND BILLING ACTIVITIES OF VARIOUS HEALTH CARE SYSTEMS.—

(A) The Comptroller General shall conduct a study of the drug purchasing and billing practices of hospitals, other institutional facilities, and managed care plans which provide covered outpatient drugs in the medicaid program. The study shall compare the ingredient costs of drugs for medicaid prescriptions to these facilities and plans and the charges billed to medical assistance programs by these facilities and plans compared to retail pharmacies.

(B) The study conducted under this subsection shall include an assessment of—

(i) the prices paid by these institutions for covered outpatient drugs compared to prices that would be paid under this section,

(ii) the quality of outpatient drug use review provided by these institutions as compared to drug use review required under this section, and

(iii) the efficiency of mechanisms used by these institutions for billing and receiving payment for covered outpatient drugs dispensed under this title.

(C) By not later than May 1, 1991, the Comptroller General shall report to the Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary"), the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the study conducted under subparagraph (A).

(2) REPORT ON DRUG PRICING.—By not later than May 1 of each year, the Comptroller General shall submit to the Secretary, the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and House of Representatives an annual report on changes in prices charged by manufacturers for prescription drugs to the Department of Veterans Affairs, other Federal programs, retail and hospital pharmacies, and other purchasing groups and managed care plans.

(3) STUDY ON PRIOR APPROVAL PROCEDURES.—

(A) The Secretary, acting in consultation with the Comptroller General, shall study prior approval procedures utilized by State medical assistance programs conducted under title XIX of the Social Security Act, including—

(i) the appeals provisions under such programs; and

(ii) the effects of such procedures on beneficiary and provider access to medications covered under such programs.

(B) By not later than December 31, 1991, the Secretary and the Comptroller General shall report to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the results of the study conducted under subparagraph (A) and shall make recommendations with respect to which procedures are appropriate or inappropriate to be utilized by State plans for medical assistance.

(4) STUDY ON REIMBURSEMENT RATES TO PHARMACISTS.—

(A) The Secretary shall conduct a study on (i) the adequacy of current reimbursement rates to pharmacists under each State medical assistance programs conducted under title XIX of the Social Security Act; and (ii) the extent to which reimbursement rates under such programs have an effect on beneficiary access to medications covered and pharmacy services under such programs.

(B) By not later than December 31, 1991, the Secretary shall report to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the results of the study conducted under subparagraph (A).

(5) STUDY OF PAYMENTS FOR VACCINES.—The Secretary of Health and Human Services shall undertake a study of the relationship between State medical assistance plans and Federal and State acquisition and reimbursement policies for vaccines and the accessibility of vaccinations and immunization to children provided under this title. The Secretary shall report to the Congress on the Study not later than one year after the date of the enactment of this Act.

(6) STUDY ON APPLICATION OF DISCOUNTING OF DRUGS UNDER MEDICARE.—The Comptroller General shall conduct a study examining methods to encourage providers of items and services under title XVIII of the Social Security Act to negotiate discounts with suppliers of prescription drugs to such providers. The Comptroller General shall submit to Congress a report on such study no later than 1 year after the date of enactment of this subsection.

Drug Utilization Review Committee 1992 Annual Report

One of the biggest changes in calendar year 1992 was the State's request for a proposal (RFP) for a DUR data sorter. Four bids were received, and First Health Services Corporation of Glen Allen, Virginia, was awarded the contract. First Health receives monthly claims information from Electronic Data Systems (EDS). The information is then run through a complex computer program to provide the DUR Committee with patient profiles that have potential problems. The Committee then reviews these profiles to determine if a letter should be sent to providers. In June the committee began to receive profiles from First Health; below are charts summarizing the activity for 1992.

Number of profiles received:

June - 599 profiles (2,800+ pages)
July - 200 profiles (752 pages)
August - 239 profiles (882 pages)
September - 342 profiles (1,439 pages)
October - 480 profiles (1,741 pages)
November - 419 profiles (1,142 pages)
December - 626 profiles (2,219 pages)

Number profiles warranting letters:	Number of letters sent:	Responses received:
June - 53	June - 66	34
July - 21	July - 25	12
August - 26	August - 27	17
September - 105	September - 126	80
October - 63	October 85	56
November - 37	November - 94	28 as of 1/26/93
December - 96	December 108	52 as of 1/26/93

Prior authorization criteria. During the year, the DUR Committee reviewed the prior authorization criteria for several products. The following is a summary of products reviewed and the committee's recommendations:

Hemophilia products - PA be discontinued
Growth hormone - recommended changes
Rifampin (Rifadin, MMD)- approved changes recommended by the EDS Drug Review Unit
Amiodarone (Cordarone, Wyeth Ayerst) - recommended changes
Cyclosporine (Sandimmune, Sandoz) - recommended prior authorization be removed

New Drug Evaluations. The following products were reviewed by the Committee with the following recommendations:

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New Drug Evaluations. The following products were reviewed by the Committee with the following recommendations:

Nicotine patches - committee recommended that these products not be added to the formulary due to the high cost of the products and low success rate

Anistreplase (eminase, SKB) - recommended it be added to the physician's injection list

Procuren - recommended this be a non-covered product

DTAP - recommended this product be added to the physician's injection list

Carnation nutren - recommended this product be covered under Durable Medical Equipment

Various wound care products - recommended these products be covered under Durable Medical Equipment

Benzodiazepine hypnotics - recommended these be non-covered products

Ace Inhibitor Audit. The Committee worked with the Drug Review Unit to perfect the Ace Inhibitor Audit. This audit identified people taking an ACE inhibitor with potassium and no loop diuretic. After receiving profiles for several months, the audit was turned off, since First Health was identifying this drug interaction in their system.

Narcotic Audit. The committee worked with the Drug Review Unit on this audit to identify potential narcotic abusers. Two audits were in place by October 1991. One identified adults receiving multiple narcotic prescriptions. These were forwarded to the Surveillance Utilization Review (SUR) Unit. The other identified children under one year of age receiving narcotics. Over 100 referrals were reviewed in 1992. 69 letters were sent and 26 responses were received. In November the DUR Committee voted to temporarily turn off this audit since the same physicians were being identified and will consider turning on the audit again in the near future.

Referrals from the SURs Unit. The EDS Surveillance Utilization Review (SUR) referred nine cases to the DUR Committee for input. In several instances the DUR Committee sent a letter to the physician regarding some of the findings by the SURs Unit.

Lock-In Letters. In May 1992, the DUR Committee became involved in the lock-in process. After a recipient had been placed on lock-in, the DUR Committee would send letters to providers informing them of their patient's lock-in status. This was done to increase communication and to prevent recipients from obtaining abusable prescriptions from multiple physicians. In October, pharmacy providers were also included. Throughout the year, 314 lock-in letters were mailed and 120 responses were received (26% response rate). Based on the responses, the lock-in letters were appreciated by providers.

Clozaril Letters. In February 1992, the committee began sending letters to physicians who had prescribed Clozaril for their patients. Throughout the year, more than 100 letters were sent to physicians stating the necessary precautions which needed to be taken. Only two phone calls and one written response have been received. In 1993 the committee will need to evaluate whether these letters should be continued.

Trental Follow-up Study. A follow-up to the 1991 Trental study was completed showing a 33.5% decrease in the number of recipients receiving Trental and a 25.5% decrease in the number of physicians prescribing Trental.

H_2 Follow-Up Study. In 1992 the follow-up to the H_2 study conducted in '91 was completed. The results were as follows: 277 recipients were in the initial study with 267 recipients receiving an H_2 and Carafate/Prilosec and 10 receiving two H_2 antagonists concurrently. In the follow-up of the 267 recipients receiving an H_2 and Carafate/Prilosec, 134 had discontinued the pattern and 107 had continued the pattern. One recipient began taking two H_2s concurrently, and 25 recipients were not able to be followed. Of the 10 recipients in the initial study that were taking two H_2 antagonists concurrently, seven had discontinued the pattern, one continued the pattern, one began taking an H_2 with carafate and one recipient was not able to be followed.

Lincomycin Follow-up Study. In the initial study 80 physicians or physician groups were identified prescribing lincomycin. 40 of the 80 physicians in the initial study continue to bill for lincomycin in the follow-up period. In addition, 43 new physicians or physician groups appeared in the follow-up study that were not in the initial study period. The results of this study signify that lincomycin prescribing continues to be a problem in Kansas, and the DUR Committee will need to continue educating providers on the uses of lincomycin.

NSAIDs follow-up Study. This follow-up study will be completed in 1993.

Educational Programs. In 1992 there were several educational programs on the Kansas DUR program and OBRA 90. Myron Leinwetter, DUR committee member, gave a one-hour presentation at the Kansas Pharmacy Annual Meeting in Lawrence, KS. At seven KPhA district meetings, a brief presentation was given on the DUR program. A handout on OBRA 90 (see attachment) was distributed at all of these programs.

DUR Newsletter. Four issues of the Kansas DUR Newsletter have been sent to providers. Other issues are in the editing process.

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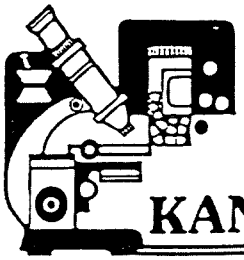

DUR EVALUATION COMMITTEE

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KANSAS DRUG UTILIZATION REVIEW NEWSLETTER

VOLUME 16 January 1994 NUMBER 1

TREATMENT OF TYPE II DIABETES WITH ORAL HYPOGLYCEMIC AGENTS

HISTORY

Currently, there are more than 11 million Americans with diabetes. Over 500,000 new cases are diagnosed each year. Diabetes and its related complications are one of the leading causes of death in the United States. Left untreated, diabetes can effect nearly every organ in the body. Diabetes remains the leading cause of both blindness and amputations. Of the 11 million diabetics, more than 90% are of the type II or non-insulin dependent type (NIDDM).

Diet is the cornerstone of therapy for the type II diabetic. When diet alone fails, pharmacotherapy with an oral hypoglycemic agent (OHA) or insulin may be considered. About 250,000 new patients are treated with sulfonylureas each year. The number of prescriptions written for sulfonylureas is annually in the tens of millions.

MECHANISM OF ACTION

Although the precise mechanisms are unknown, oral agents exert their effect initially by increasing beta cell insulin secretion. Since insulin levels return to pretreatment levels after several months, other actions must explain any continued effect. Sulfonylureas improve beta-cell response to glucose by restoring the acute phase release of insulin. Additionally, OHAs appear to directly increase the number and sensitivity of insulin receptors. Sulfonylureas have no beneficial effect on the glucose tolerance of pancreatectomized or Type I diabetic individuals.

PLACE IN THERAPY

In the early 1970's, the University Group Diabetes Program (UGDP) compared diet alone, diet plus tolbutamide, and diet plus insulin in controlling diabetes. Investigators of the UGDP concluded that treatment with tolbutamide was associated with a higher rate of death from cardiovascular causes. These conclusions led to a significant reduction in the use of sulfonylureas. Questions regarding this study led to the discovery of a number of flaws in its statistical design. In light of these findings, the ADA has rejected the UGDP conclusions and recommends that treatment be individualized for each patient.

Although controversy regarding overall safety and long-term efficacy still exists, OHAs are still preferred by most physicians and patients, particularly since daily injections are not involved. Any type II diabetic who is unable to achieve control with diet alone is a potential candidate for sulfonylureas, however, there are characteristics which may suggest optimal response. Oral agents are generally more effective in those diabetics who are 40 years of age or older with duration of diabetes less than 5 years, whose plasma glucose is only moderately elevated, who are not obese, and who have some functioning beta cells. The choice of insulin versus an OHA is generally between the physician and patient. Many clinicians still advocate starting younger patients on insulin. Elderly patients, individuals with poor eye sight, living alone, or unable to draw up and administer their own insulin should be started on an OHA.

Rec'd 3-7-94 Attn #6-12 ~~Pg. 12~~ 4

CHOICE OF SULFONYLUREAS

There is little evidence that suggests that any OHA is more effective than another in a properly selected patient. However, differences do exist with regard to pharmacokinetics and adverse effects. The older, first generation agents include tolbutamide, chlorpropamide, tolazamide, and acetohexamide. Second generation sulfonylureas, so named because of their higher potency, quicker onset, and generally longer duration of action, include glyburide and glipizide. Various properties of the sulfonylureas are outlined in table II. The highest incidence of side effects is associated with chlorpropamide. Acetohexamide has potent metabolites which may accumulate in renal insufficiency. Routine use of either chlorpropamide or acetohexamide for these reasons may not be warranted. Compliance may be an issue with tolbutamide since it generally requires twice or three times daily administration to achieve adequate glucose control. However, it may represent a safe alternative in patients with renal impairment and in the elderly. Of the first generation agents, tolazamide may be the best choice. It has an intermediate duration of action appropriate for once or twice daily administration without a likelihood of accumulation or severe hypoglycemia. Additionally, its metabolites have only weak hypoglycemic effects.

The second generation agents glyburide and glipizide have a duration of up to 24 hours. It has been argued that these agents promote a greater release of insulin after meals than do the first generation agents. Moreover, they may produce fewer side effects than do the older agents.

The absorption of glipizide is impaired by food. Therefore, it should be taken on an empty stomach. However, since it has such a rapid onset, patients should be instructed to eat within 30 minutes after ingestion. Glipizide has three active metabolites which are renally eliminated. Daily doses in excess of 15 mg should be given on a BID schedule.

Clinically, glyburide has a longer duration of action than glipizide. In addition, glyburide has no active metabolites and can be given without regard to meals. Recently, a new formulation of glyburide with improved bioavailability has been developed. A 3 mg dose of the new formulation is approximately equivalent to 5 mg of the old. However, it is unclear if the improved, more consistent bioavailability translates into significant clinical advantages. At this time, the 3 mg (Glynase) tablets are comparable in cost to other formulations. However, the patent on the old form of glyburide has expired. Despite this, no generic formulations have entered the marketplace in the 18 months since patent expiration. This fact may be related to the difficulty in formulating a consistently bioavailable glyburide product.

ADVERSE EFFECTS OF OHAs

Adverse effects associated with sulfonylureas are infrequent and mild. In general, the type, incidence and severity or side effects are similar with all OHAs. However, some clinicians feel that the second generation agents may be safer. The most common side effects are nausea, diarrhea, and rashes. An Antabuse-like reaction with alcohol is most commonly associated with chlorpropamide but may occur with any first generation agent. Sulfonylureas have been rarely associated with a variety of hematological side effects. All OHAs may cause hypoglycemia. Symptoms of hypoglycemia may be prolonged with chlorpropamide or glyburide. Other rarely reported reactions include SIADH, hepatotoxicity, Wernicke's encephalopathy, and hypothyroidism.

PRIMARY & SECONDARY FAILURE

About 60% of symptomatic patients with NIDDM receiving OHAs in addition to appropriate diet are able to achieve satisfactory control. Those 40% who fail to attain adequate control are categorized as primary failures. These patients require re-evaluation and treatment with more intensive education and/or insulin. Of patients who gained diabetic control initially, subsequent or secondary failure may be expected in about 25% of patients per year of treatment. Long term control is maintained in only about 20-30% of patients.

COMBINATION INSULIN & OHA

Several trials have attempted to improve diabetic control in NIDDM by combining insulin and sulfonylureas. Improvement in glucose control may be noted in 60% of patients. However, beneficial effects are diminished or may be lost by six months. Other drawbacks include increased costs, complex regimens, and a higher incidence of hypoglycemia.

The addition of an OHA may be beneficial in a NIDDM patient requiring over 100 U of insulin daily. Combining therapy may minimize the weight gain and atherogenesis associated with hyperinsulinemia in these patients.

TABLE II. ORAL HYPOGLYCEMIC AGENTS

Generic (Trade)	Onset	Duration	Dosage/Day Adult	Elderly	Max
Tolbutamide (Orinase)	1 hr	6-12 hr	1-2 gm	0.5-1 gm	2-3 gm
Acetohexamide (Dymelor)	1 hr	10-14 hr	.25-1.5 gm	125-250 mg	1.5 gm
Tolazamide (Tolinase)	4-6hr	10-14 hr	100-250 mg	100 mg	750 mg-1gm
Chlorpropamide (Diabinese)	1 hr	72 hr	250 mg	100 mg	500 mg
Glyburide (Diabeta, Micronase)	1.5 hr	24 hr	2.5 mg*	1.25-2.5 mg*	20 mg*
Glipizide (Glucotrol)	1 hr	10-24 hr	5 mg	2.5-5 mg	40 mg

* Approximately 60% of the dosage would achieve similar effect for Glynase™ (UpJohn)

PH+W 3-7-94 6-14 attm

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

HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE
TESTIMONY ON SENATE BILL 410
CREATING A MEDICAID DRUG UTILIZATION REVIEW BOARD

March 7, 1994

****

The SRS Mission Statement:
"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others.

****

Madam Chairman and members of the committee, on behalf of Secretary Donna L. Whiteman, I thank you for the opportunity to speak on 1993 Senate Bill 410. The Kansas Department of Social and Rehabilitation Services continues to oppose the passage of Senate Bill 410 because it unnecessarily duplicates the federal statute known as the Omnibus Budget Reconciliation Act (OBRA) of 1990. It also inappropriately adds requirements to the federal statute, and changes the structure of the longstanding successful Kansas Medicaid Drug Utilization Review Committee.

Federal Law (OBRA 90) requires that a Drug Utilization Review (DUR) system incorporating both restrospective DUR (with historical paid claims data) and prospective DUR (performed by the pharmacist counseling the patient before dispensing the prescription) be in place by January 1, 1993. The Kansas Board of Pharmacy has had a regulation requiring pharmacists to initiate patient counseling as a matter of routine; thus the Kansas Medicaid Program is in compliance with the prospective DUR requirements.

For the retrospective review requirements, the Kansas Medicaid Program has contracted with the Kansas Pharmacy Foundation since 1976 to provide a Drug Utilization Review Committee. This is a clinical committee which discusses the sometimes sensitive, confidential, and volatile issues surrounding prescription drug coverage, prescribing, dispensing, and usage. The committee meetings are intended to make unbiased and objective medical and pharmaceutical recommendations. Over the years, this committee has provided reviews of prescribing, dispensing and usage habits, based on medical and pharmaceutical expertise, free of marketing and advertising influence.

The federal statute requires that the committee be composed of licensed physicians (33 1/3 to 51%), and licensed pharmacists (at least 33 1/3%). The DUR process must be under the control of the state Medicaid Program; however, it may be contracted out, as Kansas has done. The committee is a working group of professional drug usage evaluators who have the knowledge and expertise to research the pertinent literature, and/or to request personal presentations, as needed.

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Attm # 7

The DUR Committee is composed of nine voting members, including three medical Doctors and one Osteopathic Physician. As required under the contract with the Kansas Pharmacy Foundation there is an Internal Medicine specialist as the Chair, a Family Practitioner, a Pediatrician, and a Pharmacologist. There is also a nursing home Nurse representative, and four Pharmacists, including three dispensing Pharmacists from different practice settings and a Clinical Pharmacist from Kansas University Medical Center. The DUR Program Director is also a registered Pharmacist. We feel this is a satisfactory level of DUR consultants to be charged with the responsibilities for the DUR process.

There is no federal requirement that the public or the pharmaceutical industry be included in the process, nor that any portion of the meetings be open to the public. The Division of Medical Services, however, schedules a routine quarterly meeting with industry representatives to ask for their input, and to discuss issues of mutual interest.

The Drug Utilization Review Committee's monthly meetings have been open to the public and to the pharmaceutical industry since July, 1993. This action was taken to comply with the Omnibus Appropriation bill (1993 Senate Bill 437) proviso which required the Committee to conform to the Kansas Open Meetings Act.

The essential feature of the drug utilization review process that is missed by the proponents of Senate Bill 410 and the Omnibus proviso is that SRS Medicaid officials, not the DUR Committee, are the decision makers on all pharmaceutical issues. SRS officials rely on information from various sources for decision making purposes. It is essential that one of these sources, the DUR Committee, be free from sales and marketing bias so that objective pharmaceutical decisions can be made. We urge this Committee to recommend Senate Bill 410 unfavorable for passage.

Robert L. Epps
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Income Support/Medical Services
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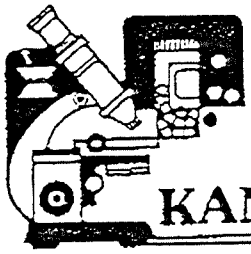
Attm #7-2
~~SB 295~~
SB 65

D.U.R.

DUR EVALUATION COMMITTEE



KANSAS DRUG UTILIZATION REVIEW

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* Voting members

RRLL
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Attn = 7-3
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J:COMM-LST 1/94

Approved:_____
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on February 23, 1993 in Room 423-S of the Capitol.

All members were present except:
Representative Tom Bishop, excused

Committee staff present: Emalene Correll, Legislative Research Department
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Representative Everhart
Robin Robinson
Mrs. Robinson
Dr. Loren Phillips, State Registrar for office of Vital Statistics
Director of Division of Information Systems,
Department of Health and Environment
Tom Bell, Kansas Hospital Association
Gary Stotts, Secretary of Corrections

Others attending: See attached list

Chair called the meeting to order.

The Chair drew attention to one set of minutes from February 17. She urged members to read them, and if there are corrections call the secretary of the Committee by 5:00 p.m. tomorrow (February 24), otherwise these minutes will be recorded approved as presented.

Chair called attention to a letter that had been sent to Dr. Harder today. See (Attachment No.1). The Chair stated she wants the Committee to be privy of what was said, how questions were raised in regard to the physical therapy licensing, registration, and scope of practice issues that the Committee has been dealing with.

Representative Heineman could not schedule an appearance for testimony again today on HB2343.

Chair drew attention to the agenda and requested a staff briefing on HB2203.

Dr. Wolff gave a comprehensive explanation of HB2203, that relates to adoption of a child born and adopted in a foreign country, i.e., the State register, upon request, shall complete a birth certificate on the receipt of a document concerning the adoption approved by Immigration and Naturalization Service of the U.S. Department of Justice, and also along with that will be certain documented proof required of the adoption of the child.

Approved
3-7-94
Attm #8

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 423-S Statehouse, at 1:30 p.m. on February 23, 1993.

CHAIR OPENED HEARINGS ON HB 2203.

Representative Everhart offered hand outs, (Attachment No. 2, her written testimony, 2-A, a memorandum of a court order, 2-B, Romanian birth certificate form #127469, 2-C Romanian birth certificate form #127490.) Rep. Everhart stated she requested this legislation in order to respond to a situation faced by Mr. and Mrs. Robinson's problems in trying to obtain Kansas birth certificates for their two children born in Romania. The birth certificates obtained in Romania are inaccurate, This couple is requesting Kansas birth certificates for their 2 adopted children. She stated the local court says they cannot re-adopt children that are already adopted, therefore a Kansas birth certificate cannot be issued. Mr. and Mrs. Robinson are hopeful this situation can be rectified by the passage of HB2203. .

Mr. Robin Robinson stated Representative remarks by Rep. Everhart covered the situation regarding their quest for birth certificates for their two adopted children born in Romania. He detailed problems they have faced with a court decision in Shawnee County that disallows re-adoption. He stated they are in possession of Naturalization papers for the children and feel that a birth certificate issued in this state would also be beneficial for the children, should they need to produce this document later in their lives. A great deal of time and money has been spent trying to resolve this issue.

Mrs. Robinson related much the same story. She is concerned that if something should happen to the one copy of the Romanian birth certificate, they would be unable to obtain other documents that require a birth certificate. She detailed problems they experienced in Romania.

Dr. Phillips, State Registrar of Vital Statistics, offered hand out (Attachment No.3). He detailed the fundamental principle in recording vital statistics, and noted the few exceptions, i.e., when a child is born in another state or country, and adopted in Kansas, they can be issued a Kansas birth certificate. (K.S.A.65-2423 (b). He stressed concerns with HB2203, i.e., to issue a birth certificate to a foreign born child, adopted in a foreign country, the state will be opening itself up for a major source of fraud. He noted that Immigration and Naturalization Services agrees with this point. He is concerned that Kansas would become a dumping ground for anyone who simply wanted to say they had adopted a child. This could open the potential for fraud and kidnapping. Without constraints, there is nothing to prevent an individual filing a birth certificate in several states, setting up a system of identification for a kidnap victim, possibly collecting public assistance, getting a driver's license. In his discussions with the Department of Immigration and Naturalization, he noted, there are no forms or documents or formal process in place that deals with a foreign born, foreign adopted child. It is his understanding that Rep. Everhart has some other ideas, and he noted the Department will be willing to take a look at other suggestions. He stated, the fundamental point he was trying to make is, the civil registration system that is in place in this country is based on certain premises, i.e., that the event that occurred is registered in the jurisdiction in which the event took place.

Chair opened the meeting to questions of conferees on HB2203. It was determined that naturalization papers are most often sufficient. Rep. Mayans related his personal story , he is now a naturalized citizen, has a valid driver's license, and found that naturalization papers are adequate documents to obtain a passport.

The birth certificate for a foreign born child was explained: it was determined there are two other states that allow a birth certificate for a foreign born, foreign adopted child, Iowa and Georgia. It was determined there have been other similar cases that have been ruled in a different manner, in other areas, that have allowed re-adoption proceeding in the state of Kansas, then permitting the issuance of a Kansas birth certificate. The questions was raised to Mr. and Mrs. Robinson if they planned to appeal the decision of the Judge in Shawnee County. They replied they do not plan to do so.

CHAIR CLOSED HEARINGS ON HB2203.

Chairperson Flower requested a staff briefing on HB2407.

Dr. Wolff gave a comprehensive explanation of HB2407.

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Attm #8.2
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HEARINGS BEGAN ON HB 2407.

Dr. Loren Phillips offered hand out, (Attachment No.4), stated that HB2407 had been requested by the Department of Health and Environment and he detailed rationale. He detailed the process of vital statistics used by the state of Kansas and noted, Kansas is regarded Nationally as the most automated vital statistics system in the United States. He stated a record can be generated in 12 seconds, however, there is a log jam at hospitals because the physicians are not getting the documents signed and sent on for the record keeping process. Currently there is no statutory authority for anyone other than the attending physician to sign the birth certificate if the birth occurs in an institution. The proposed legislation would allow a designated representative to certify that the birth did in fact take place in the hospital. He urged support.

Tom Bell, Kansas Hospital Association, (Attachment No. 5), stated support for HB2407. This legislation would in certain situations help to unclog the system and get the records on the bureau sooner. He urged support.

Numerous questions were posed, i.e., hospitals could make requirements of the attending physicians that these medical records be completed within the required time frame. It was noted it could be required, however enforcing this rule may be another matter. It appears to some members, this is an internal hospital matter, not a matter for the legislature to make a ruling.

CHAIR CLOSED HEARINGS ON HB2407.

Chair requested a staff briefing on HB2223.

Mr. Furse gave a detailed explanation of HB2223, drawing attention to a hearing scheduled previously on this legislation related to smoking in the Capitol. He noted, at an earlier date, the Committee had amended sub section (b) from HB2223 into HB2136 which was presented to the House and amended again by the House. It was suggested hearings be re-scheduled on HB2223 in order that those individuals involved with other state buildings might have an opportunity to present their testimony.

CHAIR OPENED HEARINGS ON HB2223.

Mr. Stotts, Secretary of Kansas Department of Corrections offered hand out (Attachment No.6). He stated the Department of Corrections views HB2223 as being consistent with the direction in which they are currently headed. At present, smoking is restricted to varying degrees within correctional facility offices, living units and other buildings. They have decided it will be in the best interest of everyone to apply a non-smoking policy throughout the corrections system. Reports regarding second hand smoke are startling. The Corrections Department will use the target date set out in the language in HB2223 (July, 1995), as their goal to implement this plan. They feel a policy of this type can be implemented effectively, if adequate lead time is allowed. There are programs currently being planned.

For the record, Mr. David Sofferin, Administrator's office, Topeka State Hospital was scheduled as a conferee, but did not appear.

Chair opened the meeting for questions from Committee members.

Numerous questions were asked, i.e., it was noted there is one warden who has accepted the responsibility of drafting a plan for non-smoking. The Corrections Department does not know where they will begin to implement such plans, or when, but plans are beginning to form and they feel it will work. Mr. Stotts noted, inmates are allowed to smoke outside; Corrections does not use cigarettes for earned privileges; counseling will be provided for both employees and inmates; it is hoped this program can be implemented without additional cost, but that is still an unknown factor. The state of Conneticut had implemented a plan of this type, but it did not work well because tobacco products then became contraband. It is agreed there will be problems with implementation, but the Department is confident programs of this kind can work.

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Mr. Stotts also indicated many states are looking at developing plans for programs that will curtail smoking in correction facilities. In the long run this type of a program will be the best for everyone. He noted Kansas Department of Corrections had begun a program before this letislation was introduced. If HB2223 passes in its current form with the July, 1995 date, that will be the target date the Department will strive to achieve for implementation.

CHAIR CLOSED HEARINGS ON HB2223.

Chair drew attention to HB2407, heard earlier this date, regarding vital statistics records from the hospitals, and suggested final action, if that is the wish of Committee.

Rep. Sader moved to report HB2407 adversely, seconded by Rep. Swall. No Discussion. Vote taken. Motion carried.

Chair adjourned the meeting at 2:55 p.m.

The next meeting is scheduled for February 24, 1993.

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Attach # 8-4