Approved: March 3, 2011
Date

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:00 p.m. on February 17, 2011, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Karen Braman, Kansas Health Information Exchange, Inc.
Jeff Ellis, Spencer Fane Britt Browne
Martie Ross, Spencer Fane Britt Browne
Tom Bell, Kansas Hospital Association
Jerry Slaughter, Kansas Medical Society
Pat Hubbell, Kansas Pharmacists Association
David Root, Medco Health Solutions, Inc., and Affiliates

Others attending:
See attached list.

The Chair asked for approval of the minutes for January 31, 2011, February 3, 2011, February 7, 2011, and February 8, 2011. Moved by Senator Kelsey, seconded by Senator Brungardt. The minutes were approved as submitted.

The Chair opened the hearing on **SB 141—Concerning the Department of Health and Environment, relating to school-located influenza vaccination programs**. This bill would require the Kansas Department of Health and Environment (KDHE) to apply for federal grants under the federal Patient Protection and Affordable Care Act to fund, promote, and expand school-located influenza vaccination programs to provide seasonal influenza vaccinations for school-age children. It would also require KDHE to provide community transformation grants, public health promotion outreach and education programs and would require that the KDHE website include information regarding federal grant opportunities available under the federal Act.

Dan Murray, speaking for MedImmune and Scott Brown who was unable to attend, briefly outlined what this legislation would accomplish and then stood for questions (Attachment #1). Written testimony also in favor of this legislation was provided the committee by Dr. Ellen Losew (Attachment #2) and Cathy Harding, Executive Director for the Kansas Association for the Medically Underserved (Attachment #3).

Dr. Robert Moser, Acting Secretary for the Department of Health and Environment, presented testimony in opposition to **SB 141**. He stated that his Agency has three areas of concern: (1) Mandating the application of funding would limit the agency's ability to prioritize other needs with potentially greater and longer lasting benefit to the State; (2) school-based vaccination programs, while having merit, are not the ideal model for child immunizations; and (3) the Agency does not yet have a full understanding of the requirements on states applying for the grants (Attachment #4).

Written testimony, also in opposition to this bill, was introduced from Carolyn Gaughan, Kansas Academy of Family Physicians (Attachment #5).

There being no further conferees, the hearing on **SB 141** was closed.

The minutes of the Public Health and Welfare Committee at 1:00 p.m. on February 17, 2011, in Room 546-S of the Capitol.

The hearing on **SB 133—Health information; technology and exchange of health information** was opened by the Chair. This legislation would enact the Kansas Health Information Technology and Exchange Act. This would enact state privacy provisions similar to those contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patient information held by and accessed through a Health Information Organization. The purpose is to harmonize state law with the HIPAA privacy rule in order to safeguard and protect the health information and facilitate the development and use of health information technology and exchange.

Karen Braman, Chair, Kansas Information Exchange Board of Directors, stated that passage would provide the tools needed to establish policy necessary for the reliable and secure exchange of health information and create the legal clarity that will encourage health care providers to fully participate in the health care environment of the future (Attachment #6).

Jeffrey O. Ellis, Legal Work Group, noted that the group was comprised of 28 lawyers from around the state who were primarily engaged in representing health care providers or who served on the legal staff of state agencies that regulate the health care industry. This group then achieved a consensus which resulted in the proposed legislation (Attachment #7)

In favor of this legislation was Martie Ross, an attorney who specializes in health information law, was one of the participants in the Legal Work Group. She provided a detailed explanation of the Kansas Health Information Technology and Exchange Act (K-HITE) provisions, specifically stating that it would employ a five-part strategy: (1) harmonize Kansas law with HIPAA Privacy Rule; (2) adopt uniform rules regarding identification of personal representatives for health-related matters; (3) establish standards for approved HIOs; (4) provide individual notice and opportunity to opt out of disclosures to an HIO; and (5) amend the Uniform Electronic Transactions Act to include health-related transactions (Attachment #8).

Tom Bell, Kansas Hospital Association, believes this legislation would provide much needed recognition of new electronic health records and exchange technology, clarify rules around its secure use and articulate a patient's ability to access and control information (Attachment #9).

Representing the Kansas Medical Society, Jerry Slaughter stated that **SB 133** was a critical component of our state's effort to establish a secure and highly functional health information exchange (Attachment #10).

Submitting written testimony in support of this bill was Gary Robbins, Kansas Optometric Association (Attachment #11), Dr. Robert Moser, Acting Secretary, Kansas Department of Health and Environment (Attachment #12), Dennis Lauver, Salina Area Chamber of Commerce (Attachment #13), Catherine Davis, Kansas City Quality Improvement Consortium (Attachment #14), Kenneth C. Mishler, Kansas Foundation for Medical Care, Inc. (Attachment #15), Bob Williams, Kansas Association of Osteopathic Medicine (Attachment #16), Claudia Blackburn, Sedwick County Health Department (Attachment #17), Maren Turner, AARP (Attachment #18), Carolyn Gaughan, Kansas Academy of Family Physicians (Attachment #19), Ron Brown, Wichita Health Information Exchange (Attachment #20), Edie Snethen, Kansas Association of Local Health Departments ((Attachment #21), and Michael F. Larkin, Kansas Pharmacists Association (Attachment #22).

There being no further conferees, the hearing on **SB 133** was closed.

The Chair then opened the hearing on **SB 138—Pharmacy audit integrity act**. This bill would create the Pharmacy Audit Integrity Act. The bill includes the procedures that an agency conducting a pharmacy audit on behalf of an insurance company or pharmacy benefits manager would be required to follow. The agency conducting the audit would be required to provide a copy of the final report, including any money recouped in the audit, to the plan sponsor and the State Board of Pharmacy. It would apply to contracts entered into, amended, extended, or renewed on or after January 1, 2011 but would not apply to any investigative audit that involves allegations of fraud or willful misrepresentation.

Pat Hubbell, member of the Board of Trustees of the Kansas Pharmacists Association stated that **SB 138** seeks common sense principles giving the audited pharmacy at least two weeks written notice before conducting an initial audit, limiting the period covered by the audit to two years, identifying times of

The minutes of the Public Health and Welfare Committee at 1:00 p.m. on February 17, 2011, in Room 546-S of the Capitol.

high-volume prescriptions as off-limits for conducting an audit, and basing the audit on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar order or refills for similar drugs (Attachment #23).

Robert Wenzl, Kansas Independent Pharmacy Service (Attachment #24) and Brian West (Attachment #25) submitted written testimony in favor of this bill.

Speaking in opposition to the bill, David Root, Medco Health Solutions, Inc., and Affiliates stated he felt this legislation was unnecessary and would lead to increased opportunities for fraud, wasteful spending in health care (Attachment #26),

Allen Horne, CVS Caremark (Attachment #27), Marlee Carpenter, Kansas Association of Health Plans (Attachment #28), and Stacey Fahrner, Prime Therapeutics (Attachment #29) all presented written8 testimony in opposition to **SB 138.**

There being no further testimony, the hearing on **SB 138** was closed.

The next meeting is scheduled for February 21, 2011.

The meeting was adjourned at 2:30 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: Thursday, February 17, 2011

NAME	REPRESENTING
Chad Austin	KHA
Eli House	Washburn Un.
Sara Nuiswanger	KCHP
Matt Coss	BTA
Bret Arnold	Pinegar + Smith
Danna Newton	Intern KU
John Kieffaber	Ks. Chiropractic Assn.
MIKE LARKIN	KS PHARMACISTS ASSN
Pat Hubbell	KPLA
Karen Braman	KHIE, Inc.
Martie Ross	KHIE, Inc.
JEFF ELLIS	KHIE, INC.
Robert Moser	KDHE, Sec
Sky Weste-lund	KNASW
Dan Elliott	KAMU
Sarah Hansen	KS Assn. of Addiction Professions
Kenneth Mishler	KS Foundation for Medical Care
Tim Bell	KHA

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: 2-17-2011

NAME	REPRESENTING
Gary Robbins	KsDpt SRS
[illegible]	KNASW
[illegible]	KID
LeAnn Bell	KHI
Carrie Clayton	Cerner
Kari Bruffett	KDHE
Aaron Dunker	KDHE
Deb Stidham	SRS
Sue Bowden	KDHE
Bob Williams	Ks. Assoc Osteopathic Medicine
Nancy Zogleman	Polsinelli
Larrie Ann Brown	MedCo
David Root	
Julie Hein	Hein Law Firm
Leigh Keck	Capitol Strategies
Bud Burke	Lilly USA
Terry Slaughter	KMS
Colin Thomasset	ACMHCK

MedImmune

SCHOOL-LOCATED INFLUENZA VACCINATION PROGRAMS FOR CHILDREN

Minimizing the Threat of Influenza through School-Located Influenza Vaccination (SLIV) Programs

School-based influenza vaccination programs not only help protect children from seasonal influenza and reduce absenteeism, but they also can help reduce the spread (and cost) of influenza in the community. School-based programs also help improve pandemic preparedness.

Low Flu Vaccination Rates Leave Children Unprotected

- Children and young adults 5 years to 19 years of age are 3 to 4 times more likely to be infected with influenza than adults, and these school-aged children are the major carriers, spreading the virus to other children, adults and the elderly, which causes a substantial socioeconomic impact.[1]
- Every year in the United States, on average, more than 200,000 people are hospitalized from influenza-related complications and about 36,000 people, mostly in the elderly, die from influenza-related causes.[2]
- The best way to help prevent seasonal influenza is by getting a vaccination each year. The U.S. Centers for Disease Control and Prevention (CDC) recommends annual seasonal influenza vaccination for all eligible persons in the U.S., including eligible children aged 6 months to 18 years.[3]
- Despite the CDC recommendation, vaccination rates for school-aged children are extremely low, ranging from 24.6% (healthy) to 34.7% (high-risk) in the 2008-09 influenza season.[4]
- Because of the seasonal nature of flu and the relatively short amount of time to vaccinate, most children do not receive vaccines during routine pediatrician visits.[5]
- The CDC's Advisory Committee on Immunization Practices (CDC/ACIP) recommends the influenza vaccine should be offered to all children as soon as the vaccine becomes available before the start of the season and should continue throughout the entire influenza season.[6]

The CDC and American Academy of Pediatrics (AAP) Recommend School-Located Vaccination Programs as a Way to Increase Vaccination Rates[7]

- To increase seasonal influenza vaccination rates, stakeholders have explored new immunization strategies, including the routine vaccination of school-aged children in schools.[8] Mass vaccination programs in schools have demonstrated both direct benefits to immunized children and indirect benefits to the community including the potential for reduced school absenteeism due to influenza.[9,10,11]
- Studies have shown a reduction in influenza illness in vaccinated school children,[12,13] a reduction in illness in school staff with vaccinated children[12] and a reduction in influenza-related office visits and medications in vaccinated students.[11]
- High absenteeism can occur during peaks of influenza activity.[14] A 2001 prospective survey study showed school absenteeism was greater during influenza season as compared before influenza season.[14]
- School closures can be triggered by illness-related absenteeism, usually when local officials have decided that high absenteeism has hindered the school's ability to function normally.[15]
- School-located vaccination programs have yielded vaccination rates ranging from 20% to nearly 70%.[16,17,18]
- Previous research has demonstrated that increased vaccination of children could modulate the spread of influenza in the community.[19,20]

Helping To Ensure Pandemic Preparedness

- In light of the recent Influenza A (H1N1) pandemic, U.S. vaccination plans calls for the immunization of an unprecedented number of children, potentially in the school setting. Over 28% of enrolled students were vaccinated through publically funded 2009 H1N1 School-Located Vaccination programs, according to the Office of Inspector General (OIG) at the Department of Health & Human Services.[21]
- Establishment of a school-located infrastructure for routine seasonal influenza vaccination would enhance the public health and the nation's pandemic preparedness by providing a familiar and accessible place and a practiced protocol for vaccination against influenza.

MedImmune

SCHOOL-LOCATED INFLUENZA VACCINATION PROGRAMS FOR CHILDREN

References:

(1) Neuzil KM, et.al. Illness among schoolchildren during influenza season: effect on school absenteeism, parental absenteeism from work, and secondary illness in families. Arch Pediatr Adolesc Med 2002; 156: 986-991. **(2)** Thompson, W, et al. Mortality associated with influenza and respiratory syncytial virus in the United States. JAMA. 2003; 289: 179-186. **(3)** At http://www.cdc.gov/flu/professionals/acip/primarychanges.htm , November 25, 2008. **(4)** Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010 *MMWR*. 2010; 59; RR-8: 30, Table 3. **(5)** Centers for Disease Control and Prevention – 2010-11 Influenza Prevention & Control Recommendations, Influenza Vaccination Coverage Levels; http://www.cdc.gov/flu/professionals/acip/coveragelevels.htm **(6)** Centers for Disease Control and Prevention. Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010 *MMWR*. 2010; 59; RR-8: 33-34. **(7)** American Academy of Pediatrics Committee on Infectious Diseases. Policy Statement. Prevention of Influenza: Recommendations for Influenza Immunization in Children, 2008-2009. *Pediatrics*. 2008;122:1135-1141. **(8)** Longini IM and Halloran ME. Strategy for distribution of influenza vaccine to high-risk groups and children. Am J Epidemiol 2005; 161: 303-306. **(9)** Principi N, et al. Socioeconomic impact of influenza on healthy children and their families. Pediatr Infect Dis J. 2003:22:S207-10. **(10)** Wiggs-Stayer KS, et al. The impact of mass immunization on school attendance. J School Nursing. 2006;22:219-222. **(11)** Davis MM, King JC, Moag L, et. al. Countywide school-based influenza immunization: direct and indirect impact on student absenteeism. *Pediatrics* 2008;122:e260-e265. **(12)** Rudenko, LG, et al. Efficacy of Live Attenuated and Inactivated Influenza Vaccines in Schoolchildren and Their Unvaccinated Contacts in Novgorod, Russia. *JID*. October 1993;168. **(13)** Ghendon YZ, Kaira AN, Elshina GA. The effect of mass influenza immunization in children on the morbidity of the unvaccinated elderly. *Epidemiol Infect*. 2006;134:71-78. **(14)** Neuzil KM, Hohlbein C, Zhu Y. Illness among schoolchildren during influenza season: effect on school absenteeism, parental absenteeism from work, and secondary illness in families. *Arch Pediatr Adolesc Med*. 2002;156:986-991. **(15)** Centers for Disease Control and Prevention. Impact of seasonal influenza-related school closures on families—Southeastern Kentucky, February 2008. *MMWR*. 2009;58:1405-1409. **(16)** Data on File. MedImmune, LLC. Gaithersburg, Md. **(17)** Wiggs-Stayner KS, Purdy TR, Go GN, et al. The impact of mass school immunization on school attendance. *J Sch Nurs*. 2006;22:219-222. **(18)** Mears CJ, Lawler EN, Sanders LD, Katz BZ. Efficacy of LAIV-T on absentee rates in a school-based health center sample. *J Adolesc Health*. 2009;45:91-94. **(19)** Ghendon, YZ, Kaira, AN & Elshina, GA. The effect of mass influenza immunization in children on the morbidity of the unvaccinated elderly. Epidemiol. Infect. (2006), 134, 71–78. **(20)** Monto, AS, Davenport, FM, Napier, JA et al. Modification of an outbreak of influenza in Tecumseh, Michigan by vaccination of schoolchildren. The Journal of Infectious Disease. 1970; 122: 16-25. **(21)** Department of Health & Human Services Memorandum Report: 2009 H1N1 School-Located Vaccination Program Implementation OEI-04-10-00020 – Office of Inspector General (OIG) Survey Analysis of H1N1 SLV data, 2010. June 16, 2010, p12. http://oig.hhs.gov/oei/reports/oei-04-10-00020.pdf

To Whom It May Concern-

As a rural Kansas pediatrician, I would like to voice my support for SB141. Influenza is an important disease and needs to be more widely discussed in our state in order to increase education and prevention.

Many people realize that widespread vaccination has greatly diminished the spread of what were once deadly childhood illnesses. Diptheria, polio, even meningitis from Haemophilus bacteria are now rarely encountered. Unfortunately, the public, and even many healthcare workers, do not realize that influenza is even more deadly than these now rare illnesses. We commonly hear of deaths from pertussis (whooping cough), which may kill a few hundred children per year. The public does not realize that influenza is actually the most deadly of ALL the vaccine preventable illnesses- causing over 36,000 deaths in the United States alone each year. Even more costly, approximately 200,000 hospitalizations and over 15 million infections are attributed to influenza in the U.S. each year!

How is influenza spread? It is spread through respiratory secretions, coughing, sneezing, runny nose, etc. Who are the largest culprits in this action? I'm a pediatrician- let me tell you- it's kids!! We laugh about how easily children spread germs, but it is true! Children are the most important vector in spreading influenza. Children also produce more viral particles and are capable of shedding more virus than an adult. If one stops to think about the many people a typical school-age child comes into contact with it can be sobering to think of the "shed and spread" capabilities: other children in school, teachers, day-care providers, siblings, parents, grandparents, other family members, etc.

The best way to stop the spread is to prevent the illness!

It is widely known that influenza vaccination is effective in preventing the spread of illness. Routine vaccination of school-age children has been shown in many studies throughout the world to be effective in preventing influenza infection across society as a whole! School vaccine programs are effective and an excellent opportunity to vaccinate otherwise healthy children who may not have an opportunity to visit with a doctor or clinic. High risk children, and adults, should be encouraged to continue vaccination as well.

Thank you for your concern for the health of the children of Kansas. Increased education and disease prevention statewide is exciting for those of us "in the trenches." Please consider SB141 to help improve the health of the children we serve.

Sincerely,
Ellen Losew, M.D., F.A.A.P.
Hutchinson Clinic Pediatrics
Hutchinson, Kansas

Ellen Losew, M.D., F.A.A.P.
Hutchinson Clinic
2101 N. Waldron
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KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS

strength
unity
advocacy

Testimony on:

School Based Influenza Vaccination Programs

Presented to:

Senate Public Health and Welfare Committee

By:

Cathy Harding, Executive Director
Kansas Association for the Medically Underserved

February 17, 2011

For additional information contact:

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Senate Public Health and Welfare
Date 2-17-2011
Attachment 3

Good afternoon Madame Chair and members of the Senate Public Health and Welfare Committee. I am Cathy Harding, Executive Director for the Kansas Association for the Medically Underserved (KAMU). I write to you today in support of SB 141.

KAMU supports SB 141 because we recognize that School-based influenza vaccination programs not only help protect children from seasonal influenza and reduce absenteeism, but they also can help reduce the spread (and cost) of influenza in the community. School-based programs also help improve pandemic preparedness.

The best way to help prevent seasonal influenza is by getting a vaccination each year. The U.S. Centers for Disease Control and Prevention (CDC) recommends annual seasonal influenza vaccination for all eligible persons in the U.S., including eligible children aged 6 months to 18 years.

To increase seasonal influenza vaccination rates, stakeholders have explored new immunization strategies, including the routine vaccination of school-aged children in schools.

Mass vaccination programs in schools have demonstrated both direct benefits to immunized children and indirect benefits to the community including the potential for reduced school absenteeism due to influenza.

Every year in the United States, on average, more than 200,000 people are hospitalized from influenza-related complications and about 36,000 people, mostly in the elderly, die from influenza-related causes.

Children and young adults 5 years to 19 years of age are 3 to 4 times more likely to be infected with influenza than adults, and these school-aged children are the major carriers, spreading the virus to other children, adults and the elderly, which causes a substantial socioeconomic impact.

Thank you, Madame Chair for the opportunity to provide the committee with written testimony in support of SB 141.

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Robert Moser, MD, Acting Secretary | Department of Health & Environment | Sam Brownback, Governor

SB 141 Concerning the department on health and environment, relating to School-located Influenza Vaccination Programs

Presented to
Committee on Public Health and Welfare

By
Robert Moser, MD, Acting Secretary
Department of Health and Environment

February 17, 2011

Chair Schmidt and members of the committee, I am pleased to submit written testimony on Senate Bill 141.

SB141 mandates that KDHE apply for federal grants under the federal Patient Protection and Affordable Care Act (PPACA) for the express purpose of funding, promoting and expanding school-located influenza vaccination programs to provide seasonal influenza vaccinations for school aged children. The proposed legislation specifies the sections of the health care reform act for which funding will be sought for the above purpose, and mandates application for any and all other federal and private funding opportunities for influenza prevention and vaccination.

I have a number of concerns with the legislation under consideration:

1) Mandating the application of funding for School Based Influenza Vaccination Clinics through the PPACA Transition Funding would limit the agency's ability to prioritize other needs with potentially greater and longer lasting benefit to the State.

The Centers for Disease Control and Prevention (CDC) notified its state immunization program partners of the anticipated availability of PPACA funding for immunization activities through a nationwide conference call on February 10, 2011.

PPACA immunization funding will be made through a cooperative agreement available only to existing CDC Immunization and Vaccines for Children grantees (i.e., all 50 states, territories, and certain municipalities). The new grant funding opportunity was described as a transitional "Capacity Building Assistance to Strengthen Public Health Performance" that would help move states to the provision of immunization services to all individuals through the health care reform act. The "transition" funding would be a one-time offering and the funding period would end in 2012. There are two parts and six activities to the funding, including:

- Enhancement of IIS
  - Interoperability of IIS with EHRs in the private sector (to assure capacity of HL7 standard messages received in both private sector EH
  - Vaccine ordering module that can interface with VTr

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Attachment 4

- Enhancement of infrastructure to improve operations
  - Strategic Planning for billing insurers for vaccine in public settings
  - Implementation of billing systems
  - Adult Immunization
  - School-Located Vaccination Clinics

It is not known how much will be available to immunization program applicants. The number and size of each project included in an application would be based on the applicant's priority of needs. SB 141 would prevent that prioritization.

2) School-based vaccination programs, while of value, are not the ideal model for child immunizations.

While school-based vaccination programs have value, for example in a pandemic response, childhood immunizations are best provided in a child's medical home. Additionally, school-based programs likely would require school district and local health department financial support to sustain the program beyond the limited span of this federal funding opportunity.

3) We do not yet have a full understanding of the requirements on states applying for the grants.

The formal Funding Opportunity Announcement has not been issued. We do know grant funding will be time-limited and unsustainable, and federal funding will not support ongoing maintenance of projects created through the Affordable Care Act "transition" funding opportunity. In the current fiscal environment, we need to be careful not to rely on short-term funding that might commit the State to programmatic expenses for years to come.

One-time funding, however, could benefit the development of infrastructure capacity (particularly vaccine ordering/distribution and IIS system interoperability enhancement) without creating long-term funding commitments. Further, infrastructure capacity would benefit the delivery of immunization in the private health care setting.

For these reasons, I do not support SB 141. Thank you for the opportunity to present this written testimony to the committee.

KANSAS ACADEMY OF FAMILY PHYSICIANS
CARING FOR KANSANS

Written Testimony: Senate Bill 141
Senate Public Health & Welfare Committee, February 17, 2011
By: Carolyn Gaughan, CAE, Executive Director

Chairman Schmidt and committee members:

Thank you for the opportunity to submit written comments on behalf of the Kansas Academy of Family Physicians opposing **Senate Bill 141**. The bill directs KDHE to apply for federal grants under the federal Patient Protection and Affordable Care Act to fund, promote and expand school related vaccination programs in Kansas.

While the intent sounds fine on the surface, we believe that consideration of the bigger picture brings forth issues that show SB 141 would have a detrimental effect, possibly a lasting one, if it were enacted. This bill focuses narrowly on school related immunization programs. By directing KDHE to apply for all the grants available for school related immunization programs, it effectively moves school related programs to the top of KDHE's priority list, and we believe that does not allow them flexibility to prioritize other more important aspects of immunization and seek the funding that will be available them. KDHE has an effective and well-organized Immunization Program that communicates effectively with both private and public immunization providers, understands the many issues that can be barriers to timely immunizations and seeks to ameliorate them. They work effectively to evaluate opportunities for funding and hold them up to the yardstick of what we need here in Kansas. We believe they have a clear view of Kansas' unique needs and that they effectively prioritize their efforts to appropriately respond to the needs. This bill, which would mandate that KDHE apply for school related immunization grants, ignores many other worthwhile efforts, including interoperability with private provider Electronic Medical Record (EMR) systems and the state's immunization registry to name just two. **In these times of fiscal challenges it is especially important to carefully consider and select the funding opportunities to pursue that will best serve the needs of our state. We do not believe this fits into that category.** There will be upcoming opportunities for grants in many other areas of immunization that we believe will better serve health needs of the children of Kansas. Not adopting SB 141 will preserve KDHE's ability to pursue them.

In addition we believe that immunizations, particularly childhood immunizations, are best provided in the child's medical home.

For all these reasons we respectfully request that you not adopt SB 141. Thank you for the opportunity to provide written testimony. Please let me know if you have questions.

www.kafponline.org

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Senate Public Health and Welfare
Date 2-17-2011
Attachment 5

KANSAS SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

TESTIMONY IN SUPPORT OF SB 133

THE KANSAS HEALTH INFORMATION TECHNOLOGY AND EXCHANGE ACT

By

Karen Braman, Chair of Board
Kansas Health Information Exchange, Inc.

February 17, 2011

Madam Chair and Members of the Committee:

I am Karen Braman, Chair of the Board of Directors of the Kansas Health Information Exchange, Inc. ("KHIE"). KHIE was created last year by Executive Order 10-06 as a public-private partnership to manage the expenditure of incentive funding granted to the State through the American Recovery and Reinvestment Act ("ARRA"). Kansas was granted $9,010,066 through the State Health Information Exchange Cooperative Grant Program created by ARRA to assist in the creation and implementation of the governance, policy, and technical infrastructure that will enable a standards-based electronic health information exchange to be created in our State.

Each of us receives health care services from a variety of providers: primary care physicians, specialists, hospitals, local health departments, clinical laboratories, and pharmacies, just to name a few. Presently, these providers operate in silos, with limited coordination and collaboration among them. When they do communicate, providers exchange paper records by mail, fax, or hand-delivery. Medical records are maintained in non-standardized formats, so a provider must cull through pages of documents to locate relevant information. This process is enormously frustrating for consumers: how many times have you filled out the same information on a medical history form? The lack of communication also compromises quality and places an incredible financial strain on our health care system. Because they lack a means to coordinate patients' care, each provider focuses on delivering a specific type of care to a patient, rather than working with other providers to maintain an individual's health. Electronic health information exchange, or HIE, offers the means to transform our health care system by facilitating collaboration. As one would expect, studies show those

Senate Public Health and Welfare
Date 2-17-2011
Attachment 6

communities in which providers use electronic health records and exchange information electronically enjoy higher quality care at a significantly lower cost.

The purpose of the stimulus funding designated for Kansas is to assist in promoting the widespread adoption and meaningful use of health information technology as one of the foundational steps in improving the quality and efficiency of health care. The appropriate and secure electronic exchange and consequent use of health information is a critical enabler of a high performance health care system. SB 133 now before you is essential to achieving the lofty purposes that KHIE pursues.

Kansas has long been at the forefront of efforts to deploy electronic means to exchange health information. Governor Sebelius convened health care stakeholders to study the legal and business barriers to the adoption of electronic health information exchanges in 2004. Kansas also participated in initiatives funded by the Bush administration to identify and support innovative means to assure the capability to exchange health information nationwide by 2014. The current administration expanded that effort by devoting stimulus funding to support states' efforts to create electronic exchanges, and that funding through ARRA now provides the opportunity to make electronic health information exchange a reality.

A major barrier identified through these processes beginning in 2004 was the chilling effect health care providers experienced due to conflicting and confusing laws designed to assure the secure exchange and use of health information. It is the purpose of SB 133, which is commended to you unanimously by the health care stakeholders comprising the board of KHIE, to bring harmony to the laws involved and provide health care providers clarity as to how health information may be shared reliably and securely. SB 133, if implemented, will give providers the roadmap they need to use the electronic highway to effect the efficient rendition of care without fear of legal reprisal.

The legislation before you was developed collaboratively by a broad spectrum of health care industry stakeholders, the eHealth Advisory Council, convened by Governor Parkinson through the facilitation of the Secretary of the Kansas Department of Health and Environment. That eHealth Advisory Council charged a Legal Work Group to study Kansas and federal law and develop a proposal that would eliminate legal and business barriers and provide the governance structure that will develop the policy and standards under which electronic health information exchanges will operate. That governance structure is the Kansas Health Information Exchange, the board I chair.

The Board asks you to favorably consider SB 133. Passage will give us the tools we need to establish policy necessary for the reliable and secure exchange of health information, and create the legal clarity that will encourage health care providers to fully participate in the health care environment of the future.

Jeff Ellis chaired the Legal Work Group, and I would like to invite him to address the specifics of the proposed legislation now before you.

KANSAS SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

TESTIMONY IN SUPPORT OF SB 133

THE KANSAS HEALTH INFORMATION TECHNOLOGY AND EXCHANGE ACT

By

Jeffrey O. Ellis, Chair, Legal Work Group
eHealth Advisory Council

February 17, 2011

Madam Chair and Members of the Committee:

As Karen noted, I had the distinction of chairing the Legal Work Group ("LWG") of the eHealth Advisory Council ("eHAC") process convened by Governor Parkinson through the facilitation of KDHE. The Legal Work Group was comprised of 28 lawyers from around the state who are primarily engaged in representing health care providers or who serve on the legal staff of the state agencies that regulate the health care industry in some respect. Amazing consensus was achieved within that group that has ultimately resulted in the proposal which comes before you as SB 133.

That consensus did not come easily. It was developed over several years of intense study beginning in 2006 when Kansas received grant funding to study the barriers to the electronic exchange of health information through the multi-state Health Information Security and Privacy Collaboration ("HISPC"). Over a two and one-half-year study, the initial LWG identified more than 200 Kansas statutes and regulations which potentially impact health information exchange. Those laws, which appear throughout the State's statutory structure, had evolved over many years and were characterized by their inconsistency and lack of coordination. When providers sought to comply with those laws, and to additionally meet federal privacy and security standards mandated by HIPAA, they were confounded and overwhelmed; a circumstance which caused an enormous barrier to the exchange of health information thereby inhibiting attempts to improve the efficiency and quality of health care delivery. (It also created a lot of work for health care lawyers.)

The results of the study commissioned by HISPC were reported to this committee two years ago, and the LWG proposed a legislative resolution to commit the State to an overhaul of the mosaic

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of Kansas laws to bring them into harmony. On March 19, 2009, the Kansas Senate approved Senate Resolution 1851, which articulates the following policy:

> That the laws of this State should be reviewed, modified as necessary, and construed to protect the interests of individuals in the confidentiality, security, integrity and availability of their health information; to promote the use of modern technology in the collection, use, maintenance, and exchange of health information; to promote uniformity in policy; and to codify all standards in a cohesive and comprehensive statutory structure.

When the State received the opportunity for stimulus funding to actualize the implementation of electronic health information exchange, the eHAC reconvened the LWG, with membership expanded to include representatives from state agencies, to perform the task presented by the Senate Resolution and to comply with the requirements of the stimulus funding grant.

Specifically, the LWG was charged with developing "proposed statutory revisions to remove barriers to the creation of an HIE and promote its implementation statewide and in collaboration with neighboring states, including the following: propose legislation authorizing the development of a statewide HIE; propose legislation which would provide the legal framework to operationalize a statewide HIE; assure the privacy and security of personal health information; and provide legal protection for providers and patients who participate in HIE."

SB 133 is the response to that charge. Its substance has been vetted by lawyers dealing with health care law and regulations on behalf of their provider clients and their patients; by attorneys and staff of state agencies charged with regulating the Kansas health care environment; and by representatives of the full range of health care providers who participate in the Kansas health care system.

SB 133 evolved from a conclusion by the LWG that HIPAA is an adequate, appropriate, and consistent standard to achieve privacy and security of personal health information. It adopts HIPAA as the standard for assuring the security of health information and harmonizes state law with HIPAA . It clarifies our State's confusing array of laws regarding who may make health care decisions for those who cannot make such decisions for themselves. It assures providers they will not be held liable under Kansas law if they share health information with other providers in

compliance with the law. Lastly, it assures patients that their personal health information will not be shared if they so direct, and that, if shared, the confidentiality of that information will be maintained.

Please let me introduce Martie Ross, an attorney who specializes in health information law, was one of the participants in the LWG, and was one of the primary scriveners of the proposal presented as SB 133. She will acquaint you with some of the elements of the bill and explain how they work together to accomplish the eHAC's charge and the mandate of Senate Resolution 1851. We all will stand your questions after her comments.

Memorandum

TO: Kansas Senate Public Health and Welfare Committee

FROM: Kansas Health Information Exchange, Inc.

RE: ***Detailed Explanation of Kansas Health Information Technology and Exchange Act ("K-HITE")***

DATE: February 17, 2011

PROCEDURAL HISTORY

Since 2006, several Kansas attorneys representing health care providers, insurers, consumer groups, and state agencies have been involved in the study of the legal barriers to full implementation of health information exchange. This work began with Kansas' participation in the multi-state Health Information Security and Privacy Collaboration ("HISPC"). Over a two and one-half-year period, the Legal Work Group ("LWG") produced a detailed analysis of the more than 200 Kansas statutes and regulations which may have an impact on health information exchange.

Through this process, a clear consensus emerged among LWG members: (1) Kansas health information laws are scattered across numerous statutory and regulatory provisions, are inconsistent with federal law, and do not contemplate electronic health records; (2) the lack of a cohesive legal structure poses a significant barrier to the broad use of technological advancements supporting the appropriate and secure collection, use, and exchange of health information; and (3) the best strategy for overcoming this barrier was a uniform and comprehensive statutory structure which harmonizes Kansas law with the federal HIPAA Privacy and Security Rules.

In response to these concerns, the HISPC LWG proposed a legislative resolution to commit the State to an overhaul of these laws. On March 19, 2009, the Kansas Senate approved unanimously Senate Resolution 1851, a copy of which is attached as **Exhibit A**. The resolution sets forth the following policy statement:

> That the laws of this State should be reviewed, modified as necessary, and construed to protect the interests of individuals in the confidentiality, security, integrity and availability of their health information; to promote the use of modern technology in the collection, use, maintenance, and exchange of health information; to promote uniformity in policy; and to codify all standards in a cohesive and comprehensive statutory structure.

With the formation of the eHealth Advisory Council to develop Kansas' strategic and operational plans for health information exchange, the HISPC LWG was reconvened and expanded to include additional stakeholder representatives. The current membership roster of the eHAC LWG is attached as **Exhibit B**.

The eHAC Steering Team charged the LWG with harmonizing Kansas law both internally and with federal law to remove barriers to the adoption of health information technology and to promote health information exchange within the state. Specifically, the LWG was tasked with developing "proposed statutory revisions to remove the barriers to the creation of an HIE and promote its implementation statewide and in collaboration with neighboring states, including the following: propose legislation authorizing the development of the statewide HIE; propose legislation which would provide the legal framework to operationalize a statewide HIE; assure the privacy and security of personal health information; and provide legal protection for providers and patients who participate in HIE." A copy of the LWG's charter is attached as **Exhibit C**.

Between August and December 2009, LWG members met on several occasions to craft such a legislative proposal. Initially, the members reached consensus on the subjects to be addressed in the legislation: (1) uniform definitions of relevant terms; (2) uniform rules regarding personal representatives for decisions regarding health-related matters; (3) harmonizing state health information privacy laws with the HIPAA Privacy Rule; (4) providing notice and an opportunity for an individual to "opt out" of inclusion of his or her protected health information in a health information exchange; and (5) defining the scope of state agencies' access to protected health information. Committees were formed to develop specific proposals to address each of these subjects.

The committees' work provided the content for the preliminary draft of the proposed legislation, which was then reviewed by all LWG members. A revised draft was prepared to address the concerns identified during those discussions. The LWG approved its final proposal in December 2009.

The draft K-HITE legislation was presented at the full e-HAC meeting on January 14, 2010. A copy of the presentation is attached as **Exhibit D**. Consensus approval was granted that date.

Due to concerns expressed by then-KDHE Secretary Bremby regarding the impact of the proposed legislation on state agencies, the proposal was not considered during the 2010 session of the Kansas Legislature. Over the summer, LWG representatives met with state agency representatives to address those concerns. At the agencies' requests, several minor changes were made to the draft legislation to resolve all outstanding issues. These changes also were circulated to all LWG members for their review.

KHIE's Board of Directors reviewed the draft legislation in December 2010. The Board directed revisions to afford immunity from liability for providers that followed the rules regarding disclosure of protected health information, as well as a handful of technical changes to resolve potential ambiguities. Again, these changes, along with a draft of this memorandum, were circulated to all LWG members for their review. The Board approved the draft legislation at its January 2011 meeting.

DETAILED EXPLANATION OF K-HITE PROVISIONS

K-HITE is comprehensive in its scope: the legislation addresses all legal barriers to HIE identified by the LWG. Providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in part on their ability to demonstrate participation in health information exchange. Given the limited window of opportunity to receive these payments, a piecemeal strategy to address legal barriers to HIE is not an option.

Specifically, K-HITE employs a five-part strategy to facilitate the rapid adoption of HIT and HIE: (1) harmonize Kansas law with the HIPAA Privacy Rule; (2) adopt uniform rules regarding identification of personal representatives for health-related matters; (3) establish standards for approved HIOs; (4) provide individual notice and opportunity to opt out of disclosures to an HIO; and (5) amend the Uniform Electronic Transactions Act to include health-related transactions.

I. Harmonize Kansas Law with the HIPAA Privacy Rule

Among other things, the federal HIPAA Privacy Rule (referred to herein as "HIPAA"): (1) establishes a procedure by which an individual may obtain access to his or her protected health information ("PHI") maintained in a designated record set by a health care provider or health plan ("covered entities"); (2) requires covered entities to adopt appropriate administrative, technical, and physical safeguards to prevent inadvertent disclosures of PHI; (3) permits a covered entity to use and disclose an individual's PHI for purposes of treatment, payment, and health care operations (as well as other specific purposes identified in the regulation) without the patient's written authorization, regardless of the type of information involved; and (4) establishes specific requirements for a valid written authorization for use and disclosure of PHI.

On each of these four points – access, safeguards, uses and disclosures, and authorizations – Kansas law is inconsistent with HIPAA. Before HIPAA, patient privacy protections were piecemeal. State licensing statutes and regulations required providers to maintain patient confidentiality, but provided few specific parameters. The courts recognized a provider's duty to maintain confidentiality, but case law was not sufficiently developed to provide a predictable set of rules for providers. The Kansas Legislature passed statutes and state agencies promulgated regulations which established specific rules for use and disclosure of particular types of "sensitive" information, such as diagnosis and treatment of mental health conditions and certain contagious diseases. As a result, an inconsistent, uncoordinated system of laws and regulations developed over time.

This patchwork quilt of state health information laws which was put in place before HIPAA was not undone by HIPAA. Instead, to the extent state law is "more stringent" than HIPAA (*i.e.*, imposes additional restrictions on use or disclosure of PHI or affords individuals greater rights with respect to their PHI), those rules remain in effect, layered on top of HIPAA requirements.

For a provider, these layered rules create an administrative nightmare which often hinders the disclosure of PHI for appropriate purposes. Not surprisingly, many providers are reluctant to embrace HIE absent adequate assurances that they will not be exposed to liability under these state laws.

Under K-HITE, Kansas law regarding access, safeguards, uses and disclosures, and authorizations would be harmonized with HIPAA, allowing providers to operate under the predictability of one set of well-defined rules. In effect, Kansas would preempt its own pre-HIPAA laws in favor of the national standard developed since HIPAA became effective in 2004. So long as a provider complies with HIPAA, the provider would be immune from any civil or criminal liability or adverse administrative action based on use or disclosure of PHI.[1]

LWG members gave careful consideration to the impact of "preempting" Kansas law on patients. Based on their collective experience, the members agreed HIPAA strikes a proper balance between protecting patient privacy and the need for providers to share critical information. While privacy advocates have been critical of the federal government's lack of enforcement activity relating to HIPAA violations, few have criticized the regulation itself as not affording adequate patient protections.

Access. Prior to HIPAA's effective date, the Kansas Legislature approved what is now K.S.A. 65-4970 *et seq.*, establishing a procedure by which an individual can obtain copies of his or her medical records from a provider. Unfortunately, the Kansas law imposes different requirements than the similar provision in HIPAA, creating significant confusion for providers. K-HITE proposes to repeal this law in favor of requiring all covered entities to comply with the HIPAA Privacy Rule's provision regarding access to PHI in a designated record set. K-HITE also establishes the maximum amount a covered entity may charge any person or entity for copies of such information, as HIPAA defers to state law on this point. These amounts are the same as now listed in K.S.A. 64-4970 *et seq.*

Safeguarding. Unlike HIPAA, there is no explicit provision of Kansas law requiring covered entities to adopt administrative, technical, or physical safeguards to protect PHI from inadvertent disclosures. Instead, this requirement is implicit in state licensure laws, which require providers to take appropriate measures to protect patient confidentiality. K-HITE clarifies that a covered entity that complies with the HIPAA safeguarding requirements satisfies any similar state law requirement. Stated another way, a state licensing agency could not take adverse action against a licensee or a private individual could not sue a provider based on failure to safeguard PHI if secured in a manner required by HIPAA.

Uses and Disclosures. Rather than amending dozens of state statutes and regulations which require a covered entity to obtain patient authorization prior to using or disclosing PHI, K-HITE states any such provision which may be contrary to, inconsistent with, or more restrictive than HIPAA is superseded by the new law. The proposed law, however, preserves statutory privileges and rules regarding use and disclosure of PHI in the possession or custody of any state agency.

For example, K.S.A. 65-5601 *et seq.*, states that an authorization must be obtained for any disclosure of information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition of a patient of a treatment facility (*i.e.*, a community mental health center, community service provider, psychiatric hospital, or state institution for the mentally retarded). The statute lists limited circumstances in which an authorization is not required, but those exceptions are

[1] As discussed below, K-HITE establishes rules regarding a covered entity's disclosure of PHI for purposes of health information exchange. A covered entity would be responsible for complying with these rules, in addition to HIPAA.

narrower than those listed in HIPAA. Under K-HITE, if a provider disclosed such information without an authorization as permitted under HIPAA, but not under the state statute, the provider would be immune from any liability arising out of the state law.[2]

Authorization. HIPAA includes a very specific list of requirements for a valid written authorization for the use or disclosure of protected health information. Covered entities spend a great deal of time and energy reviewing authorization forms received from third parties to determine whether such forms comply with HIPAA requirements, and some refuse to accept any form other than the one developed by that covered entity. K-HITE directs KDHE to develop a standard authorization form which satisfies HIPAA's requirements which covered entities and others can rely upon to facilitate appropriate disclosures of PHI.

Disclosures to an HIO. The section of the draft legislation addressing the privacy of PHI also establishes rules regarding the disclosure of an individual's PHI to an entity operating a health information exchange. This provision is discussed in greater detail in the sections below concerning approved HIOs.

II. Adopt Uniform Rules Regarding Identification of Personal Representatives or Health-Related Matters

Unlike other states, Kansas does not have a statute identifying who has the authority to act on behalf of an incapacitated adult, minor, or deceased individual for health-related matters in the absence of a durable power of attorney for health care decisions or legal guardian. The absence of a defined "pecking order" creates problems for providers in a number of situations, *e.g.*,

- consent for treatment
- an individual's authorization for use or disclosure of that individual's protected health information
- an individual's exercise of individual rights with respect to inclusion of PHI within an approved HIO (*see* section below concerning HIOs)
- consent for autopsy
- disposition of a decedent's remains
- consent for anatomical gift of decedent's body or part
- informed consent for an individual's participation in a research protocol
- an individual's exercise of individual rights under HIPAA or other state or federal statute or regulation

[2] Again, K-HITE establishes state law rules regarding disclosures for purposes of health information exchange, and covered entities may be liable for failure to adhere to those rules. *See* Section II of this memorandum.

As a result, providers are left to make their best guess regarding the appropriate individual to act on behalf of another individual and can face liability if their decision is challenged by an interested party.

With respect to incapacitated adults and deceased individuals, K-HITE establishes a priority order of whom a provider may rely to act as a personal representative of such individual.[3] With respect to minors, K-HITE clarifies a current ambiguity in the law by stating the person who has authority to consent for treatment for a minor also has the authority to act as the minor's personal representative for other enumerated purposes. In those cases in which no such person is available to consent on behalf of the minor, K-HITE establishes a priority order of individuals to act on behalf of the minor.[4] K-HITE also clarifies that upon reaching the age of majority or otherwise becoming emancipated, an individual gains control over his or her PHI, and that any person who previously consented for health care on behalf of the individual no longer may gain access or otherwise exercise control over that information.

K-HITE states that a provider who in good faith relies on an individual so designated as a personal representative shall be immune from any sort of liability arising out of such decision. K-HITE clarifies that no provision is intended to amend or repeal Kansas law regarding durable powers of attorney for health care, the Kansas natural death act, or statutory provisions regarding DNRs. Finally, the proposed legislation states an individual acting as a personal representative does not have the authority to revoke an individual's appointment of a durable power of attorney for health care decisions or a Kansas natural death act declaration.

III. Establish Standards for Approved HIOs

Paragraphs 20 and 21 of Executive Order 10-06 (a copy of which is attached as **Exhibit E**) charge KHIE with "promulgat[ing] standards for approval of and operation of statewide and regional [HIOs] in the state which shall be designated as "approved [HIOs]."[5] K-HITE incorporates these paragraphs, and then provides specific directions regarding one of these standards, participation agreements.

As a condition of receiving approval, an HIO must enter into a written participation agreement with any covered entity that discloses PHI to the HIO. That agreement must specify the

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[3] (1) the incapacitated adult's or deceased individual's spouse; (2) any adult son or daughter of the incapacitated adult or deceased individual; (3) either parent of the incapacitated adult or deceased individual; (4) any adult brother or sister of the incapacitated adult or deceased individual; (5) any adult grandchild of the incapacitated adult or deceased individual; or (6) a close friend of the incapacitated adult or deceased individual.

[4] (1) any person designated in writing by such parent or legal guardian to consent for the provision of health care by a health care provider for the minor; (2) any grandparent of the minor; (3) any adult brother or sister of the minor; (4) any adult aunt or uncle of the minor; (5) any adult cousin of the minor; or (6) any adult close friend of the minor's parent or legal guardian.

[5] The Executive Order uses the term "health information exchange" and references "HIEs." K-HITE uses the term "health information organization" and references "HIOs." "HIO" is the term now commonly used to refer to an entity that operates a health information exchange.

terms on which the covered entity will disclose PHI to the HIO, as well as the terms on which the covered entity may access an individual's PHI from the HIO.

Most importantly, the participation agreement must require the covered entity to give written notice to any person whose PHI is to be disclosed to the HIO. This notice is key to the "opt out" approach, as discussed in Section IV.

Although KHIE approval is not required for an HIO to conduct business in Kansas, K-HITE states that a provider cannot disclose any PHI to an HIO without the individual's written authorization unless the HIO has been approved by KHIE. As a practical matter, therefore, providers will be unwilling to accept the risk associated with disclosures to non-approved HIOs. Also, K-HITE provides that only approved HIOs are eligible for any form of financial assistance from the state, or assistance or support from the state in securing any source of funding.

IV. Provide Individual Notice and Opportunity to Opt Out of Disclosures to HIOs

Under the HIPAA Privacy Rule, a covered entity can disclose an individual's PHI for treatment purposes without a written authorization. The regulation requires the covered entity afford the individual an opportunity to request restrictions on disclosures for such purposes, but the covered entity is not required to honor those requests. Thus, absent some provision in state law, a covered entity could disclose PHI to an HIO without any notice to or authorization from the individual.

As discussed previously, K-HITE, by harmonizing Kansas law with HIPAA, would eliminate any barriers to disclosure of an individual's PHI to an HIO. To ensure consumer confidence in and support for HIE, however, patients should receive notice that their PHI will be included in an HIE, and have the opportunity to exercise some degree of control over such disclosures.

There are three possible options for consumer involvement: (1) notice only, with the opportunity to request restrictions as provided in HIPAA; (2) notice with an opportunity to opt out, and requiring the provider to honor such reasonable requests; (3) notice with disclosure to the HIO conditioned on the individual's "opt in." K-HITE elects the second option.

As explained in Section III, K-HITE requires a covered entity to enter into a participation agreement with an approved HIO as a condition of disclosing any PHI to that HIO. That agreement requires the provider to furnish written notice to an individual before disclosing his/her PHI to the HIO. K-HITE specifies the content of such notice, including (a) that the individual's PHI will be disclosed to the approved HIO to facilitate the provision of health care to the individual, and (b) that the individual (or his or her personal representative) has the right to request in writing that the covered entity not disclose any or specified categories of the individual's PHI to the approved HIO. A provider who complies with these requirements in disclosing PHI to an approved HIO would be immune from any liability relating to such disclosure.

It is contemplated these notices will be incorporated into the standard HIPAA Notice of Privacy Practices a covered entity now is required to provide to individuals with whom the provider has a direct treatment relationship. K-HITE also charges KHIE, Inc., with developing other provisions to be included in participation agreements between approved HIOs and covered entities intended to protect and preserve individuals' right to notice and opportunity to opt out.

To illustrate this process, we have included as **Exhibit F** a chart demonstrating the roles and responsibilities of each player in the process, including the individual, the provider, the approved HIO, and KHIE, Inc.

V. Amend the Uniform Electronic Transactions Act to Include Health-Related Transactions

The Kansas Uniform Electronic Transactions Act addresses the enforceability of records validated with an electronic signature. K-HITE expands the definition of "transaction" to include the provision of health care services, thus eliminating any question regarding the validity of electronic signatures on health records.

INTRODUCTION OF ORIGINAL MOTIONS AND SENATE RESOLUTIONS

Committee on **Public Health and Welfare** introduced the following Senate resolution, which was read:

SENATE RESOLUTION No. 1851—

A RESOLUTION urging review, modification and reorganization of laws pertaining to the maintenance and availability of health information.

WHEREAS, Kansans have an interest in the confidentiality, security, integrity and availability of their health information; and

WHEREAS, The availability, quality and efficiency in the delivery of health care, including establishment of medical homes, depend upon the efficient and secure collection, use, maintenance and exchange of health information; and

WHEREAS, The use of current and emerging technology facilitates the efficient and secure collection, use, maintenance and exchange of health information; and

WHEREAS, Kansas' out-dated and decentralized statutory and regulatory scheme, as well as its interaction with federal mandates, creates confusion and is a significant barrier to the efficient and secure collection, use, maintenance and exchange of health information: Now, therefore,

Be it resolved by the Senate of the State of Kansas: That the laws of Kansas should be reviewed, modified as necessary and construed so as to protect the interests of individuals in the confidentiality, security, integrity and availability of their health information; promote the use of modern technology in the collection, use, maintenance and exchange of health information; promote uniformity in policy and codify all standards in a cohesive and comprehensive statutory structure; and

Be it further resolved: That the Secretary of the Senate is directed to provide an enrolled copy of this resolution to the E-Health Advisory Committee, Kansas Health Policy Authority.

REPORTS OF STANDING COMMITTEES

Committee on **Federal and State Affairs** recommends **SB 247** be passed.

Also, **SB 75** be amended on page 1, in line 27, preceding the period by inserting ", or the consolidation of offices, functions, services and operations"; and the bill be passed as amended.

SB 179 be amended on page 1, in line 40, by striking "unlawfully"; in line 42, after "activity" by inserting ", in whole or in part,"; in line 43, by striking "when" and inserting "except when the officer has reason to believe"; also in line 43, by striking all after "The";

On page 2, in line 1, by striking "reason to believe the"; in line 2, by striking all after "(B)"; in line 3, by striking "information leading a reasonable law enforcement officer to believe"; in line 5, by striking "the"; by striking all in line 6; in line 7, by striking "reasonable law enforcement officer to believe"; in line 9, by striking "not"; in line 10, after the comma where it appears the second time, by inserting "or"; also in line 10, by striking "or religious dress"; in line 41, after "design" by inserting ", develop and implement"; also in line 41, by striking ", analysis"; in line 42, by striking all after "stops"; by striking all in line 43;

On page 3, in line 1, by striking "this subsection shall be designed no later than January 1, 2010" and inserting "of motorists and passengers"; after line 23, by inserting the following:

"(h) The provisions of this section shall expire on July 1, 2011.";

Also on page 3, in line 25, following the stricken material by inserting "(a)"; in line 26, following the stricken material by inserting "a factor"; in line 30, after "vehicle" by inserting "or pedestrian"; after line 30, by inserting the following:

"(b) No law enforcement officer shall use violations of the traffic laws as a pretext for racial profiling.";

On page 4, in line 18, by striking "and" the second time it appears, and inserting a comma; also in line 18, after "ordinances" by inserting "and labor contracts"; in line 43, by striking "specific";

On page 5, after line 18, by inserting the following:

"(b) Upon finding that an investigation is necessary, the commission shall be responsible for timely notification of the law enforcement officer or officers and their respective law enforcement agency that an investigation has been initiated and shall provide: (1) A copy

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8-13

Catherine Walberg, JD, Esq. General Counsel/Vice President	KaMMCO 623 SW 10th St. Topeka, KS 66614	cwalberg@kammco.com	785.357.2720	785.232.4704
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FINAL

eHealth Advisory Council 2009-2010
Legal and Policy Workgroup Charter

Purpose
The Legal and Policy Workgroup is responsible for reviewing Kansas statutes and regulations and proposing legislative revisions that will remove barriers and promote the adoption of HIT and HIE both intrastate and interstate. In addition, this Workgroup is responsible for creating a common set of rules to enable inter-organizational and eventually interstate HIT and HIE while protecting consumer interests.

Charge
Review Kansas law and regulations to:

- Harmonize such laws, both internally and with federal law.
- Remove barriers to the adoption of HIT and promote HIE within the state.
- Develop proposed statutory revisions to promote the implementation of an HIE statewide and interstate connectivity, including the following:
    - Legislation authorizing the development of the statewide HIE.
    - Legislation which would provide the legal framework to operationalize a statewide plan for HIT and HIE.
    - Legislation which assures the privacy and security of personal health information.
    - Legislation which provides legal protection for providers and patients who participate in HIT and HIE.
- Develop model policies and agreements to operationalize statewide HIT and HIE, including:
    - Model data-sharing agreements.
    - Model HIT and HIE participation agreements.
    - Appropriate consents and authorizations allowing for the exchange of health information.
    - Model contracts to operationalize a statewide HIT and HIE.
    - Vendor contracts and other legal agreements to guide technical services.
- Support the legal needs of statewide HIT and HIE governance entity and meet other important state policy requirements such as those related to public health and vulnerable populations.
- Propose enforcement mechanisms that ensure those implementing and maintaining health information exchange services have appropriate safeguards in place and adhere to legal and policy requirements that protect health information, thus engendering trust among HIT and HIE participants.
- Ensure policies and legal agreements needed to guide technical services prioritized by the state are implemented and evaluated as a part of annual program evaluation.

Deliverables
1. Describe the legal process required to enable HIT and HIE in Kansas.
2. Describe the laws to be amended and develop proposed legislative package by the end of 2009.
3. Describe the process for developing and maintaining policies to support the HIE.
4. Describe the process for creating, vetting, and executing trust agreements.

5. Facilitate and support legislative or legal changes to insure effective use of the state's infrastructure, such as Kan-ed.

Workgroup Member Expectations

- Members will participate in the Workgroup through the completion of an operational plan for the health information exchange which is targeted for completion Summer 2010.
- Lend your expertise to all discussions and decisions.
- Keep the statewide interests of Kansas e-Health foremost in your decisions and recommendations.
- Create the most appropriate legal framework for advancing HIE in Kansas which allows for collaboration and development of intrastate and interstate HIE.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Performance Measures

- How many trust agreements have been signed?
- Do privacy policies, procedures, and trust agreements incorporate provisions allowing for public health data use?

Value in Participating

- Proactively help to shape future policy directions that will ultimately impact your organization.
- Enable your organization to be more prepared to respond to related development and progress as it is achieved.

Workgroup Leadership

- Chair: Jeff Ellis

Members

Doug Anning
Joannah Applequist
Mary Beth Blake
Cydney Boler
Larry Buening
Michelle Carter-Gouge
Joann Corpstein
Phil Elwood
Frankie Forbes
Ann Halferty
Dick Hay
Scott Hesse
Dennis Highberger
Joy Jacobsen
Jody Joiner
Marta Fisher Linenberger
Tim Madden
Paul Marx
Kerry McQueen
John Mize
Tom O'Donnell

Cody Robertson
Martie Ross
Julie Roth
Steve Schwarm
Daric Smith
Mark Stafford
Deborah Stern
Brian Vazquez
Catherine Walberg

Workgroup Staff

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Joel Wright, TeamTech, Inc., joel@teamtechinc.com

Kansas Health Information Technology and Exchange Act

Legislative Proposal Developed By the Kansas e-Health Advisory Council Legal Work Group

January 14, 2010

K-HITE Provisions

1. Definitions
2. Privacy of protected health information
3. Personal representative
4. Disclosure of PHI for Public Health Purposes
5. Uniform Electronic Transactions Act
6. State HIT Plan and Approved HIEs

Definitions

- Incorporate HIPAA and ARRA definitions
- Key terms
  - Health information technology
  - Electronic health record
  - Personal health record
  - Interoperability
  - Health information exchange
    - Approved HIE
    - Participation agreement

Current Kansas Privacy Laws

- HIPAA Privacy Rule preempts state law unless such law affords greater privacy protections
- Kansas statutes and regulations littered with inconsistent privacy-related provisions
- Significant confusion regarding what rule applies in a particular situation
- Uncertainty freezes up exchanges of PHI

Proposed Changes

- Harmonize Kansas law with HIPAA Privacy Rule to facilitate use of EHR and HIE
- Adoption of the following HIPAA Privacy Rule provisions
  - Access to PHI
    - Repeal KSA 65-4970 *et seq.*; establish copy/production fees
  - Proper safeguarding of PHI
  - Use and disclosure of PHI
- Development of standard authorization form

Immunity

- Impossible task of identifying and amending existing statutes and regulations
- Instead, provide immunity for covered entity that complies with access, safeguarding, and use and disclosure rules
  - Criminal prosecution
  - Civil liability
  - Adverse disciplinary or licensure action
- Does not reduce privacy protections; instead provides for certainty and uniformity

Enforcement

- Like HIPAA Privacy Rule, no private cause of action
- No provision for state enforcement
  - Covered entities subject to increased enforcement and penalties under HITECH
  - At state level, a covered entity that violates the rules may be subject to:
    - Professional discipline or adverse licensure action
    - Referrals for HHS-OCR
    - Private causes of action under state common law for negligence, invasion of privacy, etc.

Disclosures to HIEs

- Under the HIPAA Privacy Rule:
  - Disclosures for treatment purposes do not require authorization
  - No opportunity for individual to request restrictions on disclosures for treatment purposes
- Our challenge: how do we establish consumer trust yet achieve the objectives of HIEs?

Notice and Opportunity to Opt Out/Request Restrictions

- Provider immune from liability for disclosures of PHI to an HIE if:
  - Current participation agreement with approved HIE
  - Disclose PHI consistent with HIE's procedures
  - Gve individual notice of opportunity to opt out/request restrictions on disclosures to the HIE
  - Adhere to individual's request for restrictions in disclosing PHI to HIE

Personal Representative

- List purposes for which personal representative may act on behalf of incapacitated adult, minor, or deceased individual
- Identify order of priority for incapacitated adults and deceased individual
- Establish that person who consents for treatment for minor also serves as personal representative for all specified purposes
- Grant immunity to providers who in good faith rely on personal representative's decision

Kansas Health Information Corporation

- State-designated public/private partnership to serve as "one-stop shop" for HIT/HIE
- Direct stakeholder involvement on Board, *e.g.*:
  - State government
  - Physicians
  - Nurses
  - Pharmacy
  - Dentisty
  - Mental Health
  - Health Plans
  - Consumers
  - Hospitals
  - Public Health
  - Long-term Care
  - Laboratories
  - Safety Net Providers
  - Employers

K-HIC's Delegated Responsibilities

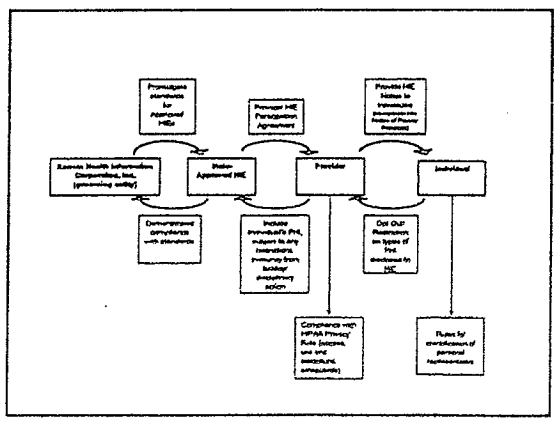
- State HIT Plan
- Loan and grant programs
- Promote adoption of EHRs (Medicaid incentive payments)
- Develop and implement education programs targeting providers and consumers
- Establish standards for approved HIEs
- Designate and oversee approved HIEs

Approved HIEs

- Develop standards
  - Federal certification requirements
  - Appropriate safeguards
  - Provider participation agreements
- Develop approval and monitoring processes

Participation Agreements

- Procedures to disclose PHI to HIE
- Procedures to access PHI from HIE
- Written notice to individuals
  - Content
  - Document delivery of notice to individuals
  - Require compliance with opt out/restrictions
  - Standards to determine reasonableness of restrictions



06.30.2010 - Executive Order 10-06 Kansas Health Information Exchange, Inc.

WHEREAS, the State of Kansas is committed to a health care delivery system that supports the secure exchange of health information for the purposes of ensuring quality, confidentiality, efficiency and effectiveness of patient-centered health care for all Kansans; and

WHEREAS, on July 24, 2009 the Governor of the State of Kansas identified the Kansas Department of Health and Environment ("KDHE") as the state agency leading health information technology planning and implementation for the State of Kansas; and

WHEREAS, the American Recovery and Reinvestment Act of 2009 ("Recovery Act") committed more than $2 billion to the Office of the National Coordinator for Health Information Technology ("ONC") to ensure that all Americans have an electronic health record by 2014; and

WHEREAS, $34 billion in Recovery Act funding is dedicated for financial incentives to Medicaid and Medicare providers nationally for the adoption and meaningful use of electronic health records, and as such, the state has a compelling interest in assisting Kansas providers to qualify for those incentives; and

WHEREAS, ONC released a funding opportunity announcement August 20, 2009 based on the Recovery Act, Title XII – Health Information Technology, Subtitle B – Incentives for the Use of Health Information Technology, §3013, requesting states to take a lead role in the development and implementation of health information exchanges ("HIEs") in the United States; and

WHEREAS, the stated purpose of this funding is to assist in the creation and implementation of the governance, policy and technical infrastructure, which will enable standards-based HIE and a high performance health care system; and

WHEREAS, it is envisioned that HIE will assist in widespread adoption and meaningful use of health information technology as one of the foundational steps in improving the quality and efficiency of health care, to ensure the appropriate and secure electronic exchange and consequent use of health information to improve quality and coordination of care as a critical enabler of a high performance health care system, and to facilitate and expand the secure, electronic movement and use of health information among organizations according to nationally recognized standards; and

WHEREAS, the State of Kansas was awarded funding amounting to $9,010,066 on February 12, 2010, through the State Health Information Exchange Cooperative Agreement Grant Program ("Program") through the ONC; and

WHEREAS, the formation of a state-wide HIE is contemplated in the grant guidance and will be part of the final strategic and operational plan ("State Plan") for Kansas under the grant; and

WHEREAS, the State Plan is due to ONC by August 31, 2010; and

WHEREAS, the Secretary of KDHE has promoted and the eHealth Advisory Council ("eHAC"), an advisory council formed by the Secretary of KDHE, recommended the formation of a not-for-profit, public-private partnership for the purpose of operating the Kansas Health Information Exchange consistent with the report of the Kansas Health Information Technology/Health Information Exchange Policy Initiative and the charge of the Kansas Health Information Exchange Commission (Executive Order 07-02) in coordination with state agencies and the Kansas Regional Extension Center.

NOW, THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby establish the Kansas Health Information Exchange, Inc. ("corporation") with the following purposes and charges:

1. The Governor of the State of Kansas shall serve as incorporator of a body politic and corporate to be known as the Kansas Health Information Exchange, Inc. ("corporation"), a Kansas not-for profit corporation which shall be structured to qualify for tax-exemption as a charitable organization and as a supporting organization of the State of Kansas pursuant to §§501(c)(3) and 509(a)(3) of the Internal Revenue Code of 1986 as amended The Governor shall incorporate the corporation as soon as practical following the issuance of this order.

2. The corporation shall act as a public instrumentality The corporation's exercise of the authority and powers conferred by this order and pursuant to any contracts necessary between state agencies and the corporation to allow for the full oversight of the corporation in regards to the intent of this order shall be deemed and held to be the performance of an essential governmental function

3 The corporation shall have all the powers necessary to achieve the purposes specified herein, including the power to

(a) accept and receive grants, gifts, or donations of money, property, services, or other things of value from any public or private entity to be held, used, or applied for any or all of the purposes specified in this order;

(b) establish administrative and accounting procedures for the operation of the corporation and enter into contracts as may be necessary under this order;

(c) provide and pay the reasonable costs of operation of advisory committees established by the board pursuant to section 4 below. Such costs may include services and technical assistance that may be necessary or desirable to carry out the purposes of this order and such work as may be assigned to or requested of the advisory committee(s) by the board

(d) subject to board approval, enter into contracts, agreements, interstate compacts, or other transactions with any federal, state, county, or municipal agency, or with any individual, corporation, private foundation, enterprise, association, or any other entity within or outside the state for the purpose of fulfilling its mission and duties;

(e) appoint or employ staff, officers, consultants, agents, and advisors, and prescribe their duties and compensation;

(f) promulgate and enforce standards for approval and operation of statewide and regional HIEs in the state including, but not limited to, rules regarding (a) access to and use and disclosure of protected health information maintained by or on an HIE, and (b) appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and availability of protected health information maintained by or on an HIE; and

(g) exercise any other powers necessary for the operation and functioning of the corporation within the purposes authorized in this order.

4. The corporation shall be governed by a board of directors ("board") comprised of residents of this state. Upon incorporation and until such time as a board of directors is constituted pursuant to duly adopted bylaws of the corporation, the existing eleven-member steering committee of the eHAC shall act as the transitional board of the corporation, with the Secretary of KDHE acting as the chairperson of such transitional board. The transitional board shall develop and approve bylaws for the corporation consistent with the provisions of this order and applicable law. The transitional board shall continue to advise KDHE in development of the State Plan in collaboration with the eHAC.

5. The board shall appoint 1 or more advisory committees to assure that the interests of the public and the stakeholders are represented. Any such advisory committee shall be broadly representative and include health care providers (including providers who serve low income and underserved populations), health plans, patient or consumer groups, health information technology vendors, employers, public health departments, health professions training programs, schools and universities, clinical researchers, representatives of regional HIEs and other users of health information technology, including those involved in care coordination of patients.

6. No part of the funds of the corporation shall inure to the benefit of, or be distributed to, its employees, officers or members of the board, except that the corporation may make reasonable payments for expenses incurred on its behalf relating to any of its lawful purposes and the corporation shall be authorized and empowered to pay reasonable compensation for services rendered to or for its benefit relating to any of its lawful purposes, including to pay its employees reasonable compensation. Upon dissolution of the corporation, any assets remaining after the satisfaction of all the corporation's obligations shall be paid over and become the property of the state and shall inure to the benefit of the residents of the State of Kansas.

7. The corporation shall be subject to the Kansas open meetings act and the Kansas open records act, except that documents and other materials submitted to the corporation shall not be public records if such records constitute protected health information, are the types of records described by K.S.A. 45-221(a)(1) and (3) or are trade secrets under the uniform trade secrets act (K.S.A. 60-3320 *et seq.* and amendments thereto).

8. The corporation shall not be subject to state purchasing laws.

9. The Governor will submit the corporation to ONC for approval as the official state designated entity for the state of Kansas, replacing KDHE in this role and assuming responsibility for promoting an HIE program. Fiduciary responsibility for the grant and the Office of the Health Information Technology Coordinator will stay with the state, through KDHE, as required by the ONC and the State HIE Cooperative Agreement Grant Program.

10. Consistent with federal requirements, the corporation shall assure that an HIE is created, operated and maintained in the state for the exchange of health information state-wide, which shall:

a. Facilitate the authorized and secure exchange of health information;

b. Use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information enabling ongoing achievement of meaningful use;

c. Connect regional health information exchanges and other stakeholders within the state to each other and to the Nationwide Health Information Network whenever it is established; and

d Connect subscribers to health information exchanges within and outside the state for the purpose of improving health care quality for individuals and patient populations.

11 The corporation shall facilitate the implementation of the State Plan consistent with the requirements of §3013(e) of the federal public health service act, 42 U.S.C 201 *et seq.*, and related guidance issued by the ONC

12 The corporation shall approve HIEs operating within the state consistent with sections 20 and 21 of this order with the intent of protecting the security, privacy and interest of the citizens of Kansas

13 The corporation may provide access to aggregated, de-identified health information, to be accessed for research purposes under such terms and conditions and subject to such controls, restrictions and limitations set forth in this order or as may from time-to-time be determined to be necessary or appropriate by the board

14. The board of directors of the corporation shall consist of fifteen (15) voting members and two (2) non-voting members for a total of seventeen (17) members as follows:

a. The Secretary of the Kansas Department of Health and Environment; or his or her designee;

b. The Executive Director of the Kansas Health Policy Authority, or his or her designee;

c. The Governor of the State of Kansas, or his or her designee;

d. 2 members appointed by the Governor who represent consumers;

e 1 member appointed by the Governor who represents employers;

f. 1 member appointed by the Governor who represents payers;

g. 1 member appointed by the Governor who represents local health departments from a list of 3 names submitted by the Kansas Association of Local Health Departments;

h. 3 members appointed by the Governor who represent hospitals, from a list of 3 names for each position submitted by the Kansas Hospital Association. 1 of the hospital representatives appointed herein shall be involved in the administration of a critical access hospital;

i. 3 members appointed by the Governor from a list of 3 names for each position by the Kansas Medical Society. At least one of the physicians appointed herein shall be a physician in a primary care specialty;

j. 1 member appointed by the Governor who represents pharmacists, from a list of 3 names submitted by the Kansas Pharmacists Association;

k. 1 member, who shall be nonvoting, shall be a representative of the University of Kansas Center for Health Information; and

l. 1 member, who shall be nonvoting, shall be a representative of the Kansas Health Information Technology Regional Center.

15. Voting members of the board appointed pursuant to subsection 11 of this order shall serve for terms of 4 years, and shall be eligible for re-appointment, but voting members of the board shall not be eligible to serve more than 2 consecutive four-year terms. The members first appointed by the Governor shall serve for terms of 2 years. Upon the expiration of the terms first appointed by the Governor, the Governor shall appoint members to serve for terms of 4 years. Whenever a vacancy occurs regarding a member of the board due to the resignation, death, removal, or expiration of a term, such member shall be appointed according to the process and to the specific position on the board as described in Section 13 of this order In the event of a vacancy during an expired term due to resignation, death or removal of a board member, the appointment shall be for the remainder of the unexpired portion of the term. Each member of the board shall hold office for the term of appointment and until a successor has been appointed. Any member of the board other than a nonvoting member may be removed by the Governor for malfeasance or misfeasance in office, regularly failing to attend meetings, or for any cause which renders the member incapable of the discharge of the duties of director.

16. The board shall meet at least 4 times per year and at such other times as it deems appropriate, or upon call by the chairperson. The board shall make, amend, and repeal bylaws, standards, procedures, and rules and regulations for the management of its affairs, not contrary to law or inconsistent with this order, as it deems expedient for the governance and management of the corporation and the operation of the health information exchanges authorized herein.

17 The board shall elect a voting member as chair and at least one other voting member as vice-chair annually. The board shall also elect a secretary and treasurer for terms to be determined by the board. The board may elect the same person to serve as both secretary and treasurer. The board may establish an executive committee and other standing or special committees, and prescribe their duties and powers. Any executive committee of the board may exercise all such powers and duties of the board as the board may delegate.

18 Members of the board are entitled to compensation and expenses as provided in K.S.A. 75-3223, and amendments thereto Members of the board attending board meetings or subcommittee meetings authorized by the board shall be paid mileage and all other applicable expenses, provided such expenses are consistent with policies established from time-to-time by the board.

19. The board shall adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders.

20. The corporation shall promulgate standards for approval of and operation of statewide and regional HIEs in the state which shall be designated as "approved HIEs" including, but not limited to, the following

a. Satisfaction of certification standards for health information exchange promulgated by the federal government;

b. Adherence to national recognized standards for interoperability;

c. Adoption and adherence to rules promulgated by the corporation regarding access to and use and disclosure of protected health information maintained by or on a health information exchange.

d. demonstration of adequate financial resources to sustain continued operations in compliance with the aforementioned standards, rules and safeguards;

e. participation in outreach activities for individuals and covered entities;

f. conduct of operation in a transparent manner to promote consumer confidence;

g. implementation of security breach notification procedures; and

h. development of procedures for entering into and enforcing the terms of participation agreements with covered entities which satisfy the requirements established by the corporation.

21. The corporation shall establish and implement:

(a) a process by which an HIE may apply for and receive approval by demonstrating compliance with the standards promulgated by the corporation pursuant to sections 18 and 19 of this order;

(b) a process by which an approved HIE shall be re-approved on appropriate intervals by demonstrating continued compliance with the standards promulgated by the corporation pursuant to sections 18 and 19 of this order; and

(c) a process for the investigation of reported concerns and complaints regarding an approved HIE and imposition of appropriate remedial and proactive measures to address any identified deficiencies.

(d) a process whereby the Kansas department of health and environment, the Kansas health policy authority, the Kansas department of social and rehabilitation services and other state agencies, including regulatory agencies responsible for licensing and disciplining health care providers may access protected health information maintained by or on an approved HIE, to the extent such agencies are authorized by state or federal law to access such protected health information to carry out their respective duties under applicable law, and whereby these agencies will be able to use the HIE to carry out their statutory responsibilities as consistent with this order.

22. Any HIE which is not an approved HIE shall not be eligible for any financial support from the state, or assistance from the state in application for federal funding.

23. An approved HIE shall not be compelled by subpoena, court order, or otherwise, to disclose protected health information relating to an individual.

24. No use or disclosure of protected health information maintained by or on any approved HIE shall be made except pursuant to rules adopted by the corporation consistent with this order. The assets of the corporation shall be used solely for the purposes of the corporation as established by this order.

25. The corporation, in collaboration with departments and agencies of state government, may establish a loan and grant program to provide for the capitalization of electronic medical records systems for eligible health care providers. Health information technology acquired under a grant or loan authorized by this section shall comply with federal standards for meaningful use. An implementation plan for this loan and grant program may be developed which shall be consistent with the State Plan.

26 The corporation shall publish an annual report which shall include an audit in accordance with generally accepted accounting principles as of the close of each fiscal year of the corporation. The corporation shall present a report to the Governor and the legislature, setting forth in detail, the operations and transactions conducted by it pursuant to this order. The corporation shall distribute its annual report by such means that will make it widely available to the public.

This document shall be filed with the Secretary of State as Executive Order No. 10-06 and shall become effective immediately.

8-25

Kansas Health Information Technology and Exchange Act

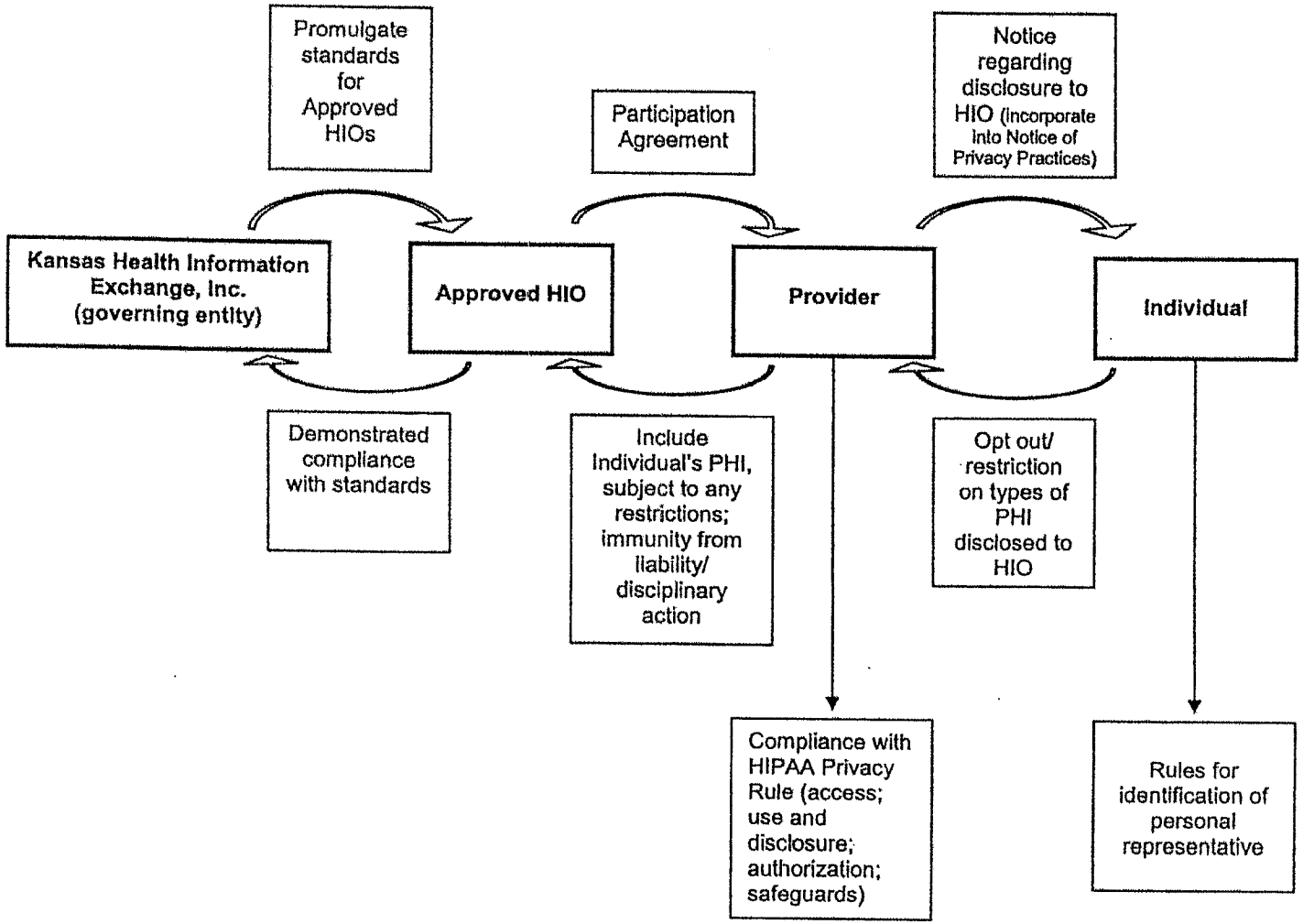


EXHIBIT F

Tom Bell
President and CEO

TO: Senate Public Health and Welfare Committee

FROM: Tom Bell
President and CEO

DATE: February 17, 2011

SUBJECT: Senate Bill 133

Thank you for the opportunity to testify as a proponent of Senate Bill 133, the Kansas Health Information Technology and Exchange Act or K-HITE. The Kansas Hospital Association's 127 community hospital members believe that this legislation will provide much needed recognition of new electronic health records and exchange technology, clarify rules around its secure use and articulate a patient's ability to access and control information.

Hospitals, physicians and other providers have always exchanged confidential patient information in the course of treating patients, conferring with experts and referring or transferring patients to appropriate levels of care. New technology will make this process seamless and more effective, but it brings with it new concerns about privacy and security.

Senate Bill 133 is critically important to the success of electronic health information exchange in Kansas. K-HITE articulates clearly that meeting federally mandated HIPAA privacy and security requirements and standards are the rules by which providers will exchange health information, providing much needed alignment of Kansas laws to the federal standard. This is the standard upon which new federal ARRA HITECH Act requirements are based and will be the national standard going forward. In an environment where electronic records are exchanged nationwide, even worldwide, we must all adhere to a common set of rules. K-HITE also lays out how patient information will be handled and how patients will be informed.

Senate Bill 133 also provides guidance that has been lacking concerning individuals who require assistance in making decisions about their health information – minors, incapacitated adults and deceased individuals. Prior to this bill, no clear guidance has been available to providers about how this can be done even in the paper record environment. KHA applauds the authors in providing this clarification.

Finally, KHA supports K-HITE's language that sets the Kansas Health Information Exchange as the authority approving HIE's in Kansas. Without this approval process, providers have no method to assure that an HIE which seeks their participation or information meets the basic standards required by ARRA or has the appropriate security in place to protect their information.

Again, the Kansas Hospital Association and its members appreciate the opportunity to support the Kansas Health Information and Exchange Act and would be available for questions should you have any.

Kansas Hospital Association • *celebrating 100 years of Kansas hos*
215 S.E. 8th Ave. • Topeka, KS 66603-3906 • Phone: (785) 233-7436 • Fax: (785) 233-(

KANSAS MEDICAL SOCIETY
Established 1859

To: Senate Public Health & Welfare Committee

From: Jerry Slaughter
Executive Director

Date: February 17, 2011

Subject: SB 133; enacting the Kansas Health Information Technology and Exchange Act

The Kansas Medical Society appreciates the opportunity to express our support for SB 133, the Kansas Health Information Technology and Exchange Act ("K-HITE"). This legislation represents several years of work and study by a group of Kansas health care law experts about the legal barriers in state law to the successful implementation of health information exchange in our state. Over the years the intersection of differing state and federal standards on issues such as health care privacy, access, security, uses and disclosures, and the transmission of protected health information has created a confusing environment for both health care providers and patients alike. This legislation eliminates that confusion, and establishes the federal HIPAA Privacy Rule as the standard for our state going forward.

A cohesive, rational approach to governing the access to, and the use of, protected health information is also absolutely essential to the development of the system through which health care providers will begin to share clinical information in a secure electronic network. That electronic network, or health information exchange (HIE), is just beginning to emerge, and this legislation is critical to the successful development of these efforts statewide.

This bill is comprehensive in its scope, and will position our state to move forward in this important endeavor by harmonizing Kansas law with the HIPAA Privacy Rule; by establishing standards for approving health information organizations; by establishing a process for individuals to exercise their right to opt-out of certain disclosures to health information organizations; and by adopting uniform rules relating to designated personal representatives for health-related decisions. The legislation also protects health care providers from liability or adverse administrative actions based on the improper use or disclosure of protected health information so long as the provider complies with the HIPAA standards adopted by the legislation.

SB 133 is a critical component of our state's effort to establish a secure and highly functional health information exchange, which will benefit patients through less duplication of services, fewer adverse drug events and medical errors, improved quality and care coordination, faster access at the point of care to necessary patient clinical information, improved efficiency in care transitions, and reduced administrative burdens. We comment SB 133 to your attention, and urge its favorable consideration. Thank you.

623 SW 10th Avenue • Topeka, Kansas

Senate Public Health and Welfare
Date 2-17-2011
Attachment 10

KANSAS
OPTOMETRIC
ASSOCIATION

1266 SW Topeka Blvd. • Topeka, KS 66612
(785) 232-0225 • (785) 232-6151(FAX)
www.kansasoptometric.org

DATE: FEBRUARY 17, 2011

TO: SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM: GARY L. ROBBINS, EXECUTIVE DIRECTOR

RE: S.B. 133

The Kansas Optometric Association wishes to express our strong support of Senate Bill 133, the Kansas Health Information Technology and Exchange Act. S.B. 133 is the result of extensive discussions by health providers, consumer advocates, state agencies, employers, technology vendors and others who share the common goal of improving the quality of health care for Kansans. It will allow interoperable secure exchange of health information to improve the coordination and quality of health care. By allowing health providers to exchange information electronically and have the latest information, it will potentially save lives through more timely treatment, preventing drug interactions, eliminating delays in test results, providing access to previous patient records and improving care in many other ways. In addition to enhancing the quality of care and patient safety, it has the potential to prevent unnecessary costs and achieve savings for the health care delivery system.

S.B. 133 is the cornerstone to allowing health information exchange by removing legal barriers to electronic health information exchange while assuring secure and safe exchange of health information. It requires amending Kansas law to be harmonized with the HIPAA Privacy Rules; establishment of standards for approving health information organizations; provisions for individual notice and the opportunity to opt out of disclosures to a health information organization; adoption of uniform rules regarding the identification of personal representatives for health information; and amending the Uniform Electronic Transactions Act to include health-related transactions.

S.B. 133 is essential to allow Kansas health providers to the opportunity meet "meaningful use" standards for health information technology thus qualifying for federal incentives for health information technology. The Kansas Optometric Association would urge you to act favorably on S.B. 133.

Senate Public Health and Welfare
Date 2-17-2011
Attachment 11

Curtis State Office Building
1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367

Kansas
Department of Health & Environment

Phone: 785-296-0461
Fax: 785-368-6388
www.kdheks.gov

Robert Moser, MD, Acting Secretary

Sam Brownback, Governor

SB 133, Kansas Health Information Technology and Exchange (KHITE) Act

Presented to
Committee on Public Health and Welfare

By
Robert Moser, MD, Acting Secretary
Department of Health and Environment

February 17, 2011

Chair Schmidt and members of the committee, I am pleased to provide comments in support of Senate Bill 133, the Kansas Health Information Technology and Exchange (KHITE) Act.

Since 2004, a group of dedicated stakeholders have worked to develop a policy and technology infrastructure plan for the state that would facilitate the secure exchange of health information among providers and patients. In 2009, the Kansas Department of Health and Environment (KDHE), borrowing heavily from earlier efforts, convened a stakeholder group of 33 members called the e-Health Advisory Council (e-HAC). This council was tasked with assisting the state in the creation of the Kansas Health Information Exchange Strategic and Operational Plan (Plan) in response to a grant opportunity provided by the Office of the National Coordinator designed to accelerate health information exchange (HIE) development at the state level.

Two major themes in the Plan are privacy and security issues related to the exchange, and the removal of barriers to participation for both providers and patients. KHITE provides a framework for addressing both of these issues by removing legal barriers to HIE and creating a practical framework for the secure exchange of health information. The substance of SB 133 has been debated and amended a number of times in the last few years by stakeholders in the Kansas HIE discussions. Through the work of the e-Health Advisory Council and its Legal Workgroup, we now have a bill that we believe removes a number of barriers to the meaningful adoption of HIE in the state, that was approved through a consensus process by the e-HAC, and has been forwarded to the Legislature with the support of both the Kansas Health Information Exchange Board of Directors and KDHE.

The e-HAC Legal Workgroup identified five areas that needed to be addressed in order for the KHITE Act to be successful in achieving the goals of stakeholders. The KHITE Act harmonizes Kansas law with the HIPAA Privacy Rule and establishes standards for approving health information organizations (HIOs) in Kansas. Next, it gives patients the right to provide notice and affords them the opportunity to opt out of disclosures to an HIO if they so choose. KHITE creates uniformity in laws regarding the identification of personal representatives for health-related matters and amends the Uniform Electronic Transactions Act to include health-related transactions.

The secure exchange of health information is a necessity if we hope to achieve meaningful improvements in coordinated patient care, health care quality, patient safety, and enabled patient responsibility. Through the proper use of HIE we hope to see improvements in these areas resulting in healthier people living longer lives while being better informed than ever before about their personal health care.

Thank you for the opportunity to discuss SB 133 with you today.

12-2

Salina
Area Chamber of Commerce
120 W. Ash, P.O. Box 586 • Salina, KS 67402-0586 • 785-827-9301 • fx 785-827-9758 • www.salinakansas.org

Testimony to Senate Committee on Public Health and Welfare - February 17, 2011

Dear Chair Schmidt and Committee Members,

I am writing in support of SB 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. Senate Bill 133 is the product of a collaborative partnership among Kansas stakeholders including employers, health care providers, consumer groups, insurers, state agencies and other interested parties. We share the goal of a secure exchange of health information to improve the safety and quality of health care for all Kansans. SB 133 is a very comprehensive approach toward this goal.

The bill addresses legal barriers to health information exchange and creates a practical system to make sure health information is in ensured in a safe and secure manner. The bill ensures the timely adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) Harmonize Kansas law with the HIPAA Privacy Rule
(2) Establish standards for approved health information organizations
(3) Provide individual notice and opportunity to opt out of disclosures to an Health Information Organization
(4) Adopt uniform rules regarding identifying personal representatives for health-related matters
(5) Amends the Uniform Electronic Transactions Act to include health-related transactions.

We believe the secure exchange of health information will improve health care quality and safety. Health care providers will be able to achieve "meaningful use" of health information technology and will receive Medicare or Medicaid incentive payments because of their ability to demonstrate participation in health information exchange.

We urge you to act favorably on SB 133 because it is a critical step in help adopt health information technology. It puts the structure for the exchange of this information to occur in a safe, secure manner.

Sincerely,

Dennis W Lauer

President and CEO

Senate Public Health and Welfare
Date 2-17-2011
Attachment 13

DATE: February 11, 2011

TO: The Honorable Vicki Schmidt, Chair
Senate Committee on Public Health and Welfare

FROM:

RE: SB 133 Kansas Health Information Technology and Exchange (K-HITE) Act

Madam Chair and Members of the Committee,

On behalf of the Kansas City Quality Improvement Consortium (KCQIC), I am writing in support of SB 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. Senate Bill 133 is the product of a long-term collaborative partnership among Kansas stakeholders including health care providers, consumer groups, insurers, state agencies, employers and other interested parties who share the goal of interoperable, secure exchange of health information to improve the coordination, safety and quality of health care for all Kansans.

KHITE is comprehensive in its scope: the legislation addresses identified legal barriers to health information exchange and creates a practical framework to facilitate the exchange of health information in a safe and secure manner. The KHITE Act facilitates the rapid adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) harmonize Kansas law with the HIPAA Privacy Rule;

(2) establish standards for approved health information organizations (HIOs);

(3) provide individual notice and opportunity to opt out of disclosures to an HIO;

(4) adopt uniform rules regarding the identification of personal representatives for health-related matters; and

(5) amend the Uniform Electronic Transactions Act to include health-related transactions.

It is our belief that the secure exchange of health information will improve health care quality and safety. Additionally, providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in large part on their ability to demonstrate participation in health information exchange.

SB 133 is an imperative step in facilitating the adoption of health information technology and exchange and puts in place the structure for this exchange to occur in a safe, secure manner. We/I appreciate the opportunity to submit testimony in support of this bill and urge you to act favorably on SB 133.

Respectfully Submitted,

Catherine L Davis

Catherine Davis RN, PHD
President/CEO

KCQIC Kansas City Quality Improvement Consortium
| 6000 N Oak, Ste. 300, Kansas City, MO |
| Ph: 816.453.4424 | Fax: 816.453.4107 | www.kcqic.or

Senate Public Health and Welfare
Date 2-17-2011
Attachment 14

Kansas Foundation for Medical Care, Inc.

2947 SW Wanamaker
Topeka, Kansas 66614-4193
Phone 785-273-2552
www.kfmc.org

Testimony on:

SB 133

Written testimony to:

Senate Public Health and Welfare Committee

By:

Kenneth C. Mishler, President & CEO
Kansas Foundation for Medical Care, Inc.

February 16, 2011

For additional information contact:

Kansas Foundation for Medical Care, Inc
2947 SW Wanamaker Dr.
Topeka, KS 66614-4193
Ph: (785) 273-2552, ext. 375
Fax: (785) 273-0737

Senate Public Health and Welfare
Date 2-17-2011
Attachment 15

DATE: February 16, 2011
RE: SB 133 Kansas Health Information Technology and Exchange (K-HITE) Act

Madam Chair and Members of the Committee, My name is Kenneth Mishler. As the President and CEO and on behalf of Kansas Foundation for Medical Care, I am writing in support of SB 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. Senate Bill 133 is the product of a long-term collaborative partnership among Kansas stakeholders including healthcare providers, consumer groups, insurers, state agencies, employers and other interested parties who share the goal of interoperable, secure exchange of health information to improve the coordination, safety and quality of healthcare for all Kansans.

As the Office of the National Coordinator's designated HIT Regional Extension Center for the State of Kansas, we are working directly with physician and hospital providers across the state to implement and advance the use of electronic health records (EHRs) within their practices. Implementing EHRs will improve the efficiency and care delivered within the provider's individual practice and organization, but to realize the full impact of electronic health information, providers must begin to share that vital information with other providers. Senate Bill 133, the K-HITE Act, provides the framework to establish a safe and secure means for sharing information between providers.

KHITE is comprehensive in its scope: the legislation addresses identified legal barriers to health information exchange and creates a practical framework to facilitate the exchange of health information in a safe and secure manner. The KHITE Act facilitates the rapid adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) harmonize Kansas law with the HIPAA Privacy Rule;

(2) establish standards for approved health information organizations (HIOs);

(3) provide individual notice and opportunity to opt out of disclosures to an HIO;

(4) adopt uniform rules regarding the identification of personal representatives for health-related matters; and

(5) amend the Uniform Electronic Transactions Act to include health-related transactions.

It is our belief that the secure exchange of health information will improve healthcare quality and safety. Additionally, providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in large part on their ability to demonstrate participation in health information exchange.

SB 133 is an imperative step in facilitating the adoption of health information technology and exchange and puts in place the structure for this exchange to occur in a safe, secure manner. We/I appreciate the opportunity to submit testimony in support of this bill and urge you to act favorably on SB 133.

Thank you for hearing our concerns, please contact me with questions.

2947 SW Wanamaker Drive•Topeka, Kansas• 66614-4193•Phone•785-273-2552•www.kfmc.org

Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612
Phone (785) 234 5563
Fax (785) 234 5564

WRITTEN TESTIMONY

Senate Committee on Public Health and Welfare
SB 133

The Kansas Association of Osteopathic Medicine (KAOM) is in support of SB 133.

The Kansas Association of Osteopathic Medicine has been participating in a number of work groups over the past few years dealing with health information technology. The exchange of health information via electronic transmission will only increase over the next few years. The exchange of electronic health records and information is a positive step towards improved health care. However, it is not without its risks.

While SB 133 addresses legal barriers, more importantly it addresses the exchange of health information in a safe and secure manner. SB 133 will align Kansas law with the HIPAA Privacy Rule; establish standards for approved health information organizations; provide individual notice and opportunity to opt out of disclosures to Health Information Organizations; adopt uniform rules regarding the identification of personal representatives for health related matters; and amend the Uniform Electronic Transactions Act to include heath-related transactions.

The health care community is rapidly moving towards electronic health records. The ability of health care providers to demonstrate participation in health information exchanges is vital for Kansas health care providers to move forward and achieve "meaningful use" of health information technology.

SB 133 is a necessary step to put in place the structure necessary for the exchange of electronic health information.

KAOM encourages you to vote in favor of SB 133.

Thank you.

Bob Williams, M.S.
KAOM Executive Director

Senate Public Health and Welfare
Date 2-17-2011
Attachment 16

SEDGWICK COUNTY HEALTH DEPARTMENT

Claudia Blackburn, MPH, RNC, CPM

Health Director

1900 E. 9th St. N. • WICHITA, KS 67214-3115 • PHONE (316) 660-7300 • FAX (316) 262-1980
www.sedgwickcounty.org

Written Testimony on Senate Bill 133

Presented to: Senate Committee on Public Health and Welfare

February 16, 2011

Madame Chair and members of the committee, I am Claudia Blackburn, representing the Sedgwick County Health Department. I am writing in support of SB 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. I was privileged to participate as the local health department representative on the e-Health Advisory Committee and am a member of the Wichita Health Information Exchange Board. This effort is critical to the success of the HIE in Kansas.

KHITE is comprehensive in its scope: the legislation addresses identified legal barriers to health information exchange and creates a practical framework to facilitate the exchange of health information in a safe and secure manner. The KHITE Act facilitates the rapid adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) harmonize Kansas law with the HIPAA Privacy Rule;
(2) establish standards for approved health information organizations (HIOs);
(3) provide individual notice and opportunity to opt out of disclosures to an HIO;
(4) adopt uniform rules regarding the identification of personal representatives for health-related matters; and
(5) amend the Uniform Electronic Transactions Act to include health-related transactions.

It is my belief that the secure exchange of health information will improve health care quality and safety. Additionally, providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in large part on their ability to demonstrate participation in health information exchange.

SB 133 is an imperative step in facilitating the adoption of health information technology and exchange and puts in place the structure for this exchange to occur in a safe, secure manner. I appreciate the opportunity to submit testimony in support of this bill and urge you to act favorably on SB 133.

AARP Kansas
555 S. Kansas Avenue
Suite 201
Topeka, KS 66603

T 1-866-448-3619
F 785-232-8259
TTY 1-877-434-7598
www.aarp.org/ks

February 11, 2011

The Honorable Vicki Schmidt, Chair
Senate Committee on Public Health and Welfare

Reference: SB 133 - Kansas Health Information Technology and Exchange (K-HITE) Act

Good morning Madam Chair and Members of the Senate Public Health and Welfare Committee. My name is Maren Turner and I am the Senior State Director for AARP Kansas. AARP Kansas represents over 341,000 members from across the state. On behalf of AARP Kansas and its members, I am writing in support of Senate Bill (SB) 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. SB 133 is the product of a long-term collaborative partnership among Kansas stakeholders including health care providers, consumer groups, insurers, state agencies, employers and other interested parties who share the goal of interoperable, secure exchange of health information to improve the coordination, safety and quality of health care for all Kansans.

K-HITE is comprehensive in its scope - the legislation addresses identified legal barriers to health information exchange and creates a practical framework to facilitate the exchange of health information in a safe and secure manner. The K-HITE Act facilitates the rapid adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) harmonize Kansas law with the HIPAA Privacy Rule;

(2) establish standards for approved health information organizations (HIOs);

(Over)

Senate Public Health and Welfare
Date 2-17-2011
Attachment 18

(3) provide individual notice and opportunity to opt out of disclosures to an HIO;

(4) adopt uniform rules regarding the identification of personal representatives for health-related matters; and

(5) amend the Uniform Electronic Transactions Act to include health-related transactions.

It is our belief that the secure exchange of health information will improve health care quality and safety. Additionally, providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in large part on their ability to demonstrate participation in health information exchange.

SB 133 is an imperative step in facilitating the adoption of health information technology and exchange and puts in place the structure for this exchange to occur in a safe, secure manner.

I appreciate the opportunity to submit testimony in support of this bill and urge you to act favorably on SB 133.

Thank you.

KANSAS ACADEMY OF FAMILY PHYSICIANS
CARING FOR KANSANS

Written Testimony: Senate Bill 133
Senate Public Health & Welfare Committee, February 17, 2011
By: Carolyn Gaughan, CAE, Executive Director

Chairman Schmidt and committee members:

Thank you for the opportunity to submit written comments on behalf of the Kansas Academy of Family Physicians supporting **Senate Bill 133**. This is an important bill to align our Kansas laws related to health information with federal HIPAA Privacy and Security Rules. This is particularly important for physicians and other providers using Electronic Health Records (EHRs). The current laws are a significant barrier to the broad use of EHRs and the bill is needed to eliminate the barriers. It supports the technological advancements that will enable secure and appropriate collection, use and exchange of health information. We urge your adoption.

KAFP is supportive of health information exchange (HIE) efforts, particularly those that are targeted to improve quality of care and increase patient safety. HIE can lead to improved patient outcomes.

For these reasons, we urge your adoption of SB 133. Thank you again for the opportunity to provide written comment. Please let me know if you have any questions.

Senate Public Health and Welfare
Date 2-17-2011
Attachment 19

WICHITA Health Information EXCHANGE
electronic medical information sharing

Medical Society of
Sedgwick County
1102 S Hillside
Wichita, KS 67211
Tel 316-683-7557
Fax 316-683-1606
www.mssconline.org
www.whie.net

DATE: February 16, 2011

TO: The Honorable Vicki Schmidt, Chair
Senate Committee on Public Health and Welfare

FROM: Ron C. Brown, MD, Chair Board of Directors, Wichita Health Information Exchange

RE: SB 133 Kansas Health Information Technology and Exchange (K-HITE) Act

Madam Chair and Members of the Committee,

On behalf of the Wichita Health Information Exchange (WHIE), I am writing in support of SB 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. WHIE is a collaborative effort of physicians, hospitals and other important health care providers to deliver health information exchange in a secure, functional manner to health care providers within our medical trade region. WHIE is proud to be a partner in the emerging Kansas Health Information Network and members of our group have been actively involved in Kansas HIT/HIE efforts for several years.

Senate Bill 133 is the product of a long-term collaborative partnership among Kansas stakeholders including health care providers, consumer groups, insurers, state agencies, employers and other interested parties who share the goal of interoperable, secure exchange of health information to improve the coordination, safety and quality of health care for all Kansans.

KHITE is comprehensive in its scope; the legislation addresses identified legal barriers to health information exchange and creates a practical framework to facilitate the exchange of health information in a safe and secure manner. The KHITE Act facilitates the rapid adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) harmonize Kansas law with the HIPAA Privacy Rule;
(2) establish standards for approved health information organizations (HIOs);
(3) provide individual notice and opportunity to opt out of disclosures to an HIO;
(4) adopt uniform rules regarding the identification of personal representatives for health-related matters; and

Senate Public Health and Welfare
Date 2-17-2011
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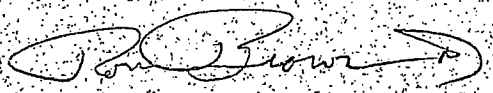
(5) amend the Uniform Electronic Transactions Act to include health-related transactions.

It is our belief that the secure exchange of health information will improve health care quality and safety. Additionally, providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in large part on their ability to demonstrate participation in health information exchange.

SB 133 is an imperative step in facilitating the adoption of health information technology and exchange and puts in place the structure for this exchange to occur in a safe, secure manner. We/I appreciate the opportunity to submit testimony in support of this bill and urge you to act favorably on SB 133.

Respectfully Submitted,



Ron C. Brown, MD
Chair, WHIE Board of Directors

C: WHIE Board of Directors

Kansas Association of Local Health Departments

KALHD

February 17, 2011

TO: The Honorable Vicki Schmidt, Chair
Senate Committee on Public Health and Welfare

RE: SB 133 Kansas Health Information Technology and Exchange (K-HITE) Act

Madam Chair and Members of the Committee,

On behalf of Kansas Association of Local Health Departments, I am writing in support of SB 133, the Kansas Health Information Technology and Exchange (K-HITE) Act. Senate Bill 133 is the product of a long-term collaborative partnership among Kansas stakeholders including health care providers, consumer groups, insurers, state agencies, employers and other interested parties who share the goal of interoperable, secure exchange of health information to improve the coordination, safety and quality of health care for all Kansans.

KHITE is comprehensive in its scope: the legislation addresses identified legal barriers to health information exchange and creates a practical framework to facilitate the exchange of health information in a safe and secure manner. The KHITE Act facilitates the rapid adoption of health information technology (HIT) and health information exchange (HIE) through a five-part strategy:

(1) harmonize Kansas law with the HIPAA Privacy Rule;
(2) establish standards for approved health information organizations (HIOs);
(3) provide individual notice and opportunity to opt out of disclosures to an HIO;
(4) adopt uniform rules regarding the identification of personal representatives for health-related matters; and
(5) amend the Uniform Electronic Transactions Act to include health-related transactions.

It is our belief that the secure exchange of health information will improve health care quality and safety. Additionally, providers' ability to achieve "meaningful use" of health information technology and thus receive Medicare or Medicaid incentive payments depends in large part on their ability to demonstrate participation in health information exchange.

SB 133 is an imperative step in facilitating the adoption of health information technology and exchange and puts in place the structure for this exchange to occur in a safe, secure manner. We/I appreciate the opportunity to submit testimony in support of this bill and urge you to act favorably on SB 133.

Respectfully Submitted,

Edie Snethen
Executive Director

KALHD

Senate Public Health and Welfare
Date 2-17-2011
Attachment 21

KPhA
Kansas Pharmacists Association

Senate Committee on Public Health and Welfare
Testimony by the
Kansas Pharmacists Association
Senate Bill 133
Submitted by Michael Larkin
Executive Director,
February 17, 2011

Chairman Schmidt and Members of the Committee:

My name is Michael Larkin, and I am the Executive Director of the Kansas Pharmacists Association. I am submitting written testimony to you today in support of Senate Bill 133 Kansas Health Information Technology and Exchange (K-HITE) Act.

For years, Kansas pharmacists have been conducting business in an electronic environment. There are many aspects of this bill that enhance the pharmacists ability to communicate effectively with healthcare providers in a effective and secure manner.

Some of the benefits that we anticipate would be realized if Senate Bill 133 is passed include a decrease in errors, greater efficiencies for pharmacists performing medication therapy management services, efficient transmission of prescriptions, and protection of providers, which is critical to their confidence in daily operations.

While there are certainly more benefits to this legislation that do not directly affect pharmacists, KPhA members realize that the overall benefits of this legislation will directly benefit all interested parties and all Kansans. We urge you to act favorably on this legislation.

Thank you very much for permitting me to provide this written testimony today. If I can clarify aspects of this testimony or answer any other questions for you, please let me know.

Michael F Larkin
Executive Director
Kansas Pharmacists Association

Senate Public Health and Welfare
Date 2-17-2011
Attachment 22

KPhA
Kansas Pharmacists Association

Senate Committee on Public Health and Welfare
Testimony by the
Kansas Pharmacists Association
SB 138
Submitted by Pat Hubbell, RPh
Member, KPhA Board of Directors
February 17, 2011

Chairman Schmidt and Members of the Committee:

My name is Pat Hubbell, and I am a practicing pharmacist from Siegler Pharmacy located in Lawrence, Kansas. I am also a member of the Board of Trustees of the Kansas Pharmacists Association and am here before you today as are representative of the Association. Thank you for allowing the Kansas Pharmacists Association to provide testimony today asking you to pass Senate Bill 138 the Pharmacy Audit Integrity Act.

There have been an increasing number of pharmacy audits conducted over the past few years in Kansas. Many of the organizations that perform these audits derive their fees based on the funds recovered during an audit of the pharmacy. This self serving method of payment in itself would make it potentially rife for abuse. But another ramification is its crushing effect on pharmacies in the state that are providing much-needed medications to Kansas citizens.

To be clear, the Kansas Pharmacists Association feels that audits are necessary to ensure proper safeguards and procedures are in place and being followed. However, the audits that are being conducted on pharmacies in Kansas are extremely unreasonable and capricious in nature. Depending on the auditor, no two audits are necessarily the same. In order for a prescription to be valid for purposes of dispensing a medication by a pharmacy, it must conform to all requirements as outlined in Kansas law.

However, time and again we have heard stories of pharmacies that have filled legally valid prescriptions and yet had the funds (product costs and dispensing fees) recovered because of a minor administrative error unrelated to the prescription or whether the patient was served. Some auditors will enter a busy pharmacy unannounced and demand to see records dating back years. If a small error is found, they will base the amount of money recouped on a projection of patients served with a similar diagnosis.

Senate Bill 138 will seek such common sense principles as giving the audited pharmacy at least two weeks written notice before conducting an initial audit, limiting the period covered by the audit to two years, identifying times of high-volume prescriptions as off-limits for conducting an audit, and basing the audit on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs

Thank you very much for permitting me to provide testimony today. If I can clarify aspects of this testimony or answer any other questions for you, please let me know.

Pat Hubbell, RPh
Siegler Pharmacy
Lawrence, Kansas
Kansas Pharmacists Association

KPSC
KANSAS INDEPENDENT
PHARMACY SERVICE CORP.

Testimony of Kansas Independent Pharmacy Service Corporation
In support of Senate Bill 138: The Pharmacy Audit Integrity Act
Presented by Robert Wenzl, Board Chairman
Submitted to the Senate Public Health and Welfare Committee
Thursday, February 17, 2011

Thank you Senator Schmidt and members of the committee for this opportunity to express our support for Senate Bill 138: The Pharmacy Audit Integrity Act.

The number and frequency of audits performed of retail pharmacies have increased dramatically in recent years, to the point that such practices have become disruptive to the efficiency of pharmacies and, in some cases, represent burdensome business practices by pharmacy benefits management companies (PBMs). Because of these business practices, the retail pharmacy community is asking the Kansas legislature to set some reasonable limits on audits that can be imposed by contract on retail pharmacies.

Audits should be reasonable in terms of the time that must be taken by pharmacies being audited and also in terms of their scope. Of particular concern is the number of prescriptions audited, the length of time covered by the audit, and the ability of the audit to extrapolate data from a small sample of prescriptions to a much larger set of prescriptions over a longer period of time.

The time period from the time a pharmacy is notified of the audit and the time the pharmacy must submit information should be reasonable, so that the audit does not disrupt the pharmacy's daily responsibility to serve patients. Ideally, a pharmacy should have 60 days to respond to an information request from an auditor. Further, audit responses should be confidential and should not be shared with third parties.

Audits perform a valuable function and are a necessary part of the routine for retail pharmacists. But the increasing frequency of audits, the extrapolations of audit data that have occurred and the unreasonable response times demanded by audit companies are undermining the support and confidence of the retail pharmacy community.

KPSC is a for profit corporation owned by independent community pharmacies throughout Kansas. On behalf of our members statewide, we urge you to support SB 138.

Providing opportunities for today and tomorrow
1020 SW Fairlawn Rd • Topeka, Kansas 66604 • 785-228-1695
Fax: 785-228-9147 Website: ks

BOWEN PHARMACY

Bowen Pharmacy
1519 Main Parsons, KS 67357
(620) 421-4950

Report on Audit

My name is Brian West, and I am the owner of Bowen Pharmacy in Parsons, KS. I recently received an audit that was shocking to me in both its breadth and scope. Unfortunately I am unable to testify in person today so I am submitting written testimony to you today in support of Senate Bill 138

In September 2010 Bowen Pharmacy received an audit from a contract auditor National Audit which consisted of 100 prescriptions plus their refills. This was an audit of around one thousand prescriptions dispensed. The average dollar was $450.00 per prescription with a total of possible recoupment to be up to around $450,000.

This audit has been a great learning experience for me, during the process I learned that there are no national or state standards that PBM's (pharmacy business managers) have to abide by for example: what constitutes requirements for a phoned in prescription. Each PBM sets their own standards and will vary from one to another with no regard for the state boards of pharmacy.

There is a major conflict of interest when the PBM's are the payer and allowed to regulate the documentation and record keeping requirements. Because PBM's set their own rules I spent over 100 hours after work compiling the information they requested. The state board of pharmacy, as the enforcer of pharmacy practice law is uniquely qualified to make unbiased assessments of appropriate pharmacy requirements and should have all authority in prescription writing.

Another conflict of interest exists when the Auditor is financially compensated on a percentage of the recouped funds. National Audit openly boasts of saving their clients 40 million dollars last year on their website, they recouped $2,400 from my pharmacy. This was on two prescriptions that according to the Kansas State Board of Pharmacy rules and regulations were filled, dispensed properly.

I would like to thank you for your time and if you have any questions please feel free to contact me at 620-421-4950 or 620-778-5740

Brian West
Pharm D
Bowen Pharmacy Parsons, KS 67357

Senate Public Health and Welfare
Date 2-17-2011
Attachment 25

medco

Statement of David Root
Medco Government Affairs
Medco Health Solutions, Inc and Affiliates
Senate Public Health Committee
SB 138
February 17, 2011

Madam Chair and members of the committee, my name is David Root and I represent Medco Health Solutions, Inc., and Affiliates, which is a pharmacy benefits management company (PBM).

Medco Health Solutions, Inc., and Affiliates is a leading health care company that is advancing innovations in the practice of pharmacy. We provide comprehensive, high quality, affordable prescription drug care to over 65 million Americans. We currently manage the prescription drug benefit for approximately 18% of the Kansas Population. We are licensed in the state as a non-resident pharmacy and a third party administrator. Thank you for the opportunity to appear before you today to express our opposition to SB 138.

Although this legislation appears to help pharmacies, we believe that this legislation is unnecessary and will lead to increased opportunities for fraud, wasteful spending in health care and abuse. We also believe it will restrict the ability of health plans and employers to ensure the benefits they are paying for are in fact the benefits their members are receiving.

We work with patients, pharmacists, physicians and health plan sponsors to improve the quality of pharmaceutical care provided to patients, while helping to control the growth in drug costs. We work under contract with health plan clients throughout the country that are providing pecription drug benefits for their members and employees. Our clients include such health care purchasers as:

Fortune 500 corporations & small employers
Local, state, and federal employee and retiree groups
Blue Cross and Blue Shield plans
Labor Unions
Insurance carriers and managed care plans.

Those health plans and employers with pharmacy benefit plans rely on us to assure them that their money is being spent appropriately. The way we assure our clients is through audits of their network pharmacies. These audits are necessary to recoup monies incorrectly paid for claims with improper quantity, improper days supply, improper coding, duplicative claims and other irregularities. SB 138 has several provisions in it that inhibit our ability to audit pharmacies on behalf of our plan sponsors and for that reason we strongly oppose this

legislation. However, if you wish to proceed with this legislation we ask that you consider the following changes: (Please see attached balloon).

Section 3a
(1) – The proposed language would require PBM's to give 2 weeks notification prior to an audit. We believe this invites the opportunity to clean the books or simply leave town. We would suggest an amendment requiring no more than five days notice.

(2) – The proposed language would require a Kansas licensed pharmacist or pharmacist technician to perform the audit. We use a licensed pharmacist or pharmacy technician to perform an audit, however we operate in all 50 states, requiring us to use a pharmacist or pharmacist technician licensed in each individual state would be an unnecessary and expensive burden, which would only lead to increased costs.

(4) – The proposed language would prohibit audits from taking place the first seven days of the month. We see no reason to dictate by law when an audit may take place. This seems extremely unnecessary and only narrows the window of opportunity for the audit to take place.

(6) – This proposed language would allow after the fact validation to substantiate a script. We provide every pharmacy that participates in our networks with a pharmacy services manual that clearly provides the necessary information required on all valid scripts. Without this procedure, we have no way to validate any actions taken on the script.

(8) – This proposed language would mandate mediation in the event of an appeal of the audit. Please remember this is a contractual relationship, and as such, each party is protected based on the rights contained in the contract. In the event that either party feels that the contract was breached, both parties have access to legal remedies. Mandating mediation is not necessary and is an intrusion of the existing contractual relationship.

(b) (2) –This proposed language would allow a pharmacist to keep the dispensing fee even though the pharmacist made a mistake, committed fraud, or something else. The idea of not allowing the dispensing fee to be part of the calculations of an overpayment is not something that we can support.

(b) (3), (4)-These are requested changes by CVS-Caremark due to their contractual relationship with the state and federal government. Please refer to CVS-Caremark testimony.

Section 4
(a) - This proposed language would require the final audit report be delivered within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. This turnaround time needs to be increased to 120 days in order for all of the procedures involved with preparation of the final report to be performed.

(b) – This proposed language would preclude us from recovering funds and if necessary, pend future payments to the pharmacy in order to recover inappropriate payments found because of the audit process. This again is not something we can support.

Section 5 – This proposed language would require the auditing entity to provide copies of the audit to the State Board of Pharmacy and the plan sponsor. We see no purpose for this requirement, in fact some plans prefer we not send them the audit. We believe the requirements of this section will only lead to increased costs by placing additional burdens on the auditing entity.

Section 6 – This legislation is retroactive which conflicts with our current contractual audit obligations with our clients, the payors. Arbitrarily changing the parameters of that contract in mid-stream would have a negative impact on the fulfillment of that contract. We would suggest that the enactment clause read: "This act applies to claims adjudicated upon contract renewal or three years after its enactment date, whichever comes first."

In addition, the language related to fraud waste and abuse language in the bill is insufficient. We would suggest that the language be amended to the following: "This act does not apply to any audit, review or investigation that is initiated based upon suspected or alleged fraud, willful misrepresentation, or abuse."
As you well know, health care is expensive and the costs are only growing:

- "Health care fraud is a pervasive and costly drain on the U.S. health care system. In 2008, Americans spent $2.34 trillion dollars on health care. Of those trillions of dollars, the Federal Bureau of Investigation (FBI) estimates that between 3 and 10 percent was lost to health care fraud." [1]
- In 2010 alone, a joint health care fraud prevention effort between the Department of Justice and the Department of Health and Human Services resulted in the recovery of more than $4 billion in taxpayer dollars. Some of the recovered money came from uncovering pharmacy fraud schemes that included fraudulent billing practices and illegal dispensing of medications. [2]

In addition to detecting fraud, audits also have a patient safety aspect. Auditors help ensure that pharmacies are complying with the Board of Pharmacy rules including proper storage of prescription drugs, posting of required signs and other requirements. In this time of limited budgets and expanding costs it seems odd that the state would pass legislation providing a lesser audit standard on a specific class of professionals than that which they uphold on vendors currently contracting with the state. Our clients, the people and organizations that pay for the drug benefit, contract with us to help them monitor and control costs, pharmacy audits are one function of that contract - these payors should have the same ability to audit the spending of the benefit in the same manner afforded the state in it's relationship with vendors.

We would urge you to vote no on Senate Bill 138. Thank you for the opportunity to share our concerns.

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[1] National Health Care Anti-Fraud Association, "Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers," October 2010, available at http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/WhitePaper_Oct10.pdf.
[2] U.S. Department of Health and Human Services & U.S. Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010," January 2011, available at http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.

26-4

Session of 2011

SENATE BILL No. 138

By Committee on Public Health and Welfare

2-8

AN ACT concerning pharmacy; creating the pharmacy audit integrity act.

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

Section 1. Sections 1 though 6, and amendments thereto, shall be known and may be cited as the pharmacy audit integrity act.

Sec. 2. As used in this act, "pharmacy benefits manager" or "PBM" means a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in contractual or employment relationship in the performance of pharmacy benefits management for a managed care company, not-for-profit hospital or medical service organization, insurance company, third-party payor or health program administered by the state board of pharmacy.

Sec. 3. (a) The entity conducting the audit shall follow the following procedures:

(1) An entity conducting an on-site audit must give the pharmacy ~~at least two weeks~~ five days written notice before conducting an initial audit;

(2) an audit that involves clinical or professional judgment must be conducted by or in consultation with a ~~pharmacist licensed in the state of the audit or the state board of pharmacy~~ licensed;

(3) the period covered by the audit may not exceed two years from the date that the claim was submitted to or adjudicated by the entity;

~~(4) the audit may not take place during the first seven days of the month due to the high volume of prescriptions filled during that time unless otherwise consented to by the pharmacy;~~ (4)

~~(5)~~ the pharmacy may use the records of a hospital, physician or other authorized practitioner to validate the pharmacy record;

~~(6) any legal prescription, in compliance with the requirements of the state board of pharmacy, may be used to validate claims in connection with prescriptions, refills or changes in prescriptions;~~ (5)

~~(7)~~ each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies; and (6)

~~(8)~~ the entity conducting the audit must establish a written appeals process. The appeals process shall include appeals of preliminary reports and final reports. ~~If either party is not satisfied with the appeal, that party may seek mediation.~~

(b) The entity conducting the audit shall also comply with the

following requirements:

(1) A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;

~~(2) calculations of overpayments shall not include dispensing fees;~~ (2)

~~(3)~~ the entity conducting the audit shall not use extrapolation in calculating the recoupments or penalties for audits; (3) unless required by state or federal contracts

~~(4)~~ the auditing company or agent may not receive payment based on a percentage of the amount recovered; and unless allowed by state or federal contracts

~~(5)~~ interest may not accrue during the audit period. (4)

Sec. 4. (a) Any preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit. Any pharmacy shall be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. Any final audit report shall be delivered to the pharmacy within ~~90~~ (120) days after receipt of the preliminary audit report or final appeal, whichever is later.

(b) ~~No charge backs, recoupment or other penalties may be assessed until the appeal process has been exhausted and the final report issued. Unless otherwise required by the federal or state law, any audit information may not be shared.~~ Auditors shall only have access to previous audit reports on a particular pharmacy conducted by that same entity.

~~Sec. 5. Any auditing entity must provide a copy of the final report, including the disclosure of any money recouped in the audit, to the plan sponsor and the state board of pharmacy.~~

Sec. ~~6.~~ (5) This act shall apply to ~~contracts entered into, amended, extended or renewed on or after January 1, 2011~~ claims adjudicated upon contract renewal or three years after its enactment date, whichever comes first. This act shall not apply to any ~~investigative~~ audit, review or investigation that is initiated based upon suspected or alleged fraud, willful misrepresentation or abuse.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.

26-5

CVS CAREMARK | 1300 I Street, N. W., Suite 525 West| Washington, DC 20005 | T: 202-772-3500

February 16, 2011

The Honorable Vicki Schmidt
Chair, Senate Committee on Public Health & Welfare
State Capitol
Topeka, KS 66612

Dear Chairwoman Schmidt:

Thank you for the opportunity to comment on SB 138, creating the pharmacy audit integrity act. CVS Caremark is the largest pharmacy health care provider in the United States. Through our integrated offerings across the entire spectrum of pharmacy care, we are uniquely positioned to provide greater access, to engage plan members in behaviors that improve their health and to lower overall health care costs for health plans, plan sponsors, and their members. As one of the country's largest pharmacy benefit managers (PBMs), we provide plan sponsors and participants access to a network of approximately 64,000 pharmacies including more than 7,100 CVS/pharmacy stores.

While this legislation appears to help pharmacies, it has the potential of unintended consequences including encouraging fraud and wasteful spending on health care. Health plans and other payors of pharmacy benefits, including state and local governments, rely on audits of network pharmacies to recoup monies incorrectly paid for claims due to improper quantity, days supply, duplicative claims and other irregularities. **In fact, the State of Kansas' own health plan contract requires the PBM "...make a diligent effort to recover overpayments or payments made in error to the pharmacy provider..."** Audit provisions in contracts between plan sponsors/payors and PBMs seek to ensure that monies, either taxpayer or private, paid to pharmacies are done so appropriately, according to contract and in compliance with the provider manuals provided to the pharmacy.

The following are some of the specific concerns with the legislation:

--The requirement that an audit that involves clinical or professional judgment be conducted with a pharmacist licensed in Kansas only adds costs to the system without any benefit to the audit process. We suggest deleting the portion mandating Kansas licensure.

--Prohibiting audits during the first seven days of the month should be deleted but allow a pharmacy to request a different date if not convenient during the first seven days.

--Many contracts offer arbitration as a means of dispute resolution however, the legislation only mentions mediation. We suggest allowing for mediation or arbitration.

--Disallowing calculations of overpayments from including dispensing fees is inappropriate if the prescription was filled in error.

--Prohibiting extrapolation is appropriate unless it is required by state or federal guidelines and the legislation should reflect these guidelines.

Senate Public Health and Welfare
Date 2-17-2011
Attachment 27

--Disallowing the PBM from receiving payment based on a percentage of the amount recovered from the audit would prevent a PBM from being appropriately compensated for the cost of the audit.

--Providing a copy of the audit results to the State Board of Pharmacy serves no purpose and only increases the costs of the audit. Results of the audit should only be given to the plan sponsor upon request.

The legislation as filed could increase PBM costs and decrease proper audit recoveries which will ultimately result in higher costs for payors, including the State, while not providing any appreciable benefit to the citizens of Kansas.

Thank you for the opportunity to submit these comments and I will be available at your convenience to discuss any questions you or your committee may have.

Thank you,

Allen K. Horne

Allen K. Horne
Vice President, Government Affairs

Kansas Association of Health Plans

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February 17, 2011

SB 138
Written Testimony before the Senate Public Health Committee
Marlee Carpenter, Executive Director

Chairman Schmidt and members of the Committee;

I am Marlee Carpenter, Executive Director of the Kansas Association of Health Plans (KAHP). The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

KAHP is here today with several concerns about SB 138. Health insurance plans contract with Pharmacy Benefits Managers (PBM) to manage pharmacy benefits for the health insurance plans. As part of this agreement, PBM's work to keep their costs low and ensure that there is no fraud or wasteful spending when administering pharmacy benefits. PBM's fulfill their contractual obligation to insurance companies by many means, including pharmacy audits. The PBM's are a key player in keeping health insurance costs in check. As health insurance costs continue to increase, these types of services become increasingly important.

KAHP has several concerns with SB 138. First, the bill requires a two week notice that a PBM must Give for a pharmacy audit. We believe that this timeframe is too long because it will allow pharmacies additional time to hide irregularities that might exist. In addition we believe that the dispensing should be refunded to the PBM if irregularities are found. We also believe that language requiring the pharmacist undertaking the audit be licensed in Kansas is limiting and request that the Kansas requirement be struck.

SB 138 will limit a health plan and a PBM's ability to manage health care costs and ensure against fraud and abuse. We ask that the above changes be made to the bill to address our concerns.

Thank you for your time and I will be happy to answer questions at any time.

PRIME THERAPEUTICS®

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February 17, 2011

Prime Therapeutics testimony to the Kansas Senate Committee on Public Health and Welfare

Madam Chairwoman and Members of the Committee:

Thank you for the opportunity to submit written testimony explaining the opposition of Prime Therapeutics to SB 138. Prime Therapeutics, LLC is a pharmaceutical benefits manager (PBM) owned by 12 non profit Blue Cross and Blue Shield companies. We manage pharmaceutical benefits for approximately 18 million covered lives.

Prime's mission is to provide high quality yet cost effective pharmacy benefits. We are one of the few full service PBMs that operate through a transparent business model, and we provide our health plan clients with an accounting of income and expenses. An effective audit process is an essential part of maintaining a high-value pharmacy network and decreasing exposure to fraud, waste, and abuse.

I'll start with a description of our audit processes. Like all businesses, Prime is audited by our clients and by the government. Our clients expect, and are entitled to, an accounting of their expenditures on pharmacy benefits to ensure that their policy holders receive the full value of their premium dollars. Likewise, federal and state governments must ensure the accuracy of pharmacy claims financed through public tax dollars. To fulfill those obligations, Prime must audit the pharmacies we do business with.

Prime performs daily claims reviews for claims over a certain dollar threshold. Daily claims reviews allow us to address most errors or inaccuracies before a payment is made and helps to reduce frequency of additional audits as well as avoid future claims recoupment.

Desktop and on-site audits are performed periodically to verify the integrity of submitted claims and payments to the pharmacy. For desktop audits, we notify pharmacies of the claims in question and a description of the required documentation. Pharmacies are given 14 business days to respond.

Pharmacies are given at least 14 days advance notice of an on site audit. Notices include information on the audit timeframe as well as required documentation. In addition to claim verification, on site audits allow us to observe the pharmacy's physical environment and identify any safety or drug storage issues.

Prime provides a written audit report of all desktop and on site audit findings with 30 days. Pharmacies have 30 days to submit an appeal.

In 2010, Prime conducted 79 audits in Kansas. Common errors identified in the audit process include instances where the pharmacist over dispensed, which circumvents the plan benefit design and in many cases allows the patient to obtain additional medicines without properly refilling. Some pharmacies did not retain adequate records to properly validate claims. Another recurring issue was pharmacies submitting post-audit validation that was not recorded at the time of dispensing. Documentation acquired for the purposes of satisfying an audit is inherently unreliable. Prime also identified instances in which the patient was given the wrong dose or the wrong directions for administration, which raises important safety concerns.

It is important to note that audits are not a revenue source for Prime. Any funds recouped from pharmacies because of improper claims submission are returned to plan sponsors.

Prime and our health plan clients to view pharmacy benefits as an investment. A patient who is well managed on drug therapy is less likely to incur unnecessary medical expenses. Prime considers pharmacists an essential part of that mission. To that end, we are continually working to develop new product offerings, such as more robust medication therapy management programs, through which we will more heavily rely on pharmacists to deliver high-quality counseling and other services to members.

New services represent additional reimbursements and billing interactions between pharmacies and PBMs. Likewise, in the post-health reform era we will see dramatic increases in tax-payer funds in the commercial market, increased access to the health system and, finally, an aging population will result in an overall increase in the need for drug therapies. As these changes are implemented, it is more important than ever for PBMs to be good stewards of health plan, policy holder, and government funds.

While we acknowledge that the vast majority of pharmacists are honest, the problem of fraudulent claims is a growing concern, and PBMs must be diligent in limiting our exposure. The federal government estimates that as much as 10% of total health expenditures, over $200 billion a year, are lost to fraudulent activities. An effective audit process not only serves as a deterrent to fraudulent activities, but enables us to ensure a higher degree of formulary compliance, which saves money for plan sponsors and policy holders.

Thank You

Stacey Fahrner

Stacey Fahrner, Vp Government Affairs

Prime Therapeutics,LLC