Approved 3-16-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p~~m~~ on March 3, , 19~~9~~92 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Senator Lana Oleen
Jean Garten, Administrator, Geary County Community Hospital
Jane Faubion, Local and Rural Health Systems, Department of Health and Environment
Chip Wheelen, Kasnas Medical Society
Robert S. Wunsch, University of Kansas Medical Center
Steve Schwarm, Board of Healing Arts

Chairman Ehrlich called the meeting to order at 10:00 a.m.

The Chairman introduced the pages assisting at the Committee meeting, and announced the visitors at the Committee meeting were Licensed Practical Nurse attending a "Day at the Capitol."

The Chairman asked for consideration of the minutes of February 24, 25, 26 and 27, 1992. Senator Burke made a motion to approve the minutes as presented, seconded by Senator Langworthy. No discussion followed. The motion carried.

Hearing on SB 693 - Defining a critically medically underserved county for KU medical scholarship purposes, requiring students who choose to pay back scholarship money double the amount received.

Senator Lana Oleen appeared before the Committee in support of **SB 693** and introduced Jean Garten, Administrator, Geary County Community Hospital who submitted written testimony and stated her support of the bill. Ms. Garten addressed the two major changes in the legislation with the proposed changes that eliminates use of the arbitrary figure of 12,000 and requires the scholarship recipient practice in a town that is considered critically medically underserved by the Kansas Medically Underserved Areas report. Ms. Garten stated with the great demand for primary care physicians, physician groups and hospitals are more than willing to pay off loans to recruit a physician, thus providing an easy out for physicians to default. (Attachment 1)

Jane Faubion, Department of Health and Environment, submitted written testimony on **SB 693** and stated the original intent of the scholarship program was to create a supply of primary care physicians for underserved areas in Kansas, and gave facts concerning the status of those underserved counties today. The bill represents an effort to reduce the number of scholarship recipients who are buying out of their service obligations and increase the supply of primary care physicians to underserved areas of Kansas. (Attachment 2) Figures relating to those in compliance with the scholarship contract, if the program is really working, and the number of physicians entering primary care were discussed.

Chip Wheelen, Kansas Medical Society, submitted written testimony in opposition to **SB 693** and stated the KMS believes the Legislature should examine options that would provide incentives to

encourage physicians to pursue residency training in primary care specialties, and that this bill represents a form of indentured servitude. (Attachment 3) Committee discussion related to those scholarship recipients that leave the state, labeling the scholarship program as a "loan", the contract to practice in a medically underserved area, the high rate of interest in the pay-back, and the original intent of the bill to get physicians into the rural areas.

Robert S. Wunsch, University of Kansas Medical Center, submitted written testimony on **SB 693** and stated he is neither a proponent or opponent of the bill, but outlined the history of the Medical Scholarship bill up to the present changes and requirements. Mr. Wunsch stated it appears if the change in line 43 on page 2 of the bill would make the provision of K.S.A. 1991 Supp. 76-376(a) (4) and 76-376(a) (6) inapplicable for those first receiving benefits after January 1, 1993. A copy of a Memo from Ronald K. Spangler, Institutional Research and Planning, KUMC, was distributed to the Committee regarding the impact of **SB 693**. (Attachment 4) Type I and II scholarships, 51% average compliance rate and $1,000,000 to administer the scholarship program, whether federal money is available to medical students at KUMC, and the Comprehensive Health Planning Council that documented the medically underserved areas were discussed.

Hearing on SB 694 - Use of criminal record/history in determining qualifications of physicians; confidentiality of complaints and patient records.

Steve A. Schwarm, Board of Healing Arts, submitted written testimony and appeared before the Committee and explained the function of the Board in relation to **SB 694.** (Attachment 5)

Due to the time frame, the Chairman announced continuation of hearing on **SB 694** upon adjournment of the Senate.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3-3-92
AM

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Donna Taylor P.O Box 153 Emporia, Ks 66801	KFLPN
VERLENE LECLEAR 1312 STATE Emporia KS 66801	KFLPN
Bernieca Smith 1016 Ash Ottawa Ks 66067	KFLPN
ELIZABETH E TAYLOR	Ks Fed of LPNs
Janet Jacobs 3031 So. Custer Wichita 67217	Ks. Fed. of LPNs
Lois Wethington, 309 W. 6th, Haysville, Ks 67060	Ks. Federation of LPN's
Marti Brooks 530 Sherman Emporia Ks 66801	KFLPN
Lisa Getz	Wichita Hospitals
Stan Chandler	Ks. Physical Therapy Asso.
Candy Bahnsen, PT Belvue, Ks	KPTA
FRANCES KASTNER Topeka	KPTA
R. Lipsey Top.	AP
Jean Madden	Geary County Hosp
David Hohtzlick	KS Hospital Assn
Chip Wheelen	Ks Medical Soc.

TESTIMONY--SENATE BILL #693

The two major changes in this legislation are as follows:

1) Currently, scholarship recipients who received their awards after December 31, 1985, must practice in a town of this state with a population of less than 12,000. The proposed change eliminates use of this arbitrary figure and requires that the scholarship recipient practice in a town that is considered critically medically underserved by the Kansas Medically Underserved Areas report. This definition quantifies the need for physicians by population to physician ratios. Just because a community is less than 12,000 population does not mean it needs physicians anymore than saying a town of greater than 12,000 does not need physicians. Junction City in particular has a population of 21,000 and yet is critically medically underserved. The way the current legislation reads, Junction City would not be eligible to recruit a scholarship recipient.

The current language is arbitrary and capricious and can do nothing more than serve the purpose of special interests.

2) Currently, scholarship recipients can default very easily on the loan forgiveness program because it allows a payback of the loan plus 15% interest. With the cost of physician recruitment, including head hunting firms, it is not uncommon to pay up to $30,000 to recruit a physician.

With the GREAT demand for primary care physicians, physician groups and hospitals are more than willing to pay off these loans to recruit a physician, thus providing an

Senate P. H & W
Attachment #1
3-3-92 AM

easy out for physicians to default. Currently, 33% of the scholarship recipients default on the program. The proposed change would require the physician pay back twice the amount of money owed plus 15% interest.

I would like to suggest that this provision will decrease dramatically the number of physicians defaulting. If defaults continue, however, there will be double funds paid back to the program to provide more scholarships for physicians in the future.

Although it may be argued that by making the penalty for default tougher, less physicians will take advantage of the program, I will argue that, by being up front with the penalties, only those serious about fulfilling an obligation will take advantage of the program, thus making it a more effective program overall.

In my final comments, I would like to say that no system is perfect. In this case, the best you can do to represent us is:

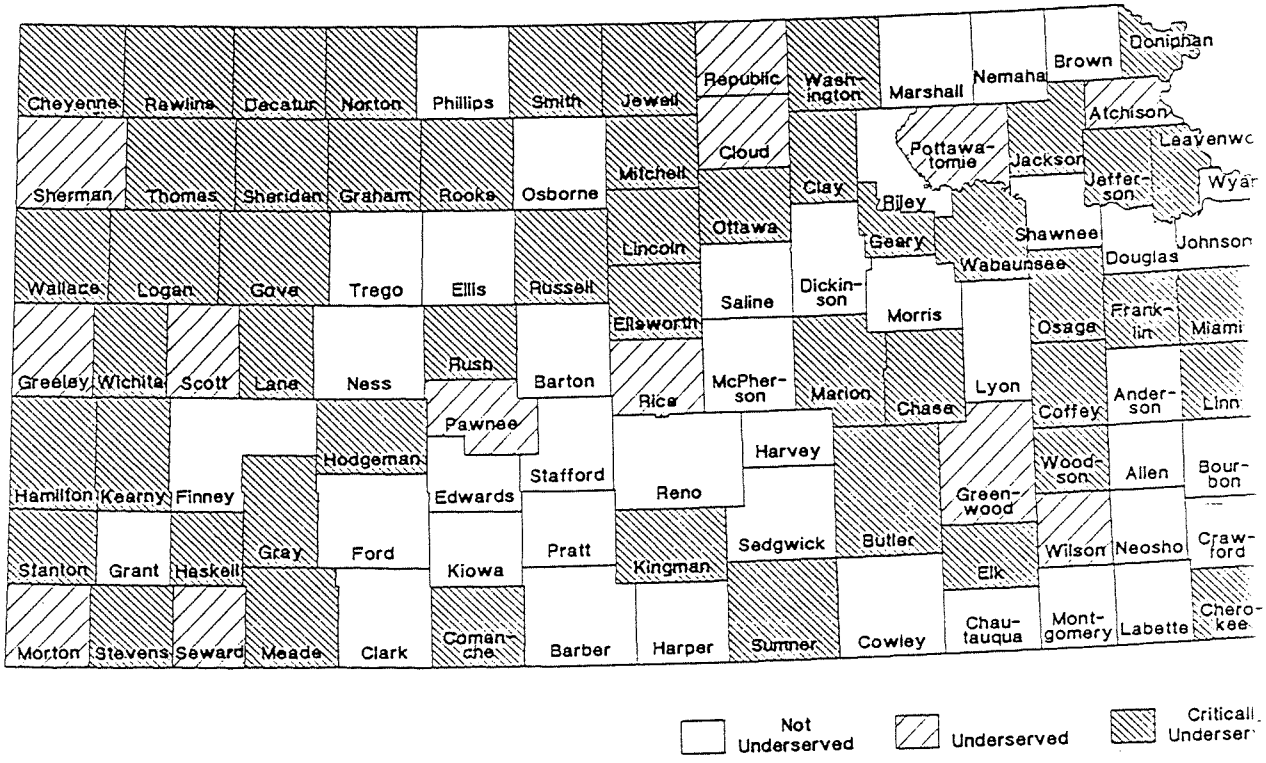
1) Use a logical and justifiable process to select the site where a physician will serve his/her obligation.

2) Put proper incentives in place for a physician to follow through on their obligation.

In this way, you can be assured that you have done your part to address the primary care physician shortage crisis in the State of Kansas and thus make healthcare accessible to those most needing the essential and basic elements of physicians services.

PRIMARY CARE

1990 UNDERSERVED AREAS



Specialties include: Family Practice; General Practice; Internal Medicine; Pediatrics

Atchison	U	Graham	CU	Logan	CU	Russell	CU
Butler	CU	Gray	CU	Marion	CU	Scott	U
Chase	CU	Greeley	U	Meade	CU	Seward	U
Cherokee	CU	Greenwood	U	Miami	CU	Sheridan	CU
Cheyenne	CU	Hamilton	CU	Mitchell	CU	Sherman	U
Clay	CU	Haskell	CU	Morton	U	Smith	CU
Cloud	U	Hodgeman	CU	Norton	CU	Stanton	CU
Coffey	CU	Jackson	CU	Osage	CU	Stevens	CU
Comanche	CU	Jefferson	CU	Ottawa	CU	Sumner	CU
Decatur	CU	Jewell	CU	Pawnee	U	Thomas	CU
Doniphan	CU	Kearny	CU	Pottawatomie	U	Wabaunsee	CU
Elk	CU	Kingman	CU	Rawlins	CU	Wallace	CU
Ellsworth	CU	Lane	CU	Republic	U	Washington	CU
Franklin	CU	Leavenworth	CU	Rice	U	Wich.*a	CU
Geary	CU	Lincoln	CU	Rooks	CU	Wilson	U
Gove	CU	Linn	CU	Rush	CU	Woodson	CU

U - Underserved (13 counties) CU - Critically Underserved (51 counties)

Refer to page 7 for information on qualifying medical facilities.

Designation effective December 31, 1990 – December 31, 1993

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 693

I am Jane Faubion and I work for the Department of Health and Environment in the Office of Local and Rural Health Systems. In that capacity, one of my major areas of concern is health manpower in underserved areas of Kansas.

As you know, part of the original intent of the Kansas Medical Scholarship program was to create a supply of primary care physicians for underserved areas in Kansas. How well the program has done toward that end is disputable but what we do know is that only about 65% or less of past scholarship recipients actually ever honored their obligation to serve in underserved areas and Kansas' crisis in terms of access to rural health care continues to worsen year after year.

The Kansas Medically Underserved Areas Report released in December of 1990 indicated that 64 of Kansas' 105 counties were considered medically underserved, 51 of them critically so. This means that they have less than one primary care doctor for every 2,695 people in the underserved counties, less than one primary care doctor for every 3,000 people in critically underserved counties. This often-quoted reference doesn't tell the whole story, however. Between January 1, 1991 and December 31, 1991, at least 24 more primary care physicians left their practices, mostly in rural counties. This exodus resulted in 12 more counties achieving an "underserved" or "critically underserved" status during the year.

As bad as this picture looks, it is guaranteed to get worse. Preliminary findings from reports generated from Board of Healing Arts licensure data indicate that over the next nine years, rural primary care doctors will be reaching age 65 about 50% faster than their urban counterparts. It appears that rural counties can anticipate losing about 16% of their primary care doctors to retirement by the turn of the century. Considering that 80% of rural physicians are primary care, this loss is very troubling. Simply to replace retiring physicians, Kansas needs at least 182 new primary care doctors by the year 2000, or about 20 a year. Add on the number of non-retiring primary care physicians who choose to relocate out of rural areas and, if it continues as badly as 1991, we'll need upwards of 40 new doctors a year.

Senate P. H&W
Attachment #2
3-3-92 A.M

Senate Bill 693 represents an effort to reduce the numbers of scholarship recipients who are buying out of their service obligations and increase the supply of primary care physicians to underserved areas of Kansas.

Given the incredible expense of medical school and the continuing supply of persons who want to be doctors, we believe we will see no decrease in the numbers of students seeking Kansas Medical Scholarships. Service in an underserved area has always been a feature of this scholarship. This was not a program designed to invite recipients with no intention of serving in rural Kansas - who came in knowing they'd buy-out in the end.

However, at 200% of the loan amount plus 15% interest, we now have a strong disincentive for buying-out scholarship recipients' loans and service obligations. At 200% of principle plus 15% interest, Kansas' future scholarship recipients will more likely be a body of people who are serious about practicing in underserved areas in the first place.

Senate Bill 693 cannot help but have a positive impact on the supply of primary care physicians to underserved areas in Kansas.

The Kansas Department of Health and Environment recommends that the Committee report S.B. 693 favorably for passage.

Testimony presented by: Jane Faubion
Office of Local and Rural Health Systems
March 3, 1992

Senate P. H&W
attachment #
2-2

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

March 3, 1992

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society

SUBJECT: Senate Bill 693, Kansas Medical Scholarship Program

The Kansas Medical Society appreciates this opportunity to express our opposition to SB 693. The KMS believes that the Legislature should examine options that would provide incentives to encourage physicians to pursue residency training in primary care specialties and to practice in medically underserved locations. This bill, however, represents a punitive approach that resembles a form of indentured servitude.

The question as to whether the State should impose more stringent penalties on medical school graduates who choose to pay back their scholarships (with interest) was thoroughly examined by a subcommittee of the 1991 SRS Task Force which discovered that other states that adopted such penalties found them to be legally unenforceable. The SRS Task Force adopted the sub-committee report which rejected the concept embodied in SB 693. The final Task Force report recommends that the Legislature consider methods of creating incentives rather than penalties. We endorse that approach to addressing the problem of primary care physician shortages throughout Kansas.

We were recently invited by the Chairman of the House Appropriations Committee to comment on the efficacy of the Medical Scholarship Program. A copy of our letter to Representative Teagarden is attached for your information.

Thank you for considering our position on this matter. We urge you to reject SB 693.

CW/cb

Attachment

Senate P. HEW
Attachment #3
3-3-92 AM

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 19, 1992

The Honorable George Teagarden
Chairman, House Appropriations Committee
State Capitol Building, Room 514-S
300 SW 10th Avenue
Topeka, Kansas 66612

Dear Representative Teagarden:

Thank you allowing us the opportunity to comment on the subject of the Kansas Medical Scholarship Program. It is appropriate that the Legislature again consider the viability of the scholarship program in its present form, since the challenge of attracting and retaining primary care physicians in our underserved areas has never been greater. Virtually everyone studying the problem of access to care in rural areas agrees that not only in Kansas, but in many other areas of the country, there is a shortage of primary care physicians. In fact, the problem is no longer just confined to the rural, underserved communities. It is now increasingly a problem of larger communities, as well as some urban areas. As background to this general problem, I would refer you to the thoughtful and comprehensive paper, "Where Have The Doctors Gone?", which was recently distributed to all legislators by the Kansas Academy of Family Physicians.

You may recall that at the inception of the scholarship program, the Kansas Medical Society had some reservations about its potential for effectiveness. First, we believed that it was inappropriately called a "scholarship" program, a distinction which we think contributed to the unrealistic expectation among many that all students who signed up for the program would actually serve out their commitment in a rural area. It was then, and still is, unrealistic to expect that a first year medical student could make an irrevocable decision about his or her specialty, and practice location seven years in advance. We find it somewhat amazing that about 60% of program participants have, or are in the process, of fulfilling their commitments.

Perhaps the first thing that the State of Kansas should do is reverse the psychology of the Medical Scholarship Program by phasing it out and replacing it with a loan program which could cover the costs incurred during medical school, as well as pay a stipend during the residency training years. Then, if a medical school graduate chooses a primary care residency, a portion of the loan could be "forgiven" immediately by the state. Upon completing primary care residency training, another fraction of the loan could be waived upon conclusion of each year of practice in a medically underserved community. This would present incentives at the important times when the physician is considering his or her specialty training and eventually, location of first practice.

3-2

Another possibility would, of course, be a cash grant or stipend to establish a primary care practice in a medically underserved town. A no-interest loan to provide start-up funding or perhaps a state income tax credit would be other possibilities. If nothing else, some way of offsetting Medicare losses for new physicians could be devised. Ironically, Congress has made it more difficult to attract and retain new physicians because Medicare reimbursements are discounted for new physicians their first five years of practice.

Currently, the Medical Scholarship Repayment Fund finances the costs of all medical scholarships and also part of the operating expenses of the Medical Center (general use). It might be advisable to dedicate use of the Scholarship Repayment Fund to financing of a loan program but this would require passage of legislation. Even if that were achieved, it might be necessary to supplement the Repayment Fund in some years depending on the success of the loan forgiveness incentive. Any cash grants or state income tax credits would be an added expense.

If you have any questions about these suggestions, please contact me or Chip Wheelen. Our phone number here at the KMS is 235-2383. Again, thanks!

Sincerely yours,

Jerry Slaughter
Executive Director

JS:ns

Testimony before the Senate Public Health and Welfare Committee on SB 693

March 3, 1992

Robert S. Wunsch
University of Kansas
Medical Center

Thank you Mr. Chairman. I am appearing as a conferee on behalf of the University of Kansas Medical Center. I do not appear as a proponent or opponent. It is the Medical Center's responsibility to administer the Medical Scholarship Program and in this connection, I am here to discuss Senate Bill 693.

Beside being a vehicle to provide finances to pay the significant increase in tuition which occurred in the late '70s, the initial focus of the Medical Scholarship Program was twofold, i.e. to retain KUMC graduates in Kansas and to provide KUMC graduates for underserved areas. There was no focus on the primary care specialties of family practice, general pediatrics and general internal medicine as is now the case. Likewise the service area available to physicians to satisfy service obligations was greater than it is today. In certain instances it was anywhere in the State of Kansas and in other' instances it was in underserved areas in Kansas. Beginning in 1982, a new service area of "critically underserved" was established. Now, for students first receiving benefits after January 1, 1986, the service area is no longer: a. anywhere in the State of Kansas; b. underserved areas or c. critically underserved areas but incorporated cities of 12,000 or less population. The designation of critically underserved and underserved areas will soon not be necessary for physicians entering practice in years to come will have first received benefits after January 1, 1986.

Senate Bill 693 changes the focus on the service area for those first receiving benefits after January 1, 1993 back to areas designated as critically underserved as opposed to cities under 12,000 population. Attached to this testimony is a memorandum dated March 2, 1992 which discusses this aspect of Senate Bill 693.

In this legislative session, a high level of legislative concern has arisen, even more than in prior years, over medical care in rural areas. As the Medical Scholarship Program now stands, "rural" seems to be defined as in areas where there are cities of 12,000 or less population. It is noted that House Bill 2941 which has been introduced this session is a bill that would significantly increase the population requirement in satisfying a service area obligation. It would allow the satisfaction of the service obligation by practicing in any county of less that 40,000 population which has a ratio of less than one practicing physician per 1,000 population. It could be argued that Senate Bill 693 in its change of focus on what satisfies a service obligation likewise might be redefining what is considered "rural". Certainly what is "rural" Kansas is legislative policy. We will administer the program however "rural" is defined.

Senate P. H&W
Attachment #4
3-3-92 AM

Additionally, Senate Bill 693 would significantly change the payment requirements for those who do not satisfy their service obligation. The bill provides that on and after January 1, 1993, any person failing to practice within a qualifying service area will be required to be repay two times the amount received plus 15% interest from the date of receipt. As worded this bill would seem to apply to students now under contract as well as those first receiving benefits January 1, 1993. A question arises in our mind that this provision is not be enforceable for those students currently under contract. It would, however, be unquestionably applicable to those first receiving benefits after January 1, 1993 as their contract would prescribe such repayment provision. It is the opinion of our personnel who administer the Medical Scholarship Program that this significant of a penalty might well prove to defeat the program.

Currently interest is at 15% on money when first received. In view of the fact that in almost all instances, the minimum time for interest to run on the first money received is seven years before repayment begins the amount initially received is more than doubled through interest. It might be well to note that in Oklahoma the repayment requirement is double the amount received but their compliance with their program in spite of such is less than our compliance with our program.

Further it appears as if the change in line 43 on page 2 would make the provision of K.S.A. 1991 Supp. 76-376 (a) (4) and 76-376 (a) (6) inapplicable for those first receiving benefits after January 1, 1993. It would seem that you might not want to be so restrictive.

I would be happy to stand for questions. Thank you

Attachment

Senate P. HEW
Attachment
4-2

The University of Kansas Medical Center

March 2, 1992

Office of Institutional Research and Planning

MEMORANDUM

TO: Bob Wunsch
Legislative Liaison

FROM: Ronald K. Spangler, Director
Institutional Research and Planning

SUBJECT: SB 693

We have examined the impact of Senate Bill 693 which would require service in critically underserved counties for KMS recipients first awarded scholarships after December 31, 1992. The change in service areas would have two separate impacts. These impacts were measured in terms of the 1991 Kansas Medically Underserved Areas Report which lists 52 counties as critically underserved in primary care.

First, the 52 critically underserved counties include two cities with 1990 U.S. Census populations of 12,000 or more: Junction City and Liberal. Under the current statutes, these two cities do not qualify as service commitment areas. Under the provision of SB 693, they would qualify since they are included in the 1991 list of critically underserved areas.

Second, there are 49 counties (excluding the four largest) which include cities of less than 12,000. Many of these cities are likely too small to support a full time primary care physician. There are still 26 cities among them that have more than 3,000 population that could theoretically support a full time physician based upon the current standard for underserved areas: 37.1 physicians per 100,000 population = 1 physician for every 2,695 persons. All of the cities listed on pages 2-4 of the attachment qualify as practice locations under the current statutes. Under the provision of SB 693, none of them would qualify. The five largest cities which would be excluded by SB 693 are: Winfield (11,931; Cowley Co.), Parsons (11,924; Labette Co.), Atchison (10,656; Atchison Co.), Independence (9,942; Montgomery Co.), and Chanute (9,488; Neosho Co.).

If you have any further questions or need additional information, please feel free to call me.

RKS:bef

Enclosure

3901 Rainbow Blvd., Kansas City, Kansas 66160-7116 • (913) 588-4870

University of Kansas Medical Center
Institutional Research and Planning

List of Cities which have 12,000 or more Population
Located in Counties which are Critically Underserved in 1991

City	Population	County
Junction City	20,604	Geary
Liberal	16,573	Seward

List of Cities with less than 12,000 population by Counties which are *Medically Underserved* or *Not Underserved* in 1991

County	City	Population
Allen	Bassett	20
	Elsmore	91
	Gas	505
	Humboldt	2,178
	Iola	6,351
	La Harpe	650
	Mildred	46
	Moran	551
	Savonburg	93
Anderson	Colony	447
	Garnett	3,210
	Greeley	339
	Harris	39
	Kincaid	170
	Lone Elm	32
	Westphalia	152
Atchison	Atchison	10,656
	Effingham	540
	Huron	75
	Lancaster	299
	Muscotah	194
Barber	Hardtner	198
	Hazelton	128
	Isabel	104
	Kiowa	1,160
	Medicine Lodge	2,453
	Sharon	256
	Sun City	88
Barton	Albert	229
	Claflin	678
	Ellinwood	2,329
	Galatia	47
	Hoisington	3,182
	Olmitz	130
	Pawnee Rock	367
	Susank	61
Bourbon	Bronson	343
	Fort Scott	8,362
	Fulton	191
	Mapleton	96
	Redfield	143
	Uniontown	290
Brown	Everest	310
	Fairview	306
	Hamlin	50
	Hiawatha	3,603
	Horton	1,885
	Morrill	299
	Powhattan	111
	Reserve	108
	Robinson	268
	Willis	86
Clark	Ashland	1,032
	Englewood	96
	Minneola	705
Clay	Clay Center	4,613
	Clifton	561
	Green	150
	Longford	68
	Morganville	181
	Oak Hill	13
	Vining	55
	Wakefield	900
Cloud	Aurora	101
	Clyde	793
	Concordia	6,167
	Glasco	556
	Jamestown	325
	Miltonvale	484
Cowley	Atlanta	232
	Burden	518
	Cambridge	74
	Dexter	320
	Udall	824
	Winfield	11,931
Crawford	Arcadia	338
	Arma	1,542
	Cherokee	651
	Frontenac	2,588
	Girard	2,794
	Hepler	150
	McCune	462
	Mulberry	555
	Walnut	214
Decatur	Dresden	73
	Jennings	188
	Norcatur	198
	Oberlin	2,197
Dickinson	Abilene	6,242
	Carlton	39
	Chapman	1,264
	Enterprise	865
	Herington	2,685
	Hope	404
	Manchester	80
	Solomon	939
	Woodbine	186
Douglas	Baldwin City	2,961

List of Cities with less than 12,000 population by Counties which are *Medically Underserved* or *Not Underserved* in 1991

County	City	Population
	Eudora	3,006
	Lecompton	619
Ellis	Ellis	1,814
	Schoenchen	128
	Victoria	1,157
Finney	Holcomb	1,400
Ford	Bucklin	710
	Ford	247
	Spearville	716
Greenwood	Climax	57
	Eureka	2,974
	Fall River	113
	Hamilton	301
	Madison	845
	Severy	357
	Virgil	91
Harper	Anthony	2,516
	Attica	716
	Bluff City	69
	Danville	56
	Freeport	8
	Harper	1,735
	Waldron	19
Harvey	Burrton	866
	Halstead	2,015
	Hesston	3,012
	North Newton	1,262
	Sedgwick	1,438
	Walton	226
Kingman	Cunningham	535
	Kingman	3,196
	Nashville	118
	Norwich	455
	Penalosa	21
	Spivey	88
	Zenda	96
Labette	Altamont	1,048
	Bartlett	107
	Chetopa	1,357
	Edna	438
	Labette	74
	Mound Valley	405
	Oswego	1,870
	Parsons	11,924
Leavenworth	Basehor	1,591
	Easton	405
	Lansing	7,120
	Linwood	409
	Tonganoxie	2,347
Lyon	Admire	147
	Allen	191
	Americus	891
	Bushong	57
	Hartford	541
	Neosho Rapids	235
	Olpe	431
	Reading	264
Marshall	Axtell	432
	Beattie	221
	Blue Rapids	1,131
	Frankfort	927
	Marysville	3,359
	Oketo	116
	Summerfield	169
	Vermillion	113
	Waterville	601
McPherson	Canton	794
	Galva	651
	Inman	1,035
	Lindsborg	3,076
	Marquette	593
	Moundridge	1,531
	Windom	136
Miami	Fontana	131
	Louisburg	1,964
	Osawatomie	4,590
	Paola	4,698
Mitchell	Beloit	4,066
	Cawker City	588
	Glen Elder	448
	Hunter	116
	Scottsville	26
	Simpson	107
	Tipton	267
Montgomery	Cancy	2,062
	Cherryvale	2,464
	Dearing	428
	Elk City	334
	Havana	121
	Independence	9,942
	Liberty	140
	Tyro	243
Morris	Council Grove	2,228
	Dunlap	65
	Dwight	365
	Latimer	20
	Parkerville	28
	White City	533

List of Cities with less than 12,000 population by Counties which are *Medically Underserved* or *Not Underserved* in 1991

County	City	Population
	Wilsey	149
Morton	Elkhart	2,318
	Richfield	50
	Rolla	387
Nemaha	Bern	190
	Centralia	452
	Corning	142
	Goff	156
	Oneida	79
	Sabetha	2,341
	Seneca	2,027
	Wetmore	284
Neosho	Chanute	9,488
	Earlton	69
	Erie	1,276
	Galesburg	160
	Stark	79
	St. Paul	687
	Thayer	435
Ness	Bazine	373
	Brownell	44
	Ness City	1,724
	Ransom	386
	Utica	208
Norton	Almena	423
	Clayton	91
	Edmond	37
	Lenora	329
	Norton	3,017
Pawnee	Burdett	248
	Garfield	236
	Larned	4,490
	Rozel	187
Pottawatomie	Belvue	207
	Emmett	165
	Havensville	135
	Louisville	215
	Olsburg	192
	Onaga	761
	St. George	397
	St. Marys	1,791
	Wamego	3,706
	Westmoreland	541
	Wheaton	106
Rawlins	Atwood	1,388
	Herndon	170
	McDonald	184
Reno	Abbyville	140
	Arlington	457
	Buhler	1,277
	Haven	1,198
	Langdon	62
	Nickerson	1,137
	Partridge	213
	Plevna	117
	Pretty Prairie	601
	South Hutchinson	2,444
	Sylvia	308
	Turon	393
	Willowbrook	95
Riley	Leonardville	374
	Ogden	1,494
	Randolph	129
	Riley	804
Rooks	Damar	112
	Palco	295
	Plainville	2,173
	Stockton	1,507
	Woodston	121
	Zurich	151
Saline	Assaria	387
	Brookville	226
	Gypsum	365
	New Cambria	152
	Smolan	195
Scott	Scott City	3,785
Stafford	Hudson	159
	Macksville	488
	Radium	47
	Seward	71
	Stafford	1,344
	St. John	1,357
Stanton	Johnson City	1,348
	Manter	186
Thomas	Brewster	296
	Colby	5,396
	Gem	104
	Menlo	50
	Rexford	171
Trego	Collyer	144
	Wakeeney	2,161
Wilson	Altoona	456
	Benedict	16
	Buffalo	293
	Coyville	78
	Fredonia	2,599
	Neodesha	2,837
	New Albany	60

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Board of Healing Arts

MEMORANDUM

TO: Senate Committee on Public Health and Welfare

FROM: Steve A. Schwerm, General Counsel

DATE: March 3, 1992

RE: **TESTIMONY ON SENATE BILL 694**

Mister Chairman and members of the Committee, thank you for the opportunity to appear before you and offer testimony on Senate Bill 694. This bill deals with three specific existing statutes under the jurisdiction of the Kansas State Board of Healing Arts. The bill involves statutes pertaining to accessibility of information currently possessed by criminal justice agencies, changing the structure of Review Committees and the confidentiality and release of official agency records.

The Board is vested by law to investigate all allegations of unprofessional conduct, dishonorable conduct and professional incompetency. As you are aware, these areas cover medical negligence, over-prescribing, performing unnecessary tests, examinations or services and a pattern or practice which demonstrates a manifest incapacity or incompetence to practice medicine. In addition to these medical issues, the Board has jurisdiction over practitioners regarding sexual misconduct, health

Senate P. H & W

Attachment # 5
3-3-92 AM

insurance fraud, conviction of a felony or Class A misdemeanor, violations of the Kansas Pharmacy Law and the United States Uniform Controlled Substance Act. A separate function of the Board is in the area of unauthorized practice of the healing arts in which individuals invade the field of medicine and actually practice medicine without being properly licensed or trained. In FY91, the Board investigated eight such incidents and took action in six. In FY92 to date, the Board has investigated five and taken action in two.

In order to sufficiently protect the public and complete thorough background investigations on applicants for licensure and to perform verification of information received during investigations, the Board is requesting authorization to be able to access and receive criminal record history information from criminal justice agencies. This would enable the Board to better investigate, gather data and carry out its mandated legislative purpose. This request is similar to authority given to other agencies, including the Kansas Racing Commission and the proposed language is modeled after the Racing Commission's statutory language (K.S.A. 1991 Supp. 74-8804[n]).

The second area of the bill deals with the change in the composition of the Review Committees. The current makeup of the Committees require two member to be from the branch of the healing arts as the person who's conduct is being reviewed and a third member in the "specialty" of the person who's conduct is being

reviewed. The proposed language would make this third member optional. Many times the involved specialty is already represented on the Committee by one of the two regular members. Additionally, the requirement of a third member in a specialty is difficult to accomplish when on an average day the Medical and Surgical Review Committee considers 20-25 cases. The present Review Committees, Board staff and the Board would still be responsible for insuring all areas of concern have been addressed prior to proceeding to any informal or formal action. This proposed language would, however, accomplish the same goal of required review but assist with logistics of such review. Another proposed change is to have the compensation of the Committee members established by the Board instead of the current $35 a day. A recent Committee meeting revealed that one of the physicians had spent approximately 87.5 hours in preparation of and at the Committee meeting for a rate of pay being 40¢ per hour.

The third and last section of the bill would address two main areas. First, it would make the Board records (including those obtained under the proposed language in section one of the bill) privileged and confidential. Currently, the Board records are only confidential. A recent Kansas Federal District Court ruling held that the Board's records are only confidential and could be accessed if the proper legal vehicle was utilized. Peer review records in the medical area are privileged but the bulk of

the Board's records are not peer review records and are not afforded that level of protection.

The final proposed language change would allow the Board to share information with other state and federal licensing, regulatory and enforcement agencies. Currently, the Kansas Social and Rehabilitation Services conducts investigations on Medicaid fraud and abuse, the Kansas Board of Nursing conducts investigations involving Advanced Registered Nurse Practitioners who are required to have a responsible physician, Health and Environment inspects and conducts investigations regarding hospitals, Health and Human Services conducts investigations regarding Medicare abuse and fraud, Postal Inspectors conduct investigations relative to mail fraud (both licensed practitioner and unauthorized practice, i.e., "bogus" cures and "quacks") and the Kansas Attorney General's Office conducts consumer protection complaint investigations. The Board also receives anonymous complaints which do not relate to a Board practitioner and currently can not refer that information to the proper agency. The Board also conducts investigations outside of the state, primarily for applicant background investigations and depending on the location of the witnesses and the location of the alleged act. The proposed language change will assist not only the Board of Healing Arts but also other state agencies through cooperative investigations, sharing of resources and elimination of duplicitous

investigations, hopefully, resulting in an economic savings overall for the State.

In conclusion, Senate Bill 694 would permit the Board to better perform its investigative duties in a more complete and thorough manner, provide protection for the Board records on a level of privileged versus only confidential and authorize the discretionary release of information to meet the needs of the Board and other state and federal agencies.

Thank you for the opportunity to appear before you and I would be happy to answer any questions you might have.