HEALTH AND SOCIAL SERVICES

COVID-19 Vaccine Mandates

Natalie Nelson
Principal Research Analyst
Natalie.Nelson@klrd.ks.gov
785-296-4418

Lindsay Archer
Research Analyst
Lindsay.Archer@klrd.ks.gov
785-296-4440

Federal Mandates

In September 2021, President Biden released his "Path Out of the Pandemic COVID-19 Action Plan," which set forth plans to increase COVID-19 vaccination rates for certain groups. An overview of these actions, and subsequent state responses, follows.

Private Employer Mandate

On November 5, 2021, the Occupational Safety and Health Administration (OSHA) issued an emergency temporary standard (ETS) mandating private employers with 100 or more employees to develop, implement, and enforce a mandatory COVID-19 vaccination policy, unless they adopt a policy requiring employees to choose to either be vaccinated or undergo regular COVID-19 testing and wear a face covering at work.

In January 2022, the U.S. Supreme Court held that the broad approach by OSHA to regulate all private employers with 100 or more employees was impermissible as the ETS took on "the character of a general public health measure, rather than an occupational safety or health standard." [*Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin.*, 211 L. Ed. 2d 448, 142 S. Ct. 661, 665.] With this ruling, the Court said OSHA could not enforce the ETS while litigation challenging the standard is ongoing and, subsequently, OSHA withdrew the ETS on January 25, 2022.

Following this decision, large businesses nationwide could not be required to mandate vaccines for employees, but states and individual businesses could enforce their own vaccine requirements, as outlined below.

State Response

During the 2021 Kansas Special Session, legislation was passed on November 22, 2021, providing that if employers do require vaccinations, medical and religious exemptions must be provided and allowing an employee to file a complaint with the Secretary of Labor alleging that an employer failed to offer an exemption, improperly denied an exemption request, or took another punitive action against the employee related to a requested exemption.

As of November 2022, no state has mandated vaccinations for private employers, and 14 states have limitations on employer mandates, such as requiring exemptions and other accommodations. Montana has prohibited all private employers in the state from mandating vaccinations. Twelve states have required vaccinations for state employees, and 15 states have prohibited such mandates for state employees.

Federal Contractor Mandate

On September 9, 2021, President Biden issued Executive Order 14042, mandating COVID-19 vaccinations for all employees working for federal contractors and subcontractors.

In December 2021, the U.S. District Court for the Southern District of Georgia ruled President Biden had likely exceeded his authority in issuing the executive order, and ordered a nationwide injunction on the federal contractor mandate. On August 28, 2022, the U.S. Court of Appeals for the 11th Circuit ruled that the nationwide injunction on the vaccine mandate was overbroad and narrowed the scope of it to apply to the plaintiffs in the case (seven states, including Kansas).

Other courts have issued separate injunctions for several states that block the enforcement of the mandate while litigation continues, and the Biden administration has stated it will not enforce the mandate until further notice.

CMS Mandate

On November 4, 2021, the Centers for Medicare and Medicaid Services (CMS) issued an emergency rule requiring staff of health care facilities that receive CMS funding to be vaccinated for COVID-19.

In January 2022, the U.S. Supreme Court upheld the mandate, stating CMS has the authority to impose requirements on those facilities as a condition of their Medicaid and Medicare participation, and because facilities in the programs have long been required to follow certain rules, including those about infection prevention and control. In October 2022, the Supreme Court declined to hear a petition appealing this decision, filed by a group of ten states (including Kansas).

State Response

On March 29, 2022, Governor Kelly announced Kansas state regulators would not enforce the health care worker mandate, resulting in a $350,000 cut in CMS funding. In response, Attorney General Schmidt asked the U.S. Supreme Court to review the legality of the mandate on May 12, 2022.

On November 17, 2022, a coalition of 22 states filed a petition under the federal Administrative Procedures Act requesting CMS to repeal its rule implementing the mandate and related guidance.

Department of Defense (DoD) Mandate

Secretary of Defense Lloyd Austin announced in August 2021 that all members of the Armed Forces under DoD authority on active duty or in the Ready Reserve, including the National Guard, must receive the COVID-19 vaccination. Each branch followed its own deadline for vaccination compliance, the last of which was June 2022, for National Guard members.

DoD has stated that National Guard members who do not show proof of vaccination and do not qualify for an authorized exemption will not be paid by the federal government when they are activated on federal status, including monthly drill weekends and the two-week annual training period. National Guard leadership has stated it foresees a drop in enlistment of 9,000 members nationwide in federal fiscal year 2023 if current vaccination policy continues.

Other Armed Forces branches have begun separating members for noncompliance with the mandate, but National Guard leaders have not begun formally separating any members as of November 2022.

State Response

Governors in seven states have formally asked Secretary Austin to not enforce the mandate for Guard members, and Alaska, Oklahoma, and Texas have filed lawsuits on behalf of their National Guard members. A number of individual servicemembers have also joined lawsuits based on the DoD's refusal to grant requested religious exemptions.

KLRD

For more information, please contact:

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

HEALTH AND SOCIAL SERVICES

Fentanyl Testing Strips

Leighann Thone
Research Analyst
Leighann.Thone@klrd.ks.gov
785-296-4181

Lindsay Archer
Research Analyst
Lindsay.Archer@klrd.ks.gov
785-296-4440

Fentanyl

According to the U.S. Drug Enforcement Administration (DEA), pharmaceutical fentanyl is a synthetic opioid medication developed for pain management and approved by the U.S. Food and Drug Administration (FDA) for pain relief and anesthetic uses. First developed in 1959, it is approximately 100 times more potent than morphine and 50 times more potent than heroin.

From 2011 through 2018, fatal overdoses associated with abuse of clandestinely produced and illegally distributed fentanyl and fentanyl analogues increased markedly. According to the National Forensic Laboratory Information System, reports on fentanyl (both pharmaceutical and clandestinely produced) increased from 5,400 in 2014 to over 56,000 in 2017, as reported by federal, state, and local forensic laboratories in the United States.

In April 2022, the DEA sent a letter to federal, state, and local law enforcement officials warning of a nationwide spike in fentanyl-related mass-overdose events.

Between October 2020 and October 2021, more than 105,000 Americans died of drug overdoses, and more than 66.0 percent of those deaths were related to fentanyl and other synthetic opioids.

Fentanyl Testing Strips

Fentanyl testing strips (FTS) are a form of inexpensive drug testing technology originally developed for urine tests, but which have been shown to be effective at detecting the presence of fentanyl in drug samples.

To use FTS, testers dissolve a small amount of the drug to be tested in water and dip the test strip into the liquid for 15 seconds. The test strip registers results within 5 minutes; typically, one line indicates fentanyl is present and two lines indicate a negative result. FTS are inexpensive, typically costing about $1 each.

FTS Research and Federal Action

A 2018 study conducted by researchers at Brown University, Boston Medical Center, and Johns Hopkins University in collaboration with law enforcement agencies found that FTS were accurate at detecting fentanyl in samples of street drugs and were unlikely to produce false negative results.

A 2017 study conducted by the Drug Overdose Prevention and Education Project in San Francisco concluded that FTS are a useful tool for harm reduction while also raising some considerations: FTS are not an effective tool for systematically documenting the presence of fentanyl in the drug supply, they can produce false positive results, and they do not provide any information about the percentages of fentanyl in drugs or detect the presence of any other drugs.

In April 2021, the federal Centers for Disease Control and Prevention (CDC) and Substance Abuse and Mental Health Services Administration (SAMHSA) announced that federal funding could be used to purchase rapid FTS in an effort to curb drug overdose deaths. The change applies to all federal grant programs, as long as the purchase of FTS is consistent with the purpose of the program.

Legality and Decriminalization of FTS

As of October 2022, FTS are legal in 26 states and the District of Columbia. In Georgia, 2022 HB 1175, which exempts testing equipment used to determine whether a controlled substance has been adulterated by a synthetic opioid from the definition of "drug related object," was signed into law in May 2022 and will take effect in July 2023.

In addition to Georgia, several states have passed legislation in recent years affecting the legality of FTS:

- Since 2018, 12 states have amended their statutory definition of "drug paraphernalia" or "drug related object" to exempt some or all types of drug testing equipment. These states include Colorado, Louisiana, Minnesota, Nevada, Tennessee, and Wisconsin;
- Four states – Nebraska, New York, South Carolina, and Wyoming – either never had a provision regarding testing equipment in statute or amended it prior to 2018;
- Nine states, including Alabama, Georgia, Louisiana, Minnesota, Tennessee, and Wisconsin, limit allowed testing equipment to only that which can detect fentanyl, fentanyl analogues, or other synthetic opioids;
- Seven states, including Illinois, Oklahoma, and North Carolina, as well as the District of Columbia, include testing equipment in their statutory definition of "drug paraphernalia" but do not have a criminal penalty for using or possessing such equipment, at least for some individuals, such as those who work for syringe service programs; and
- In 12 states where FTS are illegal, Good Samaritan fatal overdose prevention laws provide legal immunity from criminal penalty in certain situations.

Kansas Legislative Action on FTS

During the 2021-2022 biennium, FTS were addressed by amendments:

- HB 2277 (2021) would have amended the definition of "possession" and "drug paraphernalia" in the Kansas Criminal Code (Code). The House Committee of the Whole amended the bill to exempt FTS from the definition of "drug paraphernalia." The bill died in the Senate Committee on Judiciary; and
- HB 2262 (2021), regarding the Uniform Controlled Substances Act, was taken up by a 2022 Conference Committee, who agreed to amend the bill to exclude FTS from the definition of "drug paraphernalia" in the Code, remove the contents of 2022 HB 2540, and add the amended contents of HB 2262. The Conference Committee Report for HB 2540 was not adopted by the Senate, and a second Conference Committee was appointed, which agreed to remove the provision regarding FTS.

KLRD

For more information, please contact:

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

HEALTH AND SOCIAL SERVICES

KanCare: Waivers and MCO Contracts

Megan Leopold
Senior Fiscal Analyst
Megan.Leopold@klrd.ks.gov
785-296-4419

Elizabeth Cohn
Senior Research Analyst
Elizabeth.Cohn@klrd.ks.gov
785-296-4382

The Kansas Medicaid program, KanCare, is a jointly funded state and federal government program that provides health coverage to qualifying individuals. States can choose how to administer their own Medicaid program within federal guidelines, creating programs that vary from state to state. To allow this flexibility, the federal government offers waivers that allow states to waive certain provisions of the Medicaid statutes related to program design. Kansas is currently approved for two waivers: a section 1115 waiver for KanCare and a section 1915(c) waiver for home and community-based services.

KanCare: Section 1115 Waiver

In 2013, Kansas shifted from a state-operated program to KanCare, in which managed care organizations (MCOs) provide services. As part of creating KanCare, Kansas successfully applied for a Section 1115 demonstration waiver and has operated under a 1115 waiver since 2013, renewing it once in January of 2019. Generally, Section 1115 demonstrations are approved for an initial five-year period and can be extended for up to an additional three to five years, depending on the populations served. States commonly request and receive additional five-year extension approvals.

The current 1115 waiver is set to expire in December 2023, at which time Kansas must obtain a new source of authority to continue implementation of its managed care delivery system. The following are authorities being considered for the continuation of KanCare:

1115 Waiver Renewal. While Kansas has the option to pursue a renewal of the 1115 waiver, this type of waiver requires budget neutrality, or a limit on the amount of federal dollars that can be spent. This cap on federal spending may limit the state's ability to address certain initiatives such as reducing the waitlists for Home and Community Based Waivers and increasing provider reimbursement rates.

1915(b) Waiver. This type of waiver is initially granted for a two-year period and allows states to provide services through a managed care plan. While this waiver does not have a budget neutrality cap, states must demonstrate that their managed care system is cost effective. This waiver allows states to require that all state plan populations enroll in managed care, including dual eligibles (individuals who receive both Medicare and Medicaid benefits) and children with special health care needs.

State Plan Amendment. States can also permanently implement a managed care delivery system by getting a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS). State Plan amendments do not need to be renewed but do place some limits on the populations a state can require to enroll in managed care. For example, State Plan amendments do not allow states to

require dual eligibles and children with special healthcare needs to enroll in a managed care program.

All three of these authorities allow states to be exempt from certain requirements of Medicaid. For example, they each allow states to implement managed care in only some areas of the state and allow states to require people to receive their Medicaid services from a managed care plan. Regardless of the type of authority, however, states are required to comply with other federal guidelines around managed care, including reasonable access to providers and the right to change managed care plans.

KanCare Managed Care Contracts

Kansas contracts with three managed care organizations – Aetna, Sunflower Health Plan, and United Healthcare – to provide Medicaid services under KanCare. These contracts outline the relationship between the State and the MCOs and establish the state's expectations and priorities. The current contracts between each of the MCOs and the State began in January 2019 and will expire on December 31, 2023.

Although the MCO contracts are set to expire at the same time as the current 1115 waiver, the MCO contracts are not tied to the federal authority the State uses to operate KanCare. If the timing necessitated it, Kansas could shift to a new waiver or federal authority without needing to amend the MCO contracts.

KLRD

For more information, please contact:

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

Differences Between the 1115 Waiver and MCO Contracts

1115 Waiver	MCO Contracts
Governs the state's relationship with the federal government	Governs the MCO's relationship with the State
Focused on the state's authority to draw down federal funds, required reports, and other issues	Focused on the day-to-day relationships between the MCOs, providers and beneficiaries
Does not directly affect providers and beneficiaries	Directly affects providers and beneficiaries

HEALTH AND SOCIAL SERVICES

Mental Health Beds in Kansas for Adults

Dayton LaMunyon, Fiscal Analyst
Dayton.LaMunyon@klrd.ks.gov
785-296-4405

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov
785-296-4408

Psychiatric Hospital Treatment

In Kansas, the highest level of care for adults experiencing severe mental illness is provided in psychiatric hospitals. The Kansas Department for Aging and Disability Services (KDADS) oversees state-run psychiatric hospitals and licenses private psychiatric hospitals.

Pursuant to the 1990 Mental Health Reform Act, the first step for admission to a state hospital is to be screened by a community mental health center. The Care and Treatment Act for Mentally Ill Persons provides guidance for admission to the state hospitals.

Generally, those admitted to state hospitals are individuals who exhibit severe symptoms that cannot be safely and effectively treated in the community.

Osawatomie State Hospital (OSH) Campus

Founded in 1866, OSH provides inpatient psychiatric care to individuals in the eastern third of the state. In 2015, the Centers for Medicare and Medicaid Services (CMS) decertified OSH due to staffing shortages and other issues.

In 2017, CMS recertified Adair Acute Care (AAC), an independent facility on the OSH campus that met CMS certification requirements.

Between OSH and AAC, the OSH campus has 174 combined state licensed and CMS-certified beds. The OSH campus is currently undergoing a renovation to add 12 CMS-certified beds.

Larned State Hospital (LSH)

Founded in 1914, LSH serves individuals who have been voluntarily or involuntarily committed, as well as individuals charged with felony crimes and sexually violent predators. The Psychiatric Services Program (PSP) serves the voluntarily and civilly committed population. The PSP operates 90 beds.

Proposed State Hospital in Sedgwick County

An appropriation of $15.0 million to construct a hospital in Sedgwick County is included in 2022 House Sub. for SB 267. The State Finance Council has the authority to release the funds based on a recommendation of the 2022 Special Committee on Mental Health Beds, tasked with studying the topic.

The plan presented to the Special Committee is to construct a 50-bed facility in Sedgwick County, with 25 beds for voluntary admissions and 25 beds for forensic competency evaluations.

Private Psychiatric Hospitals (PPHs)

PPHs include freestanding hospitals and psychiatric units in community hospitals. PPHs allow individuals to receive care in their community. There are 330 PPH beds across the state.

SIA Program

Private psychiatric hospitals can participate in the SIA program. SIA hospitals provide state hospital level of care to individuals who would otherwise require treatment at OSH or LSH. Six private psychiatric hospitals are enrolled in the SIA program to provide inpatient psychiatric services to adults.

Short-term, Community Treatment

The role of crisis stabilization centers (CSCs) and crisis intervention centers (CICs) is to provide preventative treatment in the community to prevent future admission to a state hospital.

Crisis Stabilization Centers (CSCs)

CSCs provide urgent care in the community to **voluntary patients** for up to 72 hours. There are 95 CSC beds across the state.

Crisis Intervention Centers (CICs)

CICs provide urgent care in the community for up to 72 hours to **involuntary patients** pursuant to the Crisis Intervention Act. CICs are not active yet. KDADS has submitted proposed regulations to the Office of the Attorney General for review. Upon approval of the regulations, 62 CIC beds will be available across the state.

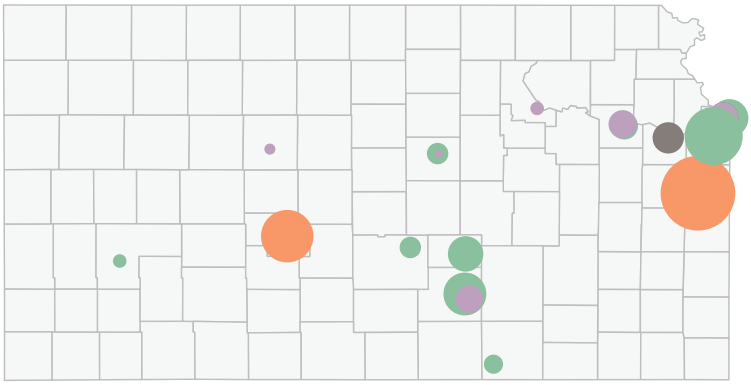
The map and chart below illustrate adult mental health bed capacity across the state.

KLRD

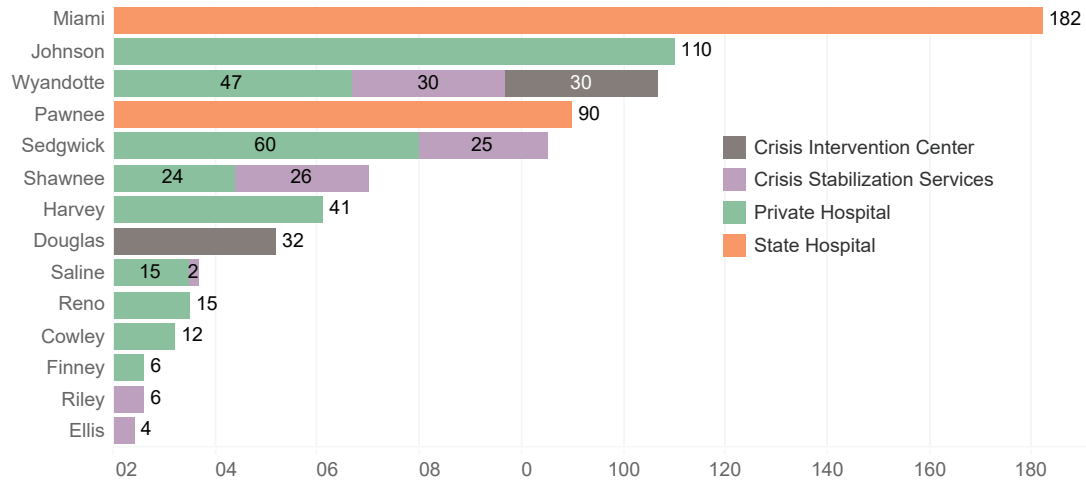
For more information, please contact:

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

Adult Mental Health Beds in Kansas



Number of Beds by County and Facility Type



HEALTH AND SOCIAL SERVICES

Mental Health Beds in Kansas for Youth

Dayton LaMunyon, Fiscal Analyst
Dayton.LaMunyon@klrd.ks.gov
785-296-4405

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov
785-296-4408

The first place for a youth to receive mental health treatment in Kansas is in a community mental health center. If the child needs more intensive care than can be provided safely and effectively in the community, the child may be treated in one of the following placements.

Children's Inpatient Acute Beds

Kansas does not operate any state-run inpatient psychiatric facilities for youth with mental illness. Instead, inpatient acute psychiatric care is provided by private hospitals.

There are 212 children's inpatient acute beds across the state. Beginning in calendar year 2023, 14 new beds will become available in Hays pursuant to a contract between the Kansas Department for Aging and Disability Services and KVC Hospitals.

State Institutional Alternative (SIA) Beds

Private psychiatric hospitals providing inpatient acute psychiatric services can enroll in the SIA program. SIA providers receive patients based on daily capacity. KVC Kansas City, KVC Wichita, and Via Christi are currently enrolled in the SIA program. Once the KVC facility in Hays opens in calendar year 2023, it will join the SIA program.

Psychiatric Residential Treatment Facilities (PRTFs)

PRTFs provide out-of-home residential psychiatric treatment to youth whose needs cannot be effectively and safely met in a community setting.

Prior to receiving services in a PRTF, all community-based services must have been exhausted. Community-based services include Home and Community Based Services under waivers, such as the Serious Emotional Disturbance waiver and the Intellectual and Developmental Disability waiver.

A PRTF is not a permanent or long-term placement. Instead, it is a treatment facility providing all psychiatric services needed by the child. The programs provide active treatment in a structured therapeutic environment.

Admission to a PRTF begins by requesting PRTF services from the child's Medicaid managed care organization (MCO). The child is then assessed for medical necessity. The MCO must render its decision within 14 days, and the child's guardian can appeal if the request for PRTF services is rejected. The child is then placed on a waitlist for a PRTF if medical necessity is met.

There are currently 9 PRTFs across the state operating a total of 424 PRTF beds.

Qualified Residential Treatment Programs (QRTPs)

QRTPs provide residential treatment under the federal Family First Prevention Services Act.

QRTPs treat children with serious emotional or behavioral disorders or disturbances. QRTP services are provided to foster children only. The goal is to provide services at QRTPs to allow foster children to successfully transition back to family care. QRTPs are tasked with:

- Facilitating family participation in the child's treatment, to the extent involvement is appropriate and in the child's best interest;
- Facilitating outreach to family members, documenting how outreach is made, and maintaining contact information for known family and fictive kin of the child;
- Documenting how family members are integrated in treatment, including post-discharge, and how sibling connections are maintained;
- Providing discharge planning and family-based aftercare support for at least 6 months post-discharge; and
- Having 24/7 access to care from registered or licensed nursing staff and other licensed clinical staff.

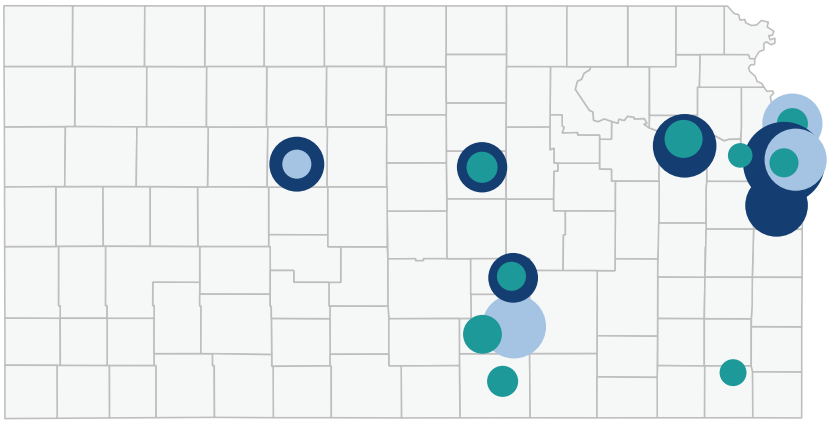
There are currently 147 QRTP beds across the state. The map and chart below illustrate current mental health beds for youth across the state.

KLRD

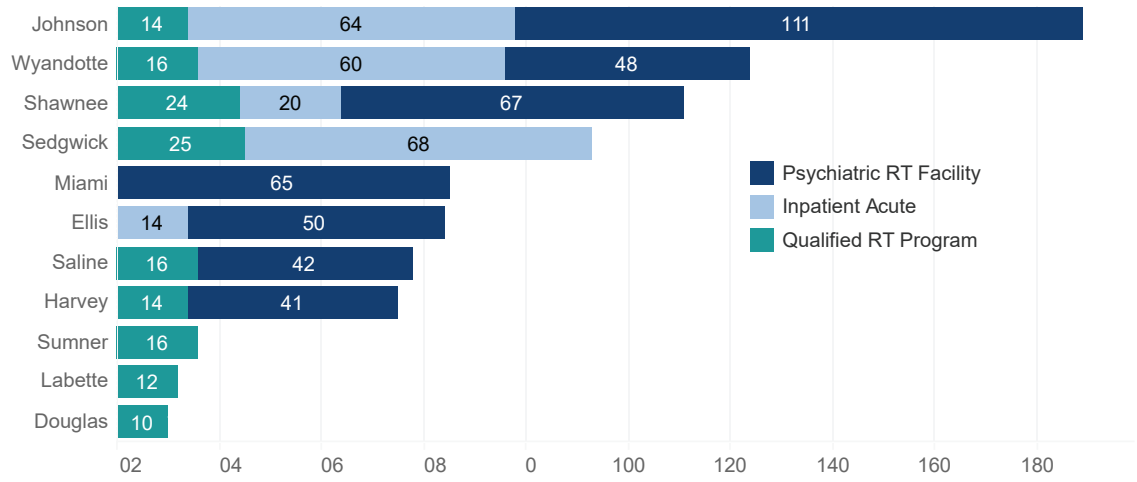
For more information, please contact:

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

Youth Mental Health Beds in Kansas



Number of Beds by County and Facility Type



** RT = "Residential Treatment"*

HEALTH AND SOCIAL SERVICES

Monkeypox (Mpox)

Elizabeth Cohn
Senior Research Analyst
Elizabeth.Cohn@klrd.ks.gov
785-296-4382

Iraida Orr
Principal Research Analyst
Iraida.Orr@klrd.ks.gov
785-296-4408

Description, Reporting, and Case Numbers

Mpox, formerly known as monkeypox, is a viral disease, specifically an orthopoxvirus,[1] and is in the smallpox virus family.

The symptoms of mpox are primarily flu-like (such as fever, headache, muscle aches and backaches, chills, and exhaustion).

In addition, a rash may occur before or after the flu-like symptoms. The rash may be painful, itch, or look like pimples or blisters. An infected person is contagious until the rash fully heals, no scabs remain, and there is a new layer of skin.[2]

1 Kansas Department of Agriculture (KDA). Spring 2022. Monkeypox Outbreak in the U.S. Kansas Animal Health News. p.6. https://agriculture.ks.gov/docs/default-source/dah-newsletters/kdah-summer-2022-newsletter.pdf?sfvrsn=39b09ac1_0

2 Kansas Department of Health and Environment. Monkeypox (Mpox) Symptoms. https://www.kdhe.ks.gov/1923/Monkeypox-Mpox

Mpox symptoms in people are required to be reported[3] to the Kansas Department of Health and Environment (KHDE) by mandated reporters, including both symptoms that are present before laboratory testing and the laboratory testing results. As of December 21, 2022, there were 44 cases of mpox in Kansas.[4]

Treatment and Vaccine

KDHE reports there are no treatments specifically available for mpox, but a treatment protocol is available based on antiviral drugs and vaccines originally developed to prevent smallpox.[5]

The U.S. Food and Drug Administration approved an emergency use vaccine, JYNNEOS, on August 9, 2022.[6] Vaccine purchase and distribution is a federal function overseen by the Administration for Strategic Preparedness and Response in the U.S. Department of Health and Human Services.

The total allocated vials nationwide of the JYNNEOS vaccine as of December 16, 2022,[7] was 1,091,650, of which 857,493 had been requested by states.

3 Kansas Department of Health and Environment. *How to Report Monkeypox/Orthopoxvirus Cases and Testing in Kansas.* https://www.kdhe.ks.gov/1948/How-to-Report-MonkeypoxOrthopoxvirus-Cas

4 *Supra note 2*

5 *Supra note 2*

6 U.S. Food and Drug Administration. Emergency Use Authorization. https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#monkeypox

7 U.S. Department of Health and Human Services Administration for Strategic Preparedness and Response. JYNNEOS Vaccine Distribution by Jurisdiction. https://aspr.hhs.gov/SNS/Pages/JYNNEOS-Distribution.aspx

Kansas is allocated 2,156 vials and has requested and received 2,156 vials.

Current availability of the vaccine in Kansas may be found on the KDHE website.

Federal Public Health Emergency

A nationwide public health emergency was declared by the U.S. Secretary of Health and Human Services on August 4, 2022,[8] for an outbreak of mpox cases. On December 6, 2022, HHS announced that a renewal of the emergency is not anticipated. If it is not extended, the mpox public health emergency will end January 31, 2023.[9] If a public health emergency is declared in Kansas, the state response would follow the Kansas Emergency Management Act, codified at KSA 48-920 *et seq.*

Zoonotic Virus

Mpox is a zoonotic virus, meaning it can spread between people and animals.[9] On August 19, 2022, the American Veterinary Medical Association[10] reported that in June 2022, researchers in France, confirmed the first known transmission of mpox to have occurred between humans and a dog.

If there is transmission to the animal population, owners of domestic animals have a duty to report diseases to the Animal Health Commissioner per KSA 47-622. The Animal Health Commissioner determines the response needed to protect the health of domestic animals as set forth in KSA 47-610 *et seq.*

8 U.S. Department of Health and Human Services Administration for Strategic Preparedness and Response. Determination that a Public Health Emergency Exists. https://aspr.hhs.gov/legal/PHE/Pages/monkeypox-4Aug22.aspx

9 Healthcaredive. *HHS to lift mpox emergency declaration as cases drop.* https://www.healthcaredive.com/news/monkeypox-mpox-public-health-emergency/638047/

10 KDA. Monkeypox Outbreak in the U.S.

11 American Veterinary Medical Association. August 19, 2022. Human-to-dog Monkeypox Transmission Case Reported. https://www.avma.org/news/human-dog-monkeypox-transmission-case-reported

KLRD

For more information, please contact:

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181