On March 6, the President’s “Hospital Cost Containment Act of 1979,” H.R. 2626, was introduced into the House of Representatives (and later in the Senate as S. 570). Unlike the previous Administration cost control bill, this year’s legislation would place a 9.7% national “voluntary” limit on the increase in total hospital expenses for 1979. Failure by the hospital industry to meet the limit would trigger a mandatory standby program for some hospitals for 1980 and subsequent years which would set ceilings on total hospital inpatient revenues per admission.

The Administration bases its 9.7% rate on estimates of three components of hospital costs: (1) a 7.9% inflation allowance for the cost of goods and services purchased by hospitals in 1979, which could be revised at year-end if the actual inflation rate is higher; (2) an 0.8% allowance for population growth; and (3) an allowance of 1% for new services. If the hospital industry as a whole fails to meet the limit, a state or even an individual hospital could still be exempt from mandatory controls in 1980 if it were under the nationwide voluntary limit which would be adjusted to take into account state population trends and local non-supervisory wage levels. The bill also exempts all hospitals in states that have HEW-approved rate/budget review mechanisms, as long as the aggregate increase for state hospital expenses falls within 1% of the national voluntary limit. Finally, rural hospitals with under 4,000 admissions, hospitals less than three years old, and hospitals with 75% of their patients enrolled in a qualified Health Maintenance Organization (HMO) would automatically be exempt from the mandatory program. The Administration projects that more than half of the nation’s community hospitals would be exempted under the above provisions.

For those hospitals which are not exempted, a mandatory program if triggered would be initiated in 1980 that would set allowable rates of increase in total inpatient revenues per admission for each hospital. The limit would: (1) be based on a national inflation allowance to cover the increase in the costs of goods and services purchased; (2) include an allowance for the actual rate of increase in non-supervisory rates experienced by that hospital; and (3) establish groups of similar hospitals and provide an efficiency bonus of up to 1% if the hospital was below the group median or an inefficiency penalty of up to 2% if the hospital was above 115% of the median of routine hospital per diem costs for its group. For example, a hospital with an initial allowable increase of 7.6%, but with actual costs at 120% of the average, would only be permitted a 6.6% increase.

The President’s bill also provides severe limits for hospitals that place an unequal burden on charge-based payors, who currently account for approximately 40% of hospital revenues. The legislation would require excess revenue from this class of payor to be placed in an escrow account which would be drawn on in future years only if revenue from charged payors was below the manda-
A hospital refusing to comply with the escrow requirement would be assessed a federal tax of 150% of the excess revenues.

Hearings on the President’s bill began on March 9, with Senator Edward Kennedy’s Subcommittee on Health and Scientific Affairs listening to comments from Administration witnesses, as well as hospital industry spokespersons. The House Interstate and Foreign Commerce Committee’s Subcommittee on Health and Environment and the House Ways and Means Committee’s Subcommittee on Health held joint hearings on March 12 to provide HEW Secretary Joseph Califano and the Administration’s chief inflation fighter, Alfred Knaus, an opportunity to clarify and answer questions about the proposed legislation. The respective House Subcommittee Chairmen, Representative Henry Waxman (D-Cal.) and Charles Rangel (D-NY), and Senator Kennedy introduced the President’s cost control bill by request.

**MEDICARE-MEDICAID REIMBURSEMENT REFORM ACT INTRODUCED**

On March 1, Senator Herman Talmadge (D-Ga.), Chairman of the Subcommittee on Health of the Senate Finance Committee, and Senator Robert Dole (R-Kan.), ranking minority member of the Committee, introduced the “Medicare-Medicaid Reimbursement Reform Act of 1979,” S. 505. The bill, essentially similar in many respects to the “Talmadge bill” introduced in the two previous sessions of Congress, would modify Medicare and Medicaid reimbursement practices for hospitals and physicians. Although Senator Talmadge has stated publicly that he does not view the bill as being in competition with the Administration’s cost containment bill, it is clear that the legislation is being viewed as an alternative to the President’s approach. In his introductory remarks, Senator Talmadge stated that: “The bill I am introducing does not involve government in its role as regulator—it is the government in its role as a purchaser of hospital care, the government as a prudent buyer.”

The hospital reimbursement changes, which would be effective with cost reporting periods beginning on or after July 1, 1980, would initially establish per diem payment limitations on routine operating costs, with costs for capital, education and training, residents and non-administrative physicians, energy, and malpractice insurance excluded. Aside from these exclusions, the bill is dramatically different from the Administration’s proposal to contain costs in that it initially sets limits only on routine inpatient costs, excluding ancillary service costs, and covers only Medicare and Medicaid reimbursement, whereas the Administration’s bill sets limits on all sources of hospital revenue.

The payment limitation under S. 505 would be determined by establishing categories of similar hospitals and setting the limitation at 115% of a category’s average routine operating cost. In establishing the comparison categories, a separate category would be established for the primary affiliates of accredited medical schools. Unlike past Talmadge proposals, the “primary affiliates” category would not be limited to one hospital per medical school. Hospitals would be classified by size, type (e.g., primary affiliates of medical schools), urban/rural setting, and by any other factors the Secretary may determine appropriate. Beginning on January 1, 1980, the Secretary would determine a target per diem rate for each group based on average adjusted routine operating costs. For costs other than
routine operating costs (e.g., ancillary costs), the Talmadge-Dole bill proposes a Health Facilities Cost Commission to study and propose limitations for other hospital costs as more sophisticated methods are developed.

Efficiency would be rewarded by allowing hospitals with costs below the target rate to keep one-half of the difference between their costs and their target rate, with the bonus payment limited to 5% of the target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115% of that rate, would be paid their actual costs. Those with costs above 115% would have their reimbursement limited to 115% of the target rate. In the second and subsequent years of the program, the target rate for hospitals above 115% would be increased by the actual dollar increase for its group in the preceding year. In calculating the group averages, however, one-half of the costs found excessive would be excluded from the calculation.

Exceptions would be permitted for hospitals which demonstrated that their excessive costs were attributable to low utilization justified by unusually high standby costs necessary to meet the needs of an underserved area; atypical costs for new hospitals; changes in services for such reasons as consolidation, sharing, or approved additions; and atypical intensity of service. The proposed legislation also exempts hospitals subject to state rate/budget reviews, if the reimbursement for the state would be no greater than that received under the program.

For physician services, S. 505 proposes new payment provisions for anesthesiologists, radiologists, and pathologists; establishes a mechanism for approving relative value schedules; permits an all-inclusive rate for free-standing ambulatory surgery centers; and proposes new criteria for determining reasonable charges. In addition, the legislation contains a number of other provisions which include: extension of the implementation date of Section 227 of the 1972 Medicare amendments until October 1, 1979; incentives for physicians to accept Medicare assignment provisions; a new higher schedule of allowable rates of return for proprietary hospitals; and payments to promote closure or conversion of under-utilized facilities. Hearings on the Talmadge-Dole bill were held on March 13-14 before the Senate Finance Health Subcommittee.

- **AAMC TESTIFIES ON ADMINISTRATION'S COST CONTAINMENT BILL AND TALMADGE-DOLE LEGISLATION**

On behalf of the Association of American Medical Colleges (AAMC), David D. Thompson, M.D., Director of the New York Hospital and former Chairman of the COTH Administrative Board, testified on March 14 before the Senate Finance Committee's Subcommittee on Health on both the Administration's cost containment proposal and the Talmadge-Dole Medicare and Medicaid reform legislation. Senator Talmadge (D-Ga.) is the Chairman of the Subcommittee and Senator Dole (R-Kan.) is its ranking minority member. Commenting first on the President's bill, Dr. Thompson outlined six major reasons for opposing this legislation: (1) it provides the Secretary of HEW with overly broad policy and administrative powers; (2) it would require exorbitant bureaucratic costs to administer; (3) the provision for calculating the wage component of the ceiling which permits a modified pass-through of non-supervisory wages is inconsistent with efforts to contain costs in a labor intensive industry; (4) the one percent allowance for service and program improvements is far below the historical average; (5) the bill's "anti-dumping" provisions is administratively unrealistic; and (6) the so-called "voluntary" limit is really a mandatory limit which undermines the truly voluntary program which is already underway and has been successful.

In contrast to the Administration's proposal, the Talmadge-Dole bill (S. 505), argued Dr. Thompson, is "a thoughtful, careful, non-precipitous proposal which will moderate hospital costs by redefining an institution's self-interest." Dr. Thompson complimented the Health Subcommittee for developing legislation that recognizes the rudimentary state-of-the-art in hospital classification schemes and provides for a combination of flexibility and a Health Facilities Cost Commission which can carefully monitor implementation.

The Association's testimony also expressed its appreciation for the provision permitting more
than one teaching hospital per medical school to be included in the teaching hospital category. While the modification in the teaching hospital category is a significant improvement, the AAMC said it remained concerned about the creation of a category for teaching hospitals because: (1) no one knows how routine operating costs in major teaching hospitals compare with routine operating costs in non-teaching hospitals; and (2) the principal source of atypical costs in major teaching hospitals results from the scope and intensity of service provided and the diagnostic mix of patients treated, not from the presence of an educational relationship with a medical school. Thus, the Association strongly recommended that the Secretary of DHEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals" before establishing a separate teaching hospital category.

With regard to the provision of exempting states with cost containment programs of their own, it was recommended that the bill be modified to include specific operating guidelines to insure that only programs that recognize the legitimate, full financial requirements of hospitals be exempted. In his closing remarks, Dr. Thompson expressed a word of caution about the provision that would permit expansion of the limits to cover some or all ancillary service departments. He stated: "From the perspective of regulatory complexity, and more importantly to us, from the standpoint of institutional management, there is a question of how far one might wish to go in this regard. The deeper one gets into comparing specific revenue centers and/or ancillary service departments, the more peculiarities of institutional characteristics become important to recognize, but difficult to quantitatively define . . . one result of such an approach would be to fractionalize the management of the hospital."

Judging from Senator Talmadge's questioning of both the Association witnesses and those from the American Hospital Association, the Subcommittee appeared intent on drawing contrasts between the Talmadge-Dole bill as a rational, carefully developed program that attempts to distinguish between efficient and inefficient hospitals and the Administration's legislation as a proposal that arbitrarily provides an across-the-board percentage which often rewards the inefficient institutions and penalizes the efficient. In questioning the Secretary of HEW, Senator Talmadge noted several times that he hoped that the Secretary's staff will work closely with the Subcommittee's staff so that an acceptable bill might result. The extent to which any compromise efforts might actually take place remains unclear.

Copies of the AAMC's testimony may be obtained from the Association's Department of Teaching Hospitals.

**MEDICARE PROPOSES NEW LIMITS ON ROUTINE SERVICE COSTS**

In the March 1st *Federal Register*, the Health Care Financing Administration (HCFA) proposed a new schedule of limits on payments to hospitals for routine inpatient services furnished Medicare beneficiaries. The new schedule of limits would apply to cost reporting periods beginning on or after July 1, 1979. HEW estimates that the number of hospitals exceeding the limits would increase from 800 to 1200. Disallowed costs would increase from $100 million to $225 million annually.

The methodology for establishing the proposed limitations, which is authorized under Section 223 of the 1972 Social Security Amendments, incorporates several concepts from Senator Herman Talmadge's (D-Ga.) Medicare-Medicaid Reform Bill and differs significantly from the methodology that has been used in the past. Since 1974, Medicare has annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its surrounding community. Unlike the current schedule, the proposed schedule would:

- Replace the present limitation on inpatient routine service costs by a limitation on general routine operating costs. To obtain general routine operating costs, capital and medical education costs are subtracted from the present inpatient routine service costs. The amount subtracted would be those presently shown on line 46 of Medicare Worksheet B in Column 2 (Depreciation: Buildings and Fixtures), Column 3 (Deprecia-
tion: Movable Equipment), Column 18 (Nursing School), and Column 19 (Intern and Resident);

- Reduce the hospital classification system from 35 categories to seven categories by deleting the variable of per capita income and using bed size and rural/urban location;

- Use a wage index derived from service industry wages to adjust the proportion of the limitations which represent wages paid;

- Use a “market basket” price index to update historical data and set projected ceilings. The market basket index is designed to measure and adjust for price changes in the goods and services purchased by hospitals.

While the revised methodology to determine limits may be a conceptual improvement, there are a number of issues which remain serious concerns:

1. Under the present limitation, the ceiling for a category is the 80th percentile plus ten percent of the mean. At least in theory, this permits all hospitals an opportunity to operate under the ceiling. By dropping the ten percent add-on, a constant 20% of the hospitals in the category would be forced to have costs over the ceiling.

2. While HCFA proposes to exclude capital and medical education costs because of their variability, exclusions for other highly varying costs such as malpractice coverage and energy costs have not been proposed.

3. The adjustment for prevailing wage differences, based on service industry wages, fails to reflect the salary and wage patterns of nurses. For example, COTH hospitals in Washington, D.C. would have the wage portion of their limitation adjusted upward to 122.33% while those in Minneapolis would have theirs adjusted downward to 84.41%. It is unlikely that nursing wages paid in Minneapolis are only 60% (84.41/122.33) of those in the D.C. area.

4. The use of only three bed size categories in non-Standard Metropolitan Statistical Areas (non-SMSAs)—less than 100, be-
tween 100-169, and over 169 beds—could cause particular problems for referral centers located in rural areas.

5. A preliminary analysis of HCFA/Medicare data shows California hospitals would be unusually hard hit by the proposal. Under the proposed limitations, $225 million in routine service costs will not be reimbursed nationwide, of which $100 million will not be reimbursed in California.

Because of these deficiencies in the proposed limitations, a COTH General Membership Memorandum was mailed on March 21st urging member hospitals to carefully review the potential impact of the limitations on their institutions and comment to HCFA. Comments, which must be received on or before April 30, should be addressed to the Administrator, HCFA, DHEW, P.O. Box 2372, Washington, D.C. 20013. Comments should refer to file code MAB-111-N. Copies of the newly proposed limitations may be obtained from the Association’s Department of Teaching Hospitals.

**MEDICARE PROPOSES REGS FOR NEW BASIS FOR MALPRACTICE COST APPORTIONMENT**

Regulations that would require malpractice costs incurred by a provider to be directly apportioned to Medicare based on Medicare malpractice loss experience, instead of the current apportionment basis of Medicare's overall utilization of provider services were proposed in the March 15th Federal Register by the Health Care Financing Administration (HCFA). The regulations would require a separate accumulation and direct apportionment of malpractice insurance premiums and self-insurance fund contributions. In addition, if a provider is paying uninsured malpractice losses directly, either through deductible or coinsurance provisions or as a governmental provider, or as a result of an award in excess of reasonable coverage limits, Medicare would reimburse the cost of these losses and any related direct costs only as attributable to Medicare beneficiaries. The purpose is to reimburse Medicare providers on a basis more closely related to actual malpractice experience.
A study, conducted under contract to HEW by Westat, Inc. of Rockville, Maryland, entitled Medical Malpractice Closed Claims Study—1976 Final Report, indicated that malpractice awards for Medicare and Medicaid patients are significantly lower in amount than losses for other patient population. The lower awards for these patients result, according to the study, because their income potential and life expectancy are less than the remainder of the patient population. Thus, the study reports, the use of overall Medicare utilization to allocate malpractice costs results in Medicare paying for a disproportionate amount of malpractice costs.

The dollar ratio of malpractice losses paid with respect to Medicare beneficiaries to total malpractice losses paid for all patients for a current cost reporting period and the preceding four-year period would be the basis for apportioning these malpractice costs to Medicare. If a provider had no malpractice claim loss experience for the five-year period with respect to Medicare beneficiaries, an actuarial estimate of Medicare's share of these current malpractice costs would be obtained by the provider from an independent actuary, insurance company or broker (whose cost would be directly assigned to Medicare for reimbursement). Medicare has selected a single provider's five-year malpractice loss ratio as the apportionment basis based on the theory that the estimated malpractice losses paid in future periods are closely related to past malpractice losses paid. However, HCFA welcomes any recommendations which could be taken into consideration in arriving at an equitable apportionment basis.

Comments on the proposed regulations will be accepted until April 30, 1979 and should be addressed to: Administrator, HCFA, DHEW, P.O. Box 2372, Washington, D.C. 20013. Please refer to file code MAB-110-P. Copies of the proposed regulations may be obtained from the Association's Department of Teaching Hospitals, which is currently reviewing them for comment.

- REPRESENTATIVE CARTER INTRODUCES LEGISLATION TO DELAY SECTION 227

Following up on his efforts of last year to obtain a repeal of the teaching physician provisions of Section 227 of the 1972 Medicare amendments, Representative Tim Lee Carter (R-Ky.) has introduced legislation to delay the date for the implementation of Section 227 until October 1, 1979. Representative Carter has sponsored this delay in implementation to provide DHEW with an opportunity to revise last year's draft regulations which were opposed by the medical education community as unworkable and inequitable. The Carter bill, H.R. 2426, was jointly referred to the House Committee on Ways and Means and the Committee on Interstate and Foreign Commerce.

A companion bill in the Senate, S. 195 was introduced earlier by Senator Dale Bumpers (D-Ark.) and ten co-sponsors (see February COHT Report). Six additional Senators—Lawton Chiles (D-Fla.), Alan Cranston (D-Cal.), Thomas Eagleton (D-Mo.), David Pryor (D-Ark.), Donald Riegle (D-Mich.), and Richard Stone (D-Fla.)—have joined as co-sponsors to S. 195.

The delay provision is also in the Talmadge-Dole Medicare and Medicaid Reform Act and was favorably voted on by the Senate Finance Committee on March 22nd.

- BILL INTRODUCED TO DEFINE INTERNS AND RESIDENTS AS EMPLOYEES

On February 15th, Representatives Frank Thompson, Jr. (D-NJ) and John Ashbrook (R-Ohio) introduced legislation which would amend the National Labor Relations Act to define interns and residents as employees for purposes of the Act. The bill, which has the same number, H.R. 2222, as its predecessor in the previous Congress, would overturn the March 1976 Cedars-Sinai decision of the National Labor Relations Board which declared that interns and residents are primarily students and should not be treated as employees under the Act. Upon introduction in the House, H.R. 2222 was referred to the Committee on Education and Labor where Representative Thompson is chairman of the Subcommittee on Labor-Management Relations and Representative Ashbrook is the ranking Republican.

The Association of American Medical Colleges is opposed to H.R. 2222 based on the belief that residency programs are an integral part of the medical education process and that the resident
is primarily a student whose relationship with
the hospital should be based on an educational
rather than an industrial model.

Hearings on H.R. 2222 have yet to be
scheduled.

- CAPITATION PROGRAM CUT 20%
IN RESCISSION PROCESS

On January 31, President Carter, as promised
in his Fiscal 1980 Budget Request (see February
COTH Report), sent to the Congress two pro-
posed rescissions for health programs for fiscal
year 1979, the current fiscal year. A proposed
rescission is a request by the Administration for
the Congress to reduce or eliminate, from the
current fiscal year's appropriations, funds pre-
viously appropriated by Congress for expendi-
ture. A proposed rescission requires approval
by a majority vote in both the Senate and the
House of Representatives within 45 Congres-
sional working days of the President's trans-
mittal of the rescission request. For the rescis-
sions submitted on January 31, this 45 day
period ended on March 27.

One proposed health rescission (R79-4) would
remove nearly $168 million from funds already
appropriated to the Health Resources Adminis-
tration (HRA). The other health rescission
(R79-3) would remove the $37 million needed
for construction of a child health building at the
National Institutes of Health (NIH). The House
Appropriations Committee adopted a rescission
bill which would have cut $61.8 million of the
$205 million in rescissions requested by the Pres-
dent for health programs. For the rescis-
sions submitted on January 31, this 45 day
period ended on March 27.

The implications of this rescission battle are
critical to the FY 1980 budget for health pro-
grams, particularly in the areas of health man-
power and biomedical research. The Carter Ad-
ministration has requested no funds for medical
school capitation in FY 1980. Senator Warren
Magnuson (D-Wash.), Chairman of both the
Senate Appropriations Committee and its Sub-
committee on Labor-HEW, has publicly asked
Dr. Donald Fredrickson, the Director of NIH, to
project a FY budget for NIH five percent below
the President's recommendations, which were
below the FY 1979 appropriated levels. These
initial skirmishes give strong indications that
the FY 1980 budget, which will be considered by
the Congress between now and September, will
undergo many attempts to reduce both direct
and indirect support for health professions insti-
tutions and their students. The present health
budget is not even likely to be maintained with-
out sustained efforts by all concerned.

The rescission process for health programs
($ in millions)

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*VOPP = Veterinary, Optometry, Podiatry and Pharmacy schools.
KENNEDY SUBMITS HEALTH PLANNING BILL

On March 5, Senator Edward M. Kennedy (D-Mass.), Chairman of the Senate Subcommittee on Health and Scientific Research, and seven of his colleagues on that Subcommittee, introduced S. 544, a bill to revise and extend the Health Planning and Resources Development Act (P.L. 93-641). The proposed legislation, which is titled “Health Planning Amendments of 1979,” is very similar to the planning bill that was approved by the Senate last July but which was lost in the legislative log jam at the end of the Congressional session. Their only major difference lies in the certificate of need review provisions and the strictness with which they would be applied to equipment purchases by physicians' offices. Last year's Senate-approved bill, which was also originally introduced by Kennedy, would have extended certificate of need review requirements to the acquisition of major medical equipment in excess of $150,000, regardless of setting or ownership. The current proposal embraces the provision approved last year by the House Commerce Subcommittee on Health and Environment which would require certificate of need review only for major medical equipment purchases over $150,000 that are used for hospital inpatients.

Other provisions in the current measure, S. 544, include the following:

1. Authorizes increased spending levels for health systems agencies (HSAs) of $150 million for fiscal year 1980, $175 million for fiscal year 1981 and $200 million for fiscal year 1982;

2. Increases authorization levels for grants to SHPDAs, authorizing $40 million for fiscal year 1980, $45 million for fiscal year 1981, and $50 million for fiscal year 1982;

3. Extends authorizations for grants for state rate regulation experiments at $6 million for fiscal year 1980, $7 million for fiscal year 1981 and $7 million for fiscal year 1982;

4. Allows for a fiscal year carry over of grant funds for IIASAs, state agencies, health services development funds and state rate regulation projects;

5. Places new emphasis on coordination of medical care planning efforts with those for mental health care and alcoholism and drug abuse programs;

6. Removes the requirement that HSAs’ health systems plans and annual implementation plans be “consistent with” the National Health Planning Guidelines. However, if they are not, the HSA would be required to provide a detailed explanation of the differences to the Secretary of HEW, the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC);

7. Amends the current law to ensure that the National Guidelines for Health Planning include standards for supply, distribution, and organization of health resources that reflect the unique circumstances and needs of medically underserved populations, including rural communities;

8. Establishes a program to assist and encourage the voluntary discontinuance of unneeded hospital services and authorizes appropriations for payments under this program at $50 million for fiscal year 1980, $100 million for fiscal year 1981, and $150 million for fiscal year 1982;

9. Clarifies that grants or contracts under Titles IV, VII, or VIII of the Public Health Service Act should not be reviewed by the HSAs unless they are to be made, entered into, or used to support the development of health resources or the delivery of health services that would make a significant change in the health services offered within the health service area;

10. Requires that before any person enters into a contractual agreement to acquire major medical equipment which costs more than $150,000 and will not be owned by or located in a health care facility, that person must notify the ap-
appropriate state agency of the intended purchase at least 30 days before contractual arrangements are entered into;

(11) Mandates technical assistance from HEW to the various planning bodies and HSA technical assistance to project applicants;

(12) Provides governors with veto power over state health plans;

(13) Authorizes the Secretary of HEW to change the boundaries of health service areas, only after securing approval of the governor(s) of the state(s) involved;

(14) Increases the membership of the National Council on Health Planning and Development from 15 to 20;

(15) Permits HSA board participation by providers whose principle place of business is within the respective health service area, although their residence may be elsewhere;

(16) Removes the stipulation that consumers on HSA boards cannot have been providers of health care within the 12 months preceding appointment and clarifies that major purchasers of health care include, but are not limited to, unions and corporations;

(17) Adds requirements for HSA staff to assure expertise in financial and economic analysis, public health and disease prevention, mental health planning and development, and use of mental health resources; and

(18) Adds a new requirement that at least one HSA staff member be assigned responsibility for providing the consumer members of the HSA governing body with such assistance as they may require to effectively perform their functions.

Hearings on S. 544 were scheduled by the Senate Subcommittee on Health and Scientific Research for March 16 and 21, with an intent to mark-up the bill on March 22. Although the AAMC did not appear before the Subcommittee, it has forwarded a written statement to Subcommittee Chairman Kennedy. The Association favored provisions in the bill that would: allow for justified inconsistencies between health systems plans and annual implementation plans and the National Guidelines for Health Planning; establish a program to assist and encourage the voluntary discontinuance of unneeded hospital services; increase authorizations for federal funding; emphasize coordination of planning efforts with those for mental health care and alcoholism and drug abuse programs; provide for carry over of grant funds; require technical assistance from HEW to HSAs and from HSAs to project applicants; and allow providers whose principle place of business is in a health service area to serve on its HSA board, although they do not actually reside in that area.

In addition, the Association’s testimony included several recommendations for strengthening and refining the present planning law: applicants for institutional health services should be encouraged to address their proposal’s impact on the clinical needs of medical education and biomedical research; Congressional intent should be clarified regarding how HSAs, in their review and approval of federal agency grants, will measure the level of significance of the service component of a grant and regarding those manpower and research grants without a significant service component that would be specifically exempted from review; HSAs be permitted to approve the limited introduction of new technologies prior to development of planning guidelines; HSAs be prohibited from conditioning approval of one health service request on an agreement to develop another health service; and HSAs and Statewide Health Coordinating Councils be required to include on their governing bodies a medical school dean, in areas with a medical school, and the chief executive officer of a tertiary care/referral hospital. The testimony concluded with the recommendation that any renewal of the Health Planning Act be accompanied by a committee report detailing criteria which will be used to evaluate the program for its continuation.

A copy of the AAMC’s testimony may be obtained from the Association’s Department of Teaching Hospitals. At the time this issue of the COTH Report was sent to press, the Administration’s health planning legislation had yet to be introduced but it was expected to be shortly. A review of the bill will be presented in the next issue of the COTH Report.
NEW BOARD DENIES FMG LIMIT WAIVER APPEAL

On May 24, 1978, a seven-member federal substantial disruption waiver appeals board was established as part of a two-tier effort to carry out a provision of the Health Professionals Educational Assistance Act of 1976 (P.L. 94-484) restricting the entry of alien physicians. The law authorized waivers of some of the new requirements for exchange visitor (J-visa) physicians until December 31, 1980, if compliance would cause a "substantial disruption of health services."

Under a procedure developed by HEW and agreed upon by the Departments of Justice and State, the Educational Commission for Foreign Medical Graduates (ECFMG) issues waivers automatically to four categories of programs and facilities. As of January 10, 1979, the ECFMG had issued waivers for 13 alien physicians requested by 11 institutions. If an institution seeks to admit more exchange visitors than its maximum allowable limit, it must appeal to the federal board.

The newly organized appeals board has denied its first appeal, a request by Boston University's Department of Anesthesiology to add an exchange visitor (J-visa) physician to its residency training program. The Board unanimously agreed that the institution had failed to prove "a substantial disruption of health services" would occur if the alien physician was not admitted to the program. The Board was willing to reconsider if the institution wished to resubmit the appeal with a stronger justification. The Board, which met for the first time on January 10, has received only the Boston appeal to date. Dr. Henry A. Foley, Health Resources Administration (HRA) Administrator and Chairman of the Board, presided at the meeting in Hyattsville, Maryland.

VETERANS' HEALTH CARE AMENDMENTS OF 1979 INTRODUCED

One of the first bills introduced in this Congress was Senator Alan Cranston's (D-Cal.) Veterans' Health Care Amendments of 1979, S. 7. He has already held two half-days of hearings on the bill. If enacted, S. 7 would add a number of substantial VA programs: a readjustment counseling program for veterans of the Vietnam era; a pilot program for treatment and rehabilitation of veterans with alcohol or drug dependence or abuse disabilities; and a pilot program of preventive health care services for certain veterans.

The bill would also substantially revise current legislative authority regarding acquisition and operation of Veterans Administration (VA) medical facilities. However, it would not affect or extend the VA/medical school relationship that authorizes: assistance in establishment of new state medical schools; grants to affiliated medical schools; assistance to health manpower training institutions; and sharing of medical facilities, equipment, and information. The authority for these latter programs expires at the end of fiscal year 1979 (September 30, 1979).

HOSPITAL PHILANTHROPY LEGISLATION INTRODUCED

On February 27th, Representative Tim Lee Carter (R-Ky.) introduced the "Voluntary Hospital Philanthropic Support Act" which is aimed at supporting and encouraging philanthropic donations to nonprofit community hospitals. Carter contends that recent health care system reforms have concentrated on correcting weaknesses rather than supporting strengths, such as philanthropy. In offering this legislation, he hopes the law will discourage overzealous cost containment efforts that remove incentives for productive voluntarism which has characterized the health industry in the past.

The bill, H.R. 2445, attempts to specifically accomplish the following:

1. Explicitly state and clarify in a formal amendment to the Social Security Act that philanthropy should be strongly encouraged and that HEW and other agencies interpreting the Social Security Act should in no way promulgate short-sighted revenue-saving restrictions which threaten philanthropic support;

2. Override any current HEW regulations that offset gifts, grants, and endowments against hospital operating expenses. The specific concern here is that in some cases, undesignated gifts or gifts designated for
The rise in hospital costs in Maryland has been significantly less than the rest of the nation. Last year's disclosure report indicated that hospital cost increases in Maryland were a full six percentage points less than the national average in 1977, and a full three percentage points less than the national average in 1976, leading to an estimated savings to Marylanders of $70 million.

The financial disclosure data also revealed the following:

- The average cost per EIPD increased 8.75% from $190.26 in 1977 to $206.90 in 1978. It should be noted that Maryland hospital rates are above the national average. While the cost of a patient day averaged about $190 in Maryland in 1977, the figure was $173.98 nationally, according to the American Hospital Association.

- The average cost per equivalent admission increased 7.84% from $1,582 in 1977 to $1,707 in 1978. This change is believed by the Commission to reflect a decrease in length of stay and in utilization of ancillary services. “Also important,” states the disclosure report, “is that with the acceptance by Medicaid and Medicare of Commission-approved rates, making Maryland the only state in the nation in which Medicare and Medicaid paid State-approved charges in all hospitals, charges were adjusted downward. Thus, hospital charges only increased 6.21% per admission—the first time in the dozen years since the enactment of Medicare and Medicaid that the average patient's bill in any state has gone up less rapidly than the cost of living.”

- The average revenue per admission increased 6.21% from $1,704 in 1977 to $1,810 in 1978.

- Total net profits of Maryland's hospitals have increased slightly from $13,488,033 in 1977 to $13,621,526 in 1978. The operating profit dropped from $4.91 million in 1977 to $2.7 million last year. But the 48 Maryland general hospital's projected budgets for this year would bring the operating profit to $4.28 million. Fourteen of the total of 58 general and specialty hospitals covered in the Commission's report showed net losses...
for their 1978 fiscal year, while 44 hospitals had profits.

- Summarizing the hospitals' expenses for charity care and bad debts, the study found hospitals averaged about 4.2 cents on the dollar, with the total amount for 47 hospitals at just under $39 million. The vast majority, over 84% of spending for charity care and bad debts, was in the metropolitan areas of the state.

The HSCRC was the first hospital rate review agency in the United States to regulate rates for all those who purchased hospital care. The Commission began regulating hospitals in 1974 and is composed of seven members interested in health care problems and appointed by the governor. The Commission, which is an independent body within the state's Department of Health and Mental Hygiene, has rate review authority which includes assuring the public that (a) a hospital's total costs are reasonably related to the total services rendered; (b) a hospital's aggregate rates are reasonably related to its aggregate costs; and (c) rates are set equitably among all purchasers of care. A copy of the Commission's third annual Disclosure of Hospital Financial and Statistical Data may be obtained for $3.00 from the Health Services Cost Review Commission, 201 West Preston Street, First Floor, Baltimore, Maryland 21201, (301) 383-6804.

**BITS AND PIECES**

**RECENT AMENDMENTS TO THE IMMIGRATION AND NATIONALITY ACT** (P.L. 94-484 and 95-83), their implications for a reduction in the number of alien physicians entering the United States, and the substantial disruption waiver application process, will be discussed by staff from HRA's Division of Medicine and the Educational Commission for Foreign Medical Graduates (ECFMG) at briefing sessions to be held by the AHA's Public General Hospital Section and the Center for Urban Hospitals. The schedule for the briefing sessions is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Time</th>
<th>Hotel</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 11</td>
<td>New York City</td>
<td>8:30-11:30 am</td>
<td>Sheraton LaGuardia</td>
</tr>
<tr>
<td>April 23</td>
<td>Cleveland, Ohio</td>
<td>1:00-4:00 pm</td>
<td>Marriott Airport</td>
</tr>
<tr>
<td>April 24</td>
<td>Chicago, Illinois</td>
<td>9:00-12:00 noon</td>
<td>Conrad Hilton Hotel</td>
</tr>
<tr>
<td>April 25</td>
<td>St. Louis, Missouri</td>
<td>1:30-4:30 pm</td>
<td>Marriott Airport</td>
</tr>
</tbody>
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Individuals planning to attend should call AHA on the toll-free number, 800-621-8132, and let the operator know which of these sessions they will be attending. Questions concerning these sessions may be directed to Alexandra Gekas, AHA, (312) 280-6424.

**THE RATE OF INCREASE OF PHYSICIANS' FEES HAS BEEN DECLINING SINCE 1975**, according to the American Medical Association's (AMA's) recently published 7th Annual Edition of Profile of Medical Practice: 1978. The profile reports that during 1977 physicians' fees rose 9.2% compared with 9.7% in 1976, according to the Consumer Price Index (CPI) which also reported that the all-items and all-services indexes rose faster in 1977 than in 1976. While the typical physician's expenses grew at a compound rate of 10.4% per year between 1969 and 1976, the average physician's net income showed only a compound rate of growth of 6% per year. The average physician's 1976 net income (before taxes) was $59,544, compared with $39,727 in 1969. His average expenses were $42,443 in 1976, compared with $21,224 in 1969. The profile also reports that the average physician had 128.5 patient visits per week in 1976, compared with 126.5 in 1975 and 125.8 in 1974. He practiced medicine 52.2 hours in 1976, compared with 51.8 hours in 1975 and 49.9 hours in 1974. A copy of the profile (OP-52) may be obtained for $5.00 from the AMA, P.O. Box 821, Monroe, Wisconsin 53566.

**THE COUNCIL ON WAGE AND PRICE STABILITY PUBLISHED IN THE FEBRUARY 13th FEDERAL REGISTER FINAL VOLUNTARY PRICE STANDARDS FOR MEDICAL AND DENTAL INSURANCE PROVIDERS.** The standards, which are
designed to achieve a reduction of approximately 15% in the "inflation trend factors" used in calculating premium costs, apply to all policies for which premiums are quoted or announced after February 15, 1979 or which are issued or renewed on or after April 1, 1979. The standard assumes that hospital spending growth will be limited to HEW’s requested voluntary 9.7% annual increase and that physicians will voluntarily restrict their fee increases to 6.5%, as previously requested by the Council. An alternative profit-margin limitation is available to insurers who provide medical and dental insurance if they demonstrate, on the basis of actual claims data, an increase in the ratio of claims to premiums or a likelihood of negative profit for the year. Health Maintenance Organizations are exempted from these standards.

GRANTS TOTALING $4.5 MILLION WILL BE AWARDED BY THE BUREAU OF HEALTH MANPOWER (BHM) IN FISCAL 1979 TO STIMULATE THE TEACHING OF GERIATRICS, APPLIED NUTRITION AND OCCUPATIONAL AND ENVIRONMENTAL HEALTH. The initiative was announced in the February 1st Federal Register. Purposes of the awards, which are authorized in Section 788(d) of the Public Health Service Act, are to: (1) support interdisciplinary educational programs in nutrition to improve the skills of primary care personnel; (2) increase awareness of future primary care physicians of the role of harmful environmental factors in causing diseases and provide instruction in diagnosis, treatment and prevention; and (3) facilitate efforts to instruct future health care practitioners about the special health needs of the elderly and the best way to meet them. A maximum of three years’ support may be requested, but priority will be given to projects that will produce usable products such as syllabi, texts or other instructional materials during the first year of support.

Of the total funding available in fiscal 1979, $2 million will be awarded for curriculum development grants in geriatrics; $1.5 million for applied nutrition; and $1 million for occupational and environmental health. Geriatrics and applied nutrition grants may be awarded to health professions (medicine, osteopathy, dentistry, optometry, pharmacy, podiatry and veterinary) schools, allied health professions or nurse training institutions of other public or non-profit entities. Support for occupational and environmental health projects is limited to schools of medicine and osteopathy. Application materials were expected to be made available on March 1st. Persons wishing to receive an application kit should write to: Grants Management Officer, BHM, 3700 East-West Highway, Hyattsville, Maryland 20782. The deadline for returning completed applications is April 23, 1979.

THE W. K. KELLOGG FOUNDATION HAS AWARDED A $350,000 GRANT TO THE COMMISSION ON GRADUATES OF FOREIGN NURSING SCHOOLS (CGFNS) to support the testing of foreign nurses seeking to come to the United States to practice. Foreign nurses must have studied medical, surgical, pediatric, psychiatric, and obstetric nursing and have passed their own country’s licensing exams in order to qualify to take the screening exam which tests both their nursing knowledge and English comprehension. On the recommendation of the Bureau of Health Manpower’s Division of Nursing, the American Nurses Association and the National League for Nursing jointly sponsored the CGFNS and designed the test which was first administered in 30 countries in October 1978. The CGFNS won’t release the results until it has conducted several tests and expects that in the future the U.S. Immigration and Naturalization Service will require certification that a foreign nurse pass the CGFNS exam before it will award an occupational preference visa.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) HAS AWARDED A GRANT OF $3.2 MILLION OVER A FIVE-YEAR PERIOD TO NORTHWESTERN UNIVERSITY’S CENTER FOR
HEALTH SERVICES AND POLICY RESEARCH (CHSPR) for assistance in setting national health care financing policy. CHSPR, which qualified for designation as a national health services policy center in a national competition, will attempt to bring a multi-disciplinary approach to analyzing problems in hospital and physician cost containment and to assessing HCFA’s demonstration and evaluation program.

SEVEN CONTRACTS TOTALING $1.4 MILLION HAVE BEEN AWARDED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) TO DEMONSTRATE ALTERNATIVE METHODS OF REIMBURSING HEALTH MAINTENANCE ORGANIZATIONS (HMOs) FOR THE CARE OF MEDICARE AND MEDICAID PATIENTS. The demonstration projects are part of HEW’s efforts to encourage Medicare and Medicaid beneficiaries to enroll in HMOs and improve the method of reimbursing HMOs for the care of these patients. In addition to providing information on alternative reimbursement methods, the HCFA expects the demonstrations to identify effective marketing and enrollment strategies and methods of monitoring HMO performance. The demonstrations, which involve an average one-year development phase, after approval, will enter a maximum three-year testing phase. The projects anticipate a total Medicare enrollment of 60,653 and a Medicaid enrollment of 17,475. The overall cost of the seven experiments is $3,892,035, of which $1,396,067 has been awarded for the development phase.

MASSACHUSETTS GENERAL HOSPITAL (MGH) IN BOSTON, CHARTERED AS AN EDUCATIONAL UNIT BY MASSACHUSETTS BOARD OF EDUCATION IN 1977, WILL BECOME THE STATE’S ONLY HOSPITAL-BASED SCHOOL. The school, which will eventually offer two bachelor’s and five master’s degree programs, will open in September 1980 with only three courses in nursing, dietetics and physical therapy. The school will be financed entirely through educational revenues, similar to a private university, and, therefore, MGH has started an active fund raising campaign. MGH had to confront numerous legal obstacles related to certificate-of-need (CON) laws because of the school’s financing approach. However, in 1978 the state legislature passed a bill exempting from CON requirements, under certain conditions, teaching and research in hospitals where these activities would not lead to an increase in the number of beds.

IN AN EFFORT TO STREAMLINE ITS TECHNICAL ASSISTANCE BUDGET, the Bureau of Health Planning has announced that it will reduce from ten to four the number of regional Centers for Health Planning as of July 1st. Funding for these four centers, which provide technical assistance and research support for local and state planning agencies, will be provided in fiscal 1980 from unspent fiscal 1979 technical assistance funds as the Bureau attempts to eliminate all such funding by 1980.

ON FEBRUARY 1, PETER W. BUTLER JOINED THE DEPARTMENT OF TEACHING HOSPITALS AS A STAFF ASSOCIATE. Mr. Butler earned a B.A. from Amherst College in 1973 and a Master of Health Services Administration from the University of Michigan’s Program in Hospital Administration in 1976. For the past two years, he has been a member of the Department of Institutional Development at the AAMC and served as Editor of MAP Notes, a quarterly publication of current management information for academic medical center administrators. Mr. Butler was also associated with the AAMC’s Management Advancement Program (MAP) and participated in several studies of management issues facing medical centers including Departmental Review in Schools of Medicine and academic tenure.

In his role with the Department of Teaching Hospitals, Mr. Butler will be responsible for the annual survey of House Staff Stipends, Benefits and Funding, as well as other departmental surveys, in addition to responsibilities for monitoring certain legislative initiatives.