COTH report

COUNCIL OF TEACHING HOSPITALS ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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## ● PRESIDENT ISSUES DIRECTIVE TO HALT FEDERAL FUNDING OF HOSPITAL CONSTRUCTION IN OVERBEDDED AREAS

In a June 10 press release from the Council on Wage and Price Stability, Alfred E. Kahn, the President's advisor on inflation, announced that President Carter has directed federal agencies to limit the use of federal funds and tax subsidies to finance the construction of unnecessary new hospital capacity and the renovation of existing hospital capacity in areas where there are already too many hospital beds. The Department of Health and Human Services (HHS) estimates that the nation now has about 130,000 unneeded hospital beds, which it believes costs the economy $4 billion, and the federal government $1.1 billion, each year.

Using the standards of no more than four acute care non-federal hospital beds per 1,000 population or at least an annual average daily occupancy rate of 80 percent to determine overbeddedness, HHS estimates that as many as 196 of the 213 health service areas in the United States may be overbedded. The purpose of the President's directive is described as an effort "to prevent *Federal* (their emphasis) funds from contributing to the worsening of this condition in areas where there are more beds than necessary to serve the population adequately." Over $850 million in federal hospital construction and renovation is budgeted for 1981. Of the nearly $5 billion in non-federal hospital capital expenditures approved by State Planning Agencies in 1979, approximately half were federally subsidized or guaranteed. In addition, Medicare and Medicaid reimbursement for capital costs will total $2.3 billion in 1981, according to HHS.

All federal programs through which funds are or could be made available for hospital construction and renovation are covered by the directive. They are:

1. Programs under which hospitals are built, owned and operated by agencies of the federal government (e.g., the Veterans Administration, Department of Defense, and the Department of Health and Human Services).
2. Federal programs that subsidize both private and public construction through grants, loans, and loan guarantees (the Departments of Housing and Urban Development, Commerce, Interior, Agriculture, Treasury and Health and Human Services, the Appalachian Regional Commission, and the Small Business Administration).
3. Programs that aid hospital construction through federal tax subsidy. Tax-free municipal bonds are used to finance private and public hospital construction.
4. Federal reimbursement for patient care. Reimbursement to hospitals for care provided to Medicare and Medicaid patients includes reimbursement of the costs of constructing facilities required to provide that care (HHS).

With regard to direct federal construction, the President's directive calls for careful review of federal needs as part of the annual

*Continued on next page*

budget process. Relative to federal grants, loans, loan guarantees, and tax-exempt bonds, the President has directed that a new administrative procedure be established to assure that these funds will not contribute to unnecessary hospital construction. Federal subsidies will be provided only where the proposed construction is consistent with approved, institution-specific state and local health facilities bed reduction plans or (in the absence of such plans) is found to be necessary after a federal review. Development of the facilities plans would be a new requirement for planning agencies, separate and distinct from their health plans. HHS has been charged with the implementation of the federal review process, which it is understood will be similar to the certificate of need process. This review will apply immediately to federal grants, loans, and loan guarantees. Legislation will be sought to extend this review to tax-exempt bonds.

Concerning Medicare and Medicaid reimbursement for construction costs, the President reiterated his support for legislation which would deny reimbursement in all states for depreciation and interest on capital expenditure projects judged to be unnecessary by state and local health planning agencies. Such denial is now automatic in only 26 states under Section 1122 of the Medicare law. The President has also directed DHHS to review other aspects of Medicare and Medicaid reimbursement policy and to develop additional legislative or administrative proposals which would provide for more stringent controls on capital expenditures and support for policy to reduce overbedding.

In the June 17 *Federal Register*, the Office of Management and Budget (OMB) issued the President's directive as a proposed Memorandum to the heads of selected federal departments and agencies. The policies established by the Memorandum will apply to all hospital construction and renovation for which federal funds have not been obligated as of the eventual effective date of a final Memorandum. Each affected department or agency shall establish procedures to insure that no federal funds are obligated for such purposes in overbedded areas unless the projects are consistent with the policies of the Memorandum. The Secretary of HHS shall: (a) establish procedures for providing timely notification of whether an area is overbedded; (b) establish criteria and standards for acceptable hospital facilities plans and for determining when, in the absence of an approved plan, proposed construction may be eligible for federal support; and (c) develop recommendations for actions to assure that Medicare and Medicaid reimbursement policies support the objective of reducing unnecessary hospital capacity.

The agency and HHS procedures, criteria, standards and recommendations will have to be submitted to OMB for approval within 30 days of the effective date of the final Memorandum. In addition, FY 1982 agency budget submissions to OMB shall include, for proposed federal hospital construction projects in an overbedded area, a description of (1) the need for construction, (2) the overbedding situation, and (3) the inability to acquire suitable existing non-federal facilities.

OMB has provided a 30-day comment period on the proposed Memorandum. Comments can be sent through July 17 to the Health Branch, OMB, Room 7002, NEOB, 726 Jackson Place, N.W., Washington, D.C. 20503. Copies of the Memorandum are available from the AAMC's Department of Teaching Hospitals.

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## AAMC COMMENTS ON PROPOSED SECTION 223 LIMITS/FINAL LIMITS RELEASED

In the April 1 *Federal Register*, the Health Care Financing Administration (HCFA) published a proposed schedule of limits on hospital inpatient routine operating costs that would become effective for cost reporting periods beginning on or after July 1, 1980. On June 2, the Association of American Medical Colleges (AAMC) submitted a letter of comment on the proposed regulations to Acting HCFA Administrator Earl Collier, Jr.

The Association argued, as it has in the past, that the methodology used to set the limits on Medicare hospital costs is simplistic, arbitrary and inconsistent with Congressional intent. As stated in P.L. 92-603, Section 223 defines reasonable costs for reimbursement under the Medicare program as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services." The proposed limits, it was argued, do not specifically define what is unnecessary or efficient, except by arbitrary statistical thresholds.

The AAMC did support two changes in this year's proposed methodology. The first was the new educational cost factor which would permit hospitals to adjust their limits upwards based on the ratio of the number of FTE residents per bed. The Association noted, however, that the application of this factor needs modification and clarification. The second change considered favorable was the expanded definition of labor costs which results in the wage index being applied to approximately 80 percent of hospital inpatient costs, as compared to 60 percent under the present limits.

With regard to other technical issues, the Association argued that:

- the methodology used to classify hospitals does not result in homogeneous groups of hospitals;
- energy and malpractice costs which are highly variable should be excluded from the limit;
- the process of adjusting for errors in cost projections needs additional explanation;
- the exceptions process is inadequate; and
- the limits do not recognize the costs associated with the provision of complex, tertiary care services to intensely ill patients.

In the June 20 *Federal Register*, HCFA issued the final Section 223 limits for cost reporting periods on or after July 1, 1980. These limits are similar to those proposed. However, several aspects of the final limits are worth noting:

- The new adjustment for teaching activity has been retained, but the reporting method has been changed. Hospitals will be required to report the number of full-time equivalent residents to their intermediary 45 days prior to start of their cost reporting period so that the intermediary can provide the estimated limit to the hospital 30 days before the beginning of the cost reporting period. The number of residents will be based on those present on the September 30 preceding the date on which the report is due. The figure will be adjusted if the number actually present on the September 30 during the cost reporting period is different from the initially reported estimate.
- The final limits for all hospital groups are slightly higher than the proposed limits because of revised inflation factors (see Table next page).
- The wage index for Minneapolis-St. Paul has been increased substantially because wage information for governmental hospitals in that SMSA, which was not previously available, is now included in the data for that SMSA. Because the wage indexes must average 1.0 nationwide, a consequence of the higher Minneapolis-St. Paul index is that all other SMSA wage indexes are slightly lower.
- Malpractice insurance costs are now subject to the payment limitations. This ruling became effective July 1, 1979 when the method of apportioning malpractice costs to the Medicare program was changed. While the April 1 proposed limits did not mention this change, the final notice does explicitly state that these costs will be excluded.

Copies of the final schedule of limits may be obtained from the AAMC's Department of Teaching Hospitals.

*Section 223 Hospital Inpatient Limits*

| Bed Size | SMSAs: Labor-Related Proposed Limit (April 1) | SMSAs: Labor-Related Final Limit (June 20) | SMSAs: Non-Labor Component Proposed Limit (April 1) | SMSAs: Non-Labor Component Final Limit (June 20) |
|---|---|---|---|---|
| Less than 100 | $98.20 | $101.17 | $26.62 | $27.55 |
| 100-404 | 97.19 | 100.49 | 27.12 | 28.04 |
| 405-684 | 94.49 | 97.09 | 26.47 | 25.25 |
| 685 and above | 99.32 | 101.55 | 29.19 | 29.93 |
| *Non-SMSAs* | | | | |
| Less than 100 | 93.95 | 95.82 | 22.65 | 23.50 |
| 100-169 | 93.16 | 95.16 | 22.72 | 23.59 |
| 169 and above | 90.07 | 91.97 | 22.36 | 23.17 |

## FIRST CONCURRENT BUDGET RESOLUTION PASSED BY CONGRESS

On June 12, following agreement by the House-Senate Conferees, both Houses of Congress passed the second conference report on the First Concurrent Budget Resolution for FY 1981. This resolution establishes a plan for achieving a balanced budget at $613.6 billion in the coming fiscal year and adjusts the fiscal 1980 budget to account for unanticipated economic developments and unplanned policy shifts. As expected, several modifications were made in the recommendations of the first conference report—a bill earlier overwhelmingly rejected by the House. These included a reduction of $800 million in the budget authority for defense, with offsetting increases of $200 million for education, $100 million for health, and $100 million for science, research and technology.

The increased allowances for health expenditures were modest, bringing the total figure for health to $71.2 billion. The increase will probably be allocated to discretionary programs, raising the level for these to between $9.3 and $9.6 billion, depending on the final estimate of the uncontrollable programs. The recommended total for the discretionary programs in the President's revised FY 1981 budget was $9.6 billion, an amount that included no funds for medical school capitation (see April *COTH Report*).

While the Budget Committee has established the ceiling of $71.2 billion for health expenditures, this is only a guideline which leaves the full Appropriations Committees and various Subcommittees in both the House and Senate with flexibility in distributing the funds among the various functions and programs within their jurisdictions. Thus, it is possible, that health appropriations could exceed the $71.2 billion ceiling. Further clarification on the various budget ceilings will not occur until September 15, the date by which Congress is legally required to complete action on the Second Concurrent Budget Resolution. After passage of the second budget resolution, Congress can then act on the FY 1981 appropriations bill. Hopefully, all this will occur prior to October 1, 1980, the start of the 1981 fiscal year.

On June 19, the House of Representatives passed H.R. 7542, a comprehensive supplemental appropriations bill for fiscal year 1980. The measure contains $17 billion in additional funds for a variety of federal programs and includes recommendations for rescission of more than $1 billion in other, previously enacted, legislation. The bill also contains an amendment modifying the controversial provision that federal Medicaid matching payments may not be made on state claims dating before October 1, 1977. The Health Care Financing Administration (HCFA) would be prevented by the amendment from permitting payments for abortions under Medicaid under these late claims. On June 17, however, President Carter signed into law P.L. 96-272, the "Child Welfare Services Act," which contains language to establish a flexible timetable for submitting claims under Medicaid.

States would be given until December 31, 1980 to submit claims dating before October 1, 1979. It is uncertain at this time as to whether P.L. 96-272 will legally supersede the language in the supplemental appropriations bill. On the Senate side, the Appropriations Committee has been meeting in an attempt to bring the FY 1980 supplemental appropriations bill to the floor as soon as possible. However, such had not yet occurred at the time this issue of the *COTH Report* went to press.

The reconciliation provisions of the first concurrent budget resolution require that the Senate Finance and the House Ways and Means Committees report to their respective budget Committees, specifying spending reductions to meet the reconciliation requirements. Both the Senate and House Committees have now completed this task.

The Senate Finance Committee agreed to:

(1) Implement certain provisions of H.R. 934, Senator Talmadge's Medicare-Medicaid Administrative and Reimbursement Reforms Act, to save $297 million. This includes $70 million from retention of the 8½ percent nursing cost differential until March 1981 (i.e., the first half of fiscal 1981) and then deferring payments during the second half of fiscal 1981, during which time the General Accounting Office (GAO) would conduct a study of the issue and develop new, more equitable nursing costs differential payment regulations for fiscal 1982;

(2) Establish a new method of reimbursement for routine operating costs, effective July 1, 1980, replacing the current Section 223 classification system with one that would provide incentive payments for below average costs and penalize hospitals with costs substantially above average. Of concern, is the fact that this new system would build a ratcheting mechanism into the reimbursement formula;

(3) Defer for one month the Periodic Interim Payment (PIP) program under Medicare, which would normally make payment during September 1981, until fiscal 1982 (which would begin in October, 1981), to achieve a $675 million savings;

(4) Calculate Medicare reasonable charges on the basis of when the service was rendered rather than when the claim was processed to save $147 million from avoiding higher payment at rates annually updated to reflect economic changes;

(5) Retain offset funds for the federal government whenever a State's claim for matching Medicaid funds is disallowed and the State appeals the decision while continuing to hold the funds in dispute, to save $75 million;

(6) Limit home health agency reimbursement, a $75 million savings; and

(7) Limit the "freedom of choice" that Medicaid patients presently have in selecting providers, to achieve a $93 million savings.

The last provision should be of particular interest to COTH members, for it would allow states greater discretion in arranging for care and services for Medicaid recipients through least cost service arrangements. Recognizing the potential impact on teaching hospitals, Sen. Abraham Ribicoff (D-Conn.) added an amendment to the provision that would ensure that the appropriate and necessary use of hospitals with graduate medical education programs would not be adversely impacted. The spending reduction measures passed by the Senate Finance Committee total $2.2 billion in savings for all programs, of which $1.4 billion would come from the health area.

The House Ways and Means Committee recommended reductions that would save an estimated $2 billion in all programs, of which $801 million would come from the health area. The House Committee took no action in relation to the 8½ percent nursing cost differential, however, it did agree to defer PIP for $675 million in savings in FY 1981. In addition, the House Committee approved provisions in H.R. 3990/ H.R. 4000, the "Medicare-Medicaid Amendments of 1980," which contain savings of $126 million in the Medicare program. The major savings would be derived from: (1) differential payment for long-term care services provided in hospitals; (2) PSRO review of routine hospital admission services and excessive preoperative

stays; (3) making Medicare payment liability secondary in automobile insurance cases; and (4) encouraging the use of outpatient surgical centers. The effective dates for the spending provisions would be postponed until mid-year 1981. More detailed descriptions of the spending reduction recommendations made by both the Senate and House Committees may be obtained from the AAMC's Department of Teaching Hospitals.

# FACES IN THE NEWS

## MAJOR HEALTH DEREGULATION LEGISLATION INTRODUCED IN HOUSE

On June 9, Congressmen Richard Gephardt (D-Mo.) and Dave Stockman (R-Mich.) introduced H.R. 7527, "The National Health Care

REP. GEPHARDT

REP. STOCKMAN

Reform Act of 1980," before the U.S. House of Representatives. The measure is intended to deregulate the health care industry and encourage competition as a means to contain health care costs. It may be recalled that it was Rep. Gephardt's substitute provisions (H.R. 5635) which aided in the defeat of the hospital cost containment proposal in 1979 and endorsed the hospital industry's Voluntary Effort (see October-November 1979 *COTH Report*).

Gephardt and Stockman argue that their measure would introduce the following changes in the nation's health care delivery system:

- Introduction of financial incentives for health care insurers and providers to contain costs and improve the quality of care.
- Elimination of existing methods of payment in favor of free-market forces to contain health care expenditures.
- Offering all Americans a broad variety of health insurance plans, while retaining their freedom to choose among health care providers. The plans would be paid for, at least in part, by employers, but there would be price and income tax incentives for workers to choose plans that offered a basic package of benefits for the lowest price.
- Enabling those Americans who now have little or no insurance to buy basic health care protection.
- Increasing the benefits that would be made available to Medicare beneficiaries by giving them the option of selecting new methods of delivery and of benefitting from the cost savings.
- Federalizing Medicaid (at the option of each state).
- Phasing out cost-based reimbursement for hospitals and other providers, which the Congressmen consider a major deterrent to effective cost containment. Providers would then compete on the basis of quality and price.
- In addition to eventually ending the current Medicare and Medicaid programs and cost-based reimbursement, the proposed legislation would also eliminate Professional Standards Review Organizations (PSROs) and the government-mandated health planning system (including all certificate of need requirements). Furthermore, Health Maintenance Organizations (HMOs) would have to compete on equal terms with other health care and insurance providers.

Of particular interest to COTH constituents, the bill would offer grants to partially compensate for the loss of revenue teaching hospitals may suffer in a competitive system. The existing system of reimbursement of education costs through Medicare would be phased out and education costs would become a line item in the federal budget. The specific provision reads: "The Secretary shall make grants to, or enter into contracts with, entities (other than educational institutions) to compensate them for *not*

*more than 70 percent of the direct costs* of providing graduate medical education and training for nurses and other health care professionals through accredited educational programs, *to the extent the Secretary finds such compensation is necessary* to provide training for needed health care professionals (emphasis added)." Both public and private non-profit hospitals could qualify. At a press conference, Rep. Gephardt stated that the nation's teaching hospitals might actually benefit by encouraging competition for specialized services. He noted that, "In a competitive environment, I would think that teaching hospitals would do better than many of them think they would. They have teritary care, which is a very valuable service, that they could market to other plans in other hospitals." Continuing on the topic of meeting the costs of education, Gephardt declared: "I think it's a lot better for our society to address those questions head on and make a societal decision about how much to spend and how much we should spend—and obviously we should spend money—on education and research in teaching hospitals."

The National Health Care Reform Act of 1980 is based on Qualified Health Care Plans which could be sponsored by any person or agency or government. Sponsors could include hospitals, doctors, Blue Cross, Blue Shield, commercial insurance companies, or others who would develop innovative delivery mechanisms. Each citizen would receive a Health Care Contribution from the federal government in one of the following four forms:

(1) The present exclusion from income tax for health care premiums paid by employers on behalf of their workers would be maintained, but the exclusion would be provided only if the contribution is used to pay for the premium in a Qualified Plan. Initially, until 1985, the limit would be the national average Medicare expenditure, which at present is approximately $1,300. Later, it would be limited to the average premiums paid by similarly situated individuals in an area, although no worker would have an exclusion which is less than what his employer paid on his behalf before the bill was enacted. A worker who chose a health plan with a premium less than his employer's contribution would be able to keep the difference in cash, tax free, up to $500.

(2) For people whose employers do not pay the cost of the premiums in Qualified Health Care Plans or who are themselves self-employed, a tax credit would be granted which would be equal to the amount spent by the person for the premium, but no higher than the exclusion provided to other workers. The tax credit would be refundable so that the individual would receive the money from the government even if the cost of the Plan premium was greater than his tax liability.

(3) Medicare beneficiaries would have the option of remaining with the present Medicare benefits system or entering a voucher system in which they would receive a direct federal Health Care Contribution for use to buy coverage from a plan offered in the competitive system. The health care contribution for these individuals would be equal to the average cost of health plans purchased by Medicare beneficiaries. Those who selected a lower cost plan would be able to keep the difference as a tax-free refund. Plans providing services to Medicare individuals would be required to provide benefits which are greater than those currently covered by Medicare. For instance, outpatient drugs would be provided and there would be no limitation on the number of hospital inpatient days. The Medicare program would be considered abolished once 50 percent of its beneficiaries had opted out of the old program.

(4) After a four-year period for the competitive system to become established, Medicaid recipients and poor people not now eligible for Medicaid would be eligible to come under the Act. States would have the option of joining a federalized Medicaid system. If they made the selection, they would avoid further increases in their Medicaid costs. The bill provides that expenditures for health care for the

poor by states electing to be covered by the new program would be no greater than it was this year, indexing for inflation. Eligible recipients would be provided a direct Health Care Contribution that would allow them to buy coverage from a competitive plan and enable them to join the mainstream of community health care delivery. The contribution would be equal to the average of the premiums paid and out-of-pocket expenditures incurred by the other members of the community for health care provided by Qualified Plans.

Qualified Health Care Plans would be required to accept all applicants without regard to health status. They would provide all covered services for prepaid premiums, placing them at financial risk for their efficiency and encouraging them to avoid delivery of unnecessary services. The Plans would be required to provide a specified minimum level of care and would be free to provide additional care if they wished and charge additionally for it. In effect, consumers who joined Plans that effectively managed costs would get more for their money. Plans that were not cost effective and performed inadequately in providing services would lose customers and risk going out of business. Out of this gradual evolution, Gephardt and Stockman believe a system would emerge based on incentives to provide quality services to patients at the lowest costs.

Plans would be encouraged to compete on the amount of care provided for the premiums charged. However, they would be required to provide all acute care services, without financial or durational limitations, after a member of the Plan had spent more than $2,900 in one year. To protect members from a plan's bankruptcy, a fund would be established to insure that coverage is available for the duration of outstanding contracts. A new entity, the Health Benefits Assurance Corporation, would control the fund and check financial viability before the Secretary of Health and Human Services deemed health plans qualified. This corporation would be private, but would operate within the Treasury Department.

The bill's sponsors estimate that the revenue costs of their proposal to the federal government will be $10 billion for the first year, increasing to $14 billion in the second. They believe, however, that between the fifth and the tenth year, the new system should pass the break-even point and begin to save money. With only six months remaining in the 96th Congress during a Presidential election year, it is unlikely that Congress will take action on the measure at this time. However, the bill's cosponsors believe that offering the legislation now will enable them to further refine their proposal for swifter processing early in the next Congressional session. The bill has been jointly referred to the House Committees on Ways and Means, Interstate and Foreign Commerce, the Judiciary, and Post Office and Civil Service. Hearings have yet to be scheduled.

## ● COMBINED CATASTROPHIC COVERAGE/ CONSUMER CHOICE BILL INTRODUCED IN HOUSE

On June 6, Rep. James Jones (D-Okla.) introduced H. R. 7528, the "Consumer Health Expense Control Act." The measure is designed to control consumer health expenses by insuring all Americans against catastrophic health expenses and by discouraging over-insurance for and over-utilization of health care. According to Rep. Jones, his proposal comprises a combination of the competitive model cost control bill and the catastrophic health insurance program introduced respectively by fellow House Ways and Means Committee members, Rep. Al Ullman (D-Ore.) and Rep. James Martin (R-N.C.)—(see March *COTH Report*).

REP. JONES

H.R. 7528 would encourage, but not require, employers to make available to all full-time employees a "qualified health plan" that would cover catastrophic medical expenses that exceed

$3,500 in out-of-pocket expenses. The employer would pay 50 percent of the least expensive premium. A low cost plan would also be made available to the employees. This could be the only plan the employer offers. Any contribution by an employer to an employee's plan that exceeds $100 per month per family would be treated as taxable wages. If the employer chooses to offer more than one health plan and the employee chooses a plan costing less than the employer's contribution, the employee would reecive a rebate (tax-free for the first $100 per year).

The bill would establish a fall-back government catastrophic plan called "Medicap." The Medicap program would be administered by the Department of Health and Human Services and is designed to be patterned after the Medicare program with minimal extension of the existing system. However, Rep. Jones contends that employees who are offered a qualified plan would be likely to take it because (a) they could get group rates, (b) they are guaranteed some employer subsidy, (c) they could buy a more comprehensive plan for less money if they chose to privately insure rather than use the Medicap, and (d) they would be subject to a stiff penalty under Medicap if they were offered a qualified plan by their employer and refused it because of the fall-back government plan. Similar to the public catastrophic plan proposed by Rep. Martin, Medicap would be open to everyone, but designed specifically for those who lack access to other insurance. In the current bill, however, a limit on spending would be established for Medicap.

States would be required to maintain their present Medicaid programs and would not be allowed to curtail their involvement in the health care of the needy because of the Medicap program. Under Medicare, the bill would modify reimbursements to prepaid plans so that Medicare would pay on a prospective capitation basis, 95 percent of the cost determined geographically. Overall, the Consumer Health Expense Control Act would be financed by "earmarked" revenues generated by taxes on employer contributions over the ceiling set for tax deductible premium payments. The cost of the entire program would be less than these new revenues, making for no additional costs to the federal government, according to Rep. Jones' estimates.

Jones expressed the wish that H.R. 7528 would serve as "a useful guide to any full-scale debate on national health insurance." The bill has been referred jointly to the Health Subcommittees of the House Committees on Ways and Means and Interstate and Foreign Commerce. No dates have yet been scheduled for hearings.

## ● SENATE HEARINGS HELD ON LEGISLATION TO ASSIST FINANCIALLY DISTRESSED HOSPITALS

On June 25, hearings were conducted by the Senate Labor and Human Resources Subcommittee on Health and Scientific Research on the subject of aid to financially distressed hospitals. The hearings were chaired by Sen. Howard Metzenbaum (D-Ohio), who sat in for Subcommittee Chairman Edward Kennedy (D-Mass.) who was in New York City speaking at Metropolitan Hospital. Metropolitan is one of those "financially distressed" hospitals that the Department of Health and Human Services (HHS) has, in recent days, rescued from financial insolvency temporarily with demonstration project funding.

SEN. JAVITS

Under discussion at the hearings were two proposals introduced by Sen. Jacob Javits (R-N.Y.) as a program package to assist fiscally troubled hospitals. The bills include:

- *S. 2840—The Financially Distressed Hospital Assistance Act*, which makes emergency grants available to severely distressed hospitals to avert closure. Under this bill, grant funds could be used to pay current debts, to encourage improved management practices and to undertake appropriate reorganization of health services in a hospital and surrounding community.

- *S. 2841—The Hospital Ambulatory Services Reimbursement Reform Act,* designed to keep acute financial crises from recurring once stability has been achieved and to prevent such crises from occurring in other hospitals which serve large numbers of medically indigent persons. This would be accomplished by requiring Medicare and Medicaid to pay their proportionate share of the non-reimbursed cost of delivering covered outpatient services for medically indigent persons to hospitals which meet specified eligibility criteria.

First among the witnesses was HHS Undersecretary Nathan Stark. He was accompanied by Earl Collier, Acting HCFA Administrator and Karen Davis, Ph.D., Deputy Assistant Secretary for Health Planning and Evaluation. In his statement, Stark emphasized that the primary responsibility for the viability of financially distressed hospitals must rest with states and localities, and that federal assistance should *not* become a long-term "bail out." He reviewed the HHS strategy on the issue and expressed several concerns regarding the Javits' legislative package. The basic features of the HHS approach are:

- establishing a coordinated HHS operating structure to assure consistency among HHS programs and to respond to requests for assistance;
- using existing and proposed Medicare and Medicaid demonstration and waiver authorities; and
- using certain existing Public Health Service (PHS) grant and loan programs.

Stark emphasized that HHS believes that current PHS authorizations give the Department adequate statutory base for dealing with the problem. Sen. Javits disagreed, citing the difficulty with which Secretary Harris has to date made decisions regarding emergency funding of distressed urban hospitals. He argued that this was demonstrative of the lack of an adequate federal mechanism by which to address the issue. He suggested that HHS work with him to refine the current legislative proposals in order to get at more permanent solutions.

With respect to S. 2840, HHS believes that there are several problems: (1) the program would duplicate several existing programs and would require a new administrative structure; (2) the requirements for self-sufficiency over time are weak, as are the incentives for hospitals to improve their operations and financial management; (3) requirements for substantial increases in state and local support, if necessary, are lacking; (4) inpatient deficits which are also a significant cause of financial distress in some hospitals are not addressed; and (5) it is difficult to know if the criteria for financial distress are appropriate or can be easily administered. Overall, HHS believes that given the authorities that already exist and the difficulties in both measuring financial distress and developing criteria, a new $200 million grant program is premature at the present time.

Some of the same concerns were applied to S. 2841 by HHS. The approach of requiring Medicare and Medicaid to pay a proportionate share of the costs of bad debts and charity care in certain fiscally distressed hospitals drew several concerns: (1) effective targeting criteria have not yet been developed; (2) a requirement that the hospital must be determined to be necessary by the state and local health planning agencies is not included; (3) while this proposal focuses only on outpatient services, there is evidence that inpatient deficits are also critical factors in causing financial distress in some hospitals; (4) it is inappropriate for the Medicare share of indigent outpatient care to be based on Medicare's share of both inpatient and outpatient services; (5) there would be substantial difficulties in administering this provision, particularly performing the 125 percent of poverty income test and defining deficits without a standardized cost reporting system and accounting rules; and (6) HHS simply does not feel it is appropriate to use the Medicare trust funds, which are financed on the basis of premiums and payroll taxes, to finance care for uncovered individuals.

Next to testify was a panel of hospital representatives which included Donald Cook, Executive Director of Children's Hospital of Los Angeles, Henry Manning, President of the Cuyahoga County Hospitals in Cleveland, and Robert Johnson, Executive Director of D.C. General Hospital in Washington. They were accom-

panied by Al Manzano, Executive Director of the American Hospital Association's Washington Office. Their testimony was very supportive of the intent of the Javits' bills, but saw them only as interim measures until more comprehensive, long-term solutions could be developed. They made several recommendations regarding ways of refining the legislation and suggested a number of alternatives for the future.

A copy of the complete text of S. 2840 and S. 2841, as published in the June 17 *Congressional Record*, may be obtained from the AAMC's Department of Teaching Hospitals.

## ● NEWMAN CHOSEN AS NEW HCFA ADMINISTRATOR

Howard Newman, who for the past six years has been President of the Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, has been named by HHS Secretary Patricia Harris as the new Administrator of the Health Care Financing Administration (HCFA), effective July 7. Newman, 45, succeeds Leonard Schaeffer, whose resignation was effective June 1. From 1970-1974, Newman served as Commissioner of the Medical Services Administration in HEW, directing Medicaid activities. Prior to this post, he was Associate Administrator of the Pennsylvania Hospital in Philadelphia and was Assistant Vice President of Roosevelt Hospital in New York City. In addition to A.B. and M.B.A. degrees from Dartmouth, Newman earned an M.S. degree from Columbia University's School of Public Health and Administrative Medicine and a law degree from Temple University.

## ● POLICY DENYING MEDICARE REIMBURSEMENT FOR JOINT NURSING EDUCATION COSTS REVERSED

In the cases of *St. Luke's Hospital v. BCA/Blue Cross of Iowa and South Dakota* (PRRB Dec. No. 80-D6) and *Mount Marty Hospital Association, d/b/a Sacred Heart Hospital v. BCA/Blue Cross of Iowa and South Dakota* (PRRB Dec. No. 80-D5), acting Administrator of the Health Care Financing Administration (HCFA) Earl M. Collier, Jr., reversed the Agency's long-standing policy of denying Medicare reimbursement for joint nursing education costs. His rulings affirmed Provider Reimbursement Review Board (PRRB) decisions which were favorable to the providers and found that such expenses are allowable costs. In his determination, the Administrator appears to have followed the rule of the Seventh Circuit U.S. Court of Appeals decision in *St. Johns Hickey Memorial Hospital v. Califano* (see July 1979 *COTH Report*), which affirmed the PRRB's policy of allowing reimbursement for a hospital's payments to a neighboring college to support a transferred nursing education program. The court rejected HCFA's assessment that such expenses were inconsistent with the definition of approved educational costs within the Medicare reimbursement regulations because the educational programs were operated outside the hospital.

In upholding the Board in the current decisions, the HCFA Administrator stated that "the analysis followed by the Board and approved by the Seventh Circuit appears to be reasonable . . . for providers phasing out nursing programs and claiming reimbursement for contributions to joint nursing education programs." More specifically, reimbursement was allowed in these cases because the following criteria were met:

- The agreement was made and payments began at the time the educational institution started the nursing program;
- The nursing education program was transferred from the hospital to the college at least one year before the inception of the Medicare program and payments began at the same time the hospital began participation in the educational program;
- Additional payments by the provider to an existing program already supported by other providers did not increase the total amount of payments by all the providers; and
- The providers demonstrated that the basis of their payments to the educational institutions has not been increased—any increased payments resulting from an increase in the basis of payment would not be allowable.

In view of these two decisions, it seems HCFA policy has shifted and that nursing education costs will be considered reimbursable in future

cases if the criteria described above are met. Therefore, hospitals participating in joint nursing education programs are advised to include such costs on their Medicare cost reports as allowable and to inform their intermediaries of these recent rulings. Copies of the PRRB and Administrator's decisions in the two South Dakota cases may be obtained from the AAMC's Department of Teaching Hospitals.

## ● REVISED MEDICARE HOSPITAL CONDITIONS OF PARTICIPATION PROPOSED

In the June 20 *Federal Register,* the Health Care Financing Administration (HCFA) issued a notice of proposed rulemaking (NPRM) revising the hospital conditions of participation under Medicare and Medicaid. The current conditions have been in effect since 1966, without any major changes. The revised conditions were over two and a half years in the making and are intended to simplify the regulatory requirements which hospitals must meet to be certified for participation in Medicare and Medicaid. Current regulations will be amended to take into consideration changes in delivery of hospital services and the training and roles of health personnel. The proposed amendments would add greater requirements for accountability, while allowing flexibility for hospitals in performing administrative and managerial functions, according to HCFA. They are intended, HCFA states, to hold down costs while maintaining an acceptable level of patient care. The revised conditions would establish minimum requirements and are not intended to limit hospitals from establishing higher requirements.

Among the major modifications made by the proposed regulations are the following:

- *Personnel qualifications*—Qualifications for personnel not previously covered in the regulations would be established. The qualifications for directors of services would be related directly to the scope and complexity of the services offered. Wherever possible, the regulations would recognize training and experience in lieu of solely academic credentialing and would require hospitals to be responsible for ensuring that staff demonstrate continuing competence.
- *Quality assessment and accountability*—The development of a hospital-wide quality assurance program would be required. The chief executive officer and directors of organized services would be required to assess staff performance and report on activities and evaluative findings. The governing body would be responsible for reviewing the program findings and implementing changes in response to them.
- *Responsibility for contracted services*—Hospitals would be permitted to contract out certain services, but would explicitly be required to remain accountable for the quality of services furnished.
- *Patients' rights*—Hospitals will be required to have written policies clearly defining the rights of patients.
- *Medical Staff*—Procedural requirements for granting staff privileges, all committee and meeting requirements, and requirements for consultation or autopsies, would all be eliminated. New provisions would include more specific requirements on the review of clinical privileges, provisions for the medical direction of house staff, and provisions of medical supervision of physician assistants, nurse practitioners, and nurse midwives.
- *Nursing services*—Provisions applying to the administration of drugs would include more detailed and specific requirements on accountability and safety, and would be more flexible regarding types of personnel permitted to administer drugs, receive verbal drug orders, and give blood or parenterals.
- *Medical records*—The current requirement that original reports be filed in the medical record would be deleted. The requirement that all reports be signed would be modified; the proposed regulations would require instead that all entries be authenticated by the person responsible for the services furnished and by the person making the entry. These changes would be consistent with Joint Commission on Accreditation of Hospitals (JCAH) requirements and are intended to recognize and permit increased use of computer systems in medical record

keeping. In addition, firmer standards on the security of medical records are proposed.

- *Pharmaceutical services*—Clearer standards for accountability and quality control would be established, and basic specific requirements for emergency pharmaceutical services would be expanded. The requirement that pharmacists have special training in hospital pharmacy would be deleted, as small rural hospitals may not have access to personnel with such training.
- *Radiologic services*—Due to the inherent risks of diagnostic and therapeutic radiology and the danger to patients of unnecessary exposure, the proposed regulations would place greater emphasis on the qualifications of the director of the service and other personnel, and would also provide specific requirements on equipment design and use, operating conditions, radiation protection surveys and personnel monitoring.
- *Equal rights*—The governing body of the hospital would be required to insure that the hospital operates in accordance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
- *Life safety from fire*—The proposed regulations would adopt the 1973 edition of the Life Safety Code of the National Fire Protection Association (NFPA) as the fire safety requirements for hospitals which do not qualify for certain specified exceptions. These exceptions would provide for recognition of hardship situations, acceptance of state codes in lieu of the Life Safety Code, and for participation of hospitals that continue to meet the requirements of the 1967 edition of the Code if they do so on the effective date of these regulations.
- *Surgical circulators*—The current regulations specify that only registered nurses may perform circulating duties in the operating room. The revised conditions would also allow licensed practical (vocational) nurses and surgical technologists (operating room technicians) to perform circulating duties. In addition, a registered nurse would be required to be immediately available in the operating suite to respond to emergencies.
- *Nuclear medicine services*—A new condition of participation for nuclear medicine services would be created. The regulations would specify minimum requirements for organization of the service, accountability, safety, and records.
- *Outpatient services*—It is proposed that if outpatient surgery is offered, the standards applicable to inpatient surgery must be met. The current requirements for clinic organization, conferences, and meeting minutes would be deleted.
- *Emergency services*—Hospitals will be required to evaluate their emergency service capabilities; coordinate planning with an overall community plan, if possible; and inform the community served of the services offered. In addition, hospitals will be required not to refuse treatment to patients for other than medical reasons.
- *Special care units*—A new condition of participation would be established for special care units, requiring such units in participating hospitals to meet minimum requirements for organization, accountability, and delivery of services. A similar new condition of participation would be established for psychiatric services which are offered in a general acute care hospital setting.

Consideration will be given to written comments or suggestions on the proposed conditions of participation received on or before August 19, 1980. Such comments should be addressed to: Administrator, HCFA, DHHS, P.O. Box 17082, Baltimore, Maryland 21235. In commenting, please refer to file HSQ-16-P. Copies of the proposed regulations may be obtained from the AAMC's Department of Teaching Hospitals.

## ENFORCEMENT OF CHANGES IN "HOSPITAL-BASED" PHYSICIAN REGS ENJOINED

A preliminary injunction to block implementation of HCFA's March 11 Notice (see April *COTH Report*) regarding reimbursement of

physicians having contractual arrangements with hospitals was issued June 4 by a federal district court in Arkansas. The Notice was to have become effective July 1, 1980 and was published to advise of HCFA's intent to enforce regulations which were originally issued in 1966, shortly after Medicare began.

Claiming that the Notice represented a "reinterpretation" of the original regulations, the plaintiffs—the American College of Pathologists, the Arkansas Hospital Association, the Arkansas Society of Pathologists, and others—charged that the HCFA policy: (1) had violated the Congressional intent of the Medicare law to reimburse pathologists under Part B of Medicare for the professional component of their services; (2) had violated the HHS Secretary's own regulation against influencing contractual agreements between hospitals and physicians; (3) constituted a major policy change with respect to reimbursement of "hospital-based" pathologists and violated the Administrative Procedures Act; and (4) would seriously affect hospital/physician agreements in the State of Arkansas.

It is understtod that HCFA plans to either appeal the court decision or file a motion for dismissal on the grounds that the court lacked jurisdiction on the issue. In the meantime, HCFA issued a notice in the June 20 *Federal Register* announcing that "pending further action in court, Part B charge payments for the alleged professional component of clinical laboratory services furnished in a hospital setting may be continued."

## ● AAMC TESTIFIES AT HEARING ON ACTIVITIES OF VA INSPECTOR GENERAL

On June 11, John A. D. Cooper, M.D., President of the Association of American Medical Colleges (AAMC), testified at an oversight hearing of the Senate Veterans' Affairs Committee concerning the activities of the Veterans Administration (VA) Inspector General. Dr. Cooper stated that the primary concern of the Association relates to the manner in which the field staff of the Inspector General's office has carried out its responsibility to eliminate fraud, abuse, waste and mismanagement in the VA. He explained that the heavy-handed tactics used by some investigators have intimidated the VA personnel and created tension in the otherwise productive relationships between the VA and affiliated medical schools. The AAMC testimony emphasized the importance of respecting the rights of individuals under investigation and the need for the staff of the Inspector General's office to develop an understanding of the unique nature of medical practice and the complexities of the affiliation relationships between the VA and the medical schools.

Specifically, with reference to auditing the attendance of part-time physicians, the AAMC noted that the rules established for general applicability to civil servants may be inappropriate in the case of part-time doctors who cannot rigidly adhere to a preordained schedule if they are to meet their professional responsibilities. The Association also commented upon inquiries made by staff of the office of the Inspector General into questions related to the quality of health care, questions the AAMC believes are beyond both the authority and competence of that office. The Association stated that in order for any review of the professional performance of physicians to be appropriate, it must be undertaken by individuals who possess the training and expertise necessary to evaluate the quality of medical care; thus, the Association supported the recommendation that a separate office of Medical Inspector be established for this purpose.

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

## ● AAMC TESTIFIES ON LOW-LEVEL RADIOACTIVE WASTE DISPOSAL

On June 11, Parker Coddington, Director of Governmental Relations, Harvard University, testified on behalf of the Association of American Medical Colleges (AAMC), the Association of American Universities, and the National Association of State Universities and Land-Grant Colleges, before the U.S. Radiation Policy Council. The hearings were on the subject of low-level radioactive waste disposal, the by-products of medical diagnostic and therapeutic treatment and research. Coddington began his

testimony by expressing how heartened the Associations are that the Council has set as one of its four goals of highest priority the establishment of a federal policy on the disposal of low-level radioactive waste originating in medical and research institutions. He stated that Harvard's experience during last year's shut-down of the only three public disposal sites in the country (see October-November 1979 *COTH Report*) convinced him of the need for the earliest possible estabilshment and implementation of such a policy. He noted that during the shutdown, Harvard and other institutions came within a few days of exceeding their storage capacities and of being forced to terminate various operations for patient care and diagnostic procedures, as well as major biomedical research programs. However, he emphasized, "while this crisis produced great concern among the universities and several agencies of government, it so far has produced no solution to the problem of disposal of radioactive waste. Nor has public understanding of the problem been much improved or have conflicting overly restrictive local, state, and federal regulations been reviewed and made coherent and reasonable."

Coddington explained that in the hope of finding some possible remedies for these problems, the Associations created a waste disposal study group. He then reviewed the four major recommendations developed by the study group. These included:

(1) Hospitals, bioresearch and non-bioresearch institutions should take increasing responsibility for the intelligent, safe, local management of radioactive waste by: (a) sorting short-lived from long-lived radionuclides, (b) storing and holding short-lived nuclides until these have decayed to levels which would permit their safe disposal, (c) sorting long-lived isotopes by level of activity and by class as to aqueous or organic liquids or solids and (d) exploring new methods of disposal appropriate to level of radioactivity, half-life and institutional setting.

(2) The Nuclear Regulatory Commission should continue its present policy with regard to air and aqueous disposal effluent levels for radionuclides but with one minor amendment that will permit each institution to dispose of a maximum of 5.0 Curie for $^{3}H$ and 1.0 Curie for $^{14}C$ compounds annually (over and above the present 1.0 Curie annual total for all of the nuclides). The Radiation Policy Council should undertake to see that all federal agencies adopt these amended standards.

(3) A "de minimus" level of radioactive waste should be defined by the Radiation Policy Council, and adopted by all federal agencies and by those states which have agreements with federal agencies, so that waste containing less than 0.1 microCurie per gram or milliliter can be incinerated and/or transported and/or buried and/or stored locally without special regulations other than those required for any non-radioactive hazards of the wastes.

(4) Wastes generated by biomedical isotope and radiopharmaceutical manufacturers which are not disposable locally should receive priority and preferential access to national waste disposal sites.

Coddington closed his remarks by stating that undertaking these actions would not add to the national burden of radioactivity either overall or on a daily basis, but would indeed reduce the volume of waste that must be transported to and permanently stored at the present three disposal sites by an estimated 70 percent. "More important," he emphasized, "it would go far toward assuring the uninterrupted benefits of the use of diagnostic and therapeutic radioisotopes in the treatment of human illness, as well as assuring the continuation of that basic biomedical research from which will certainly come conquests of many existing human disabilities." Copies of the complete text of Mr. Coddington's statement may be obtained from the AAMC's Department of Teaching Hospitals.

## ● GAO EXAMINES COST CONTROL POTENTIAL OF HMOs

Based on an analysis of twenty group practice and staff model types of health maintenance organizations (HMOs), the U.S. General Account-

ing Office (GAO) found the following:

—These federally qualified HMOs were taking into consideration the relative costs of providing services when deciding whether to use the services of medical staffs, ambulatory health centers, and/or hospitals. Because the costs of these services are not affected by third party payments, HMOs should be able to allocate these resources efficiently and help control health care costs.

—If the HMOs analyzed, which ranged in size from 1,131 to 37,087 members, continued to grow, the per unit cost of providing care will fall. GAO cautions, however, that sufficient demand and good management are prerequisites for these HMOs to achieve lowest per unit costs.

—Given sufficient growth in enrollment, well-managed HMOs eventually would achieve maximum efficiency. But without the discovery and use of new productivity-increasing technology, further reductions in costs are unlikely.

—As their term of operation lengthens, these HMOs, on the average, are experiencing increases in the real cost of providing care. This could lead to some deterioration in the financial positions of many federally qualified HMOs that are incurring deficits and are not increasing enrollments.

The GAO noted that it "could not determine precisely how large an HMO must be to realize all economies of scale, since larger (than 37,000-member) HMOs were not represented in the sample." The Department of Health and Human Services (HHS) considers the GAO findings generally positive and has agreed to undertake study of the topics suggested by GAO for further research and analysis on HMOs. Single complimentary copies of the GAO report, entitled "Health Maintenance Organizations Can Help Control Health Care Costs," No. PAD-80-17, May 6, 1980, can be obtained from: U.S. General Accounting Office, Distribution Section, Box 6015, Gaithersburg, Maryland 20760.

## NEWS BRIEFS

ON JUNE 26, COTH CHAIRMAN-ELECT STUART MARYLANDER APPOINTED THE PLANNING COMMITTEE FOR THE 1981 COTH SPRING MEETING. Selected to chair the Planning Committee was James W. Bartlett, M.D., Medical Director of the Strong Memorial Hospital of the University of Rochester. The other Committee members include Sheldon S. King, Director of Hospital and Clinics of the University of California, San Diego; John E. Ives, Executive Director of the Shands Teaching Hospital of the University of Florida; J. Robert Buchanan, M.D., President of the Michael Reese Hospital and Medical Center in Chicago; and Alan Zamberlan, Director of the VA Medical Center in Ann Arbor, Michigan. A review of the successful 1980 Spring Meeting held in Denver was presented in the last issue of the *COTH Report*.

THE TRANSFER OF STUDENT ASSISTANCE PROGRAMS FROM THE HEALTH RESOURCES ADMINISTRATION (HRA) TO THE HEALTH SERVICES ADMINISTRATION (HSA) HAS BEEN APPROVED BY HHS SECRETARY PATRICIA HARRIS. The transfer will mean that HRA will retain programs that deal with aid to health professions education institutions, as well as the health manpower shortage designation function, while direct student support (including the National Health Service Corps Scholarship programs) will be operated by HSA. The reorganization was essentially initiated by Sen. Warren Magnuson (D-Wash.), Chairman of the Appropriations Committee and author of the National Health Service Corps law, who asked that the Corps scholarship program be transferred to HSA to join administration of the payback portion of the plan. Although it has been rumored for some time, the Secretary made no mention of any plans to move health planning programs to the Health Care Financing Administration at any time in the near future.

OF THE 375,000 ACTIVE PHYSICIANS IN THE UNITED STATES, MORE THAN 182,000 PRACTICE "PRIMARY CARE" MEDICINE, according to the American Medical Association (AMA). The attraction of growing numbers of physicians into the "primary care" specialties is described by the AMA as "a quiet revolution" taking place in the world of medicine, reversing a trend which began after World War II when the percentage of physicians who classified themselves as providing "primary care" medicine declined to a low of 30 percent in 1974. *The 1979-80 Directory of Residency Training Programs* recently published by the AMA shows that 51 percent (32,839) of the 64,332 young physicians enrolled in residency training programs in the U.S. are in "primary care" programs. And, of the 23,176 positions to be filled for the 1980-81 academic year, 12,221 (53 percent) will be in "primary care" fields—family practice, internal medicine, obstetrics/gynecology, and pediatrics. The biggest increases in the past decade among "primary care" physicians have been in the areas of family practice, internal medicine, and pediatrics. Since the first family medicine residency program was approved in 1970, 21,611 physicians have entered family practice.

HEALTH CARE COSTS COULD TRIPLE BY 1990, according to a recent study by the Health Care Financing Administration (HCFA). The study, which is reported in the Winter issue of HCFA's quarterly journal *Health Care Financing Review*, assumes that if the nation's health care system were to remain unchanged over the next ten years, the nation's health bill, which will reach $245 billion this year, would soar to $758 billion by the end of the decade. The assumption is made that historical trends and relationships in the medical care sector and in the economy as a whole will continue in the future, and that, within the decade, no mandatory cost containment program or national health insurance program will be enacted. The study reports that national health care expenditures, which were $863.00 per person in 1978, could be expected to exceed $3,000.00 per person in 1990. Health care financed by federal, state and local governments is projected to exceed $325 billion in 1990, up from $78 billion in 1978. As a percentage of the gross national product, health expenditures rose from 6.2 percent to 9.1 percent between 1965 and 1978 and are projected to stay in an upward spiral, reaching 10.5 percent by 1985 and 11.5 percent by 1990.

The HCFA study examined various factors affecting national health expenditures, including population changes, physician supply and third-party payments. In assessing outlays for hospital care, the study reported that they "comprise the largest category of health expenditures," and projected that they would increase from 40 percent ($76 billion) of the total in 1978 to 44 percent (nearly $335 billion) in 1990. HCFA estimated that increases in hospital expenditures would average 13.1 percent annually for the 1978-1990 period, below the 1965-1978 average of 13.9 percent. HCFA stresses that the conclusions made in the report are not predictions, but assumptions for the purpose of making projections. However, this did not stop former HCFA Administrator Leonard D. Schaeffer from utilizing the report as an opportunity to demonstrate the need for enactment of the Administration's hospital cost containment legislation in a recent press release.

A complimentary copy of the Winter issue of *Health Care Financing Review* may be obtained from ORDS Publications, Room 1E9, Oak Meadows Building, 6340 Security Boulevard, Baltimore, Maryland 21235.

A SPECIAL FOCUS OF THE DISCUSSIONS REGARDING THE RAPID INCREASE IN HEALTH CARE EXPENDITURES HAS BEEN THE INCREASING PROPORTION OF THE GROSS NATIONAL PRODUCT (GNP) DEVOTED TO HEALTH CARE. This fraction was 4.4% in 1960, 7.2% in 1970, and reached 9.0% in 1979. Many reasons have been suggested for this increase, including aging of the population, increased public financing, and

advancement of biomedical knowledge. Comparatively speaking, however, it is not clear that the current expenditure level is too high. To provide some perspective on this matter, the Social Security Administration recently completed a study comparing these figures for the United States with those of other advanced industrial countries. The results show the U.S. occupying a middle position, behind West Germany, Sweden, and the Netherlands, but ahead of France, Canada, Australia, Finland and the United Kingdom. Furthermore, all of these countries have experienced a substantial escalation in health care expenditures as a percentage of GNP. The full report is available in *Social Security Bulletin,* January 1980/ Vol. 43, No. 1, pages 3-8.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) HAS ADOPTED A NEW REGULATORY MANAGEMENT SYSTEM WHICH INCLUDES A PROCESS FOR DEVELOPING A REGULATIONS PLAN AT THE BEGINNING OF EACH FISCAL YEAR, according to an announcement in the June 12 *Federal Register*. Each initiative in the plan is designed to achieve specific programmatic goals and objectives in accordance with priorities. The plan includes a projected schedule for publishing each regulatory initiative in priority order. The annual HCFA plan supplements the Semi-Annual Agenda of Regulations published by the Department of Health and Human Services (HHS) in June and December of each year in accordance with a Presidential Executive Order. The HCFA plan includes: (1) initiatives which appear in the Semi-Annual Agenda of Regulations because HCFA and the Secretary of HHS have concluded that specific regulatory changes are needed; (2) new initiatives at an early stage of consideration where HCFA and the Secretary have not yet concluded that specific regulatory changes are needed; and (3) routine initiatives that provide guidelines for existing regulations. HCFA states it published the plan to provide the public with advanced notice, as early as possible, of regulation initiatives that are planned or under active consideration. According to the issued notice, proposed regulations concerning reimbursement of physician costs in teaching hospitals (file code #BPP-11-P) under Section 227 of the 1972 Medicare amandments were scheduled for publication by the end of June. It is understood, however, that issuance of these regulations is expected to be delayed until at least late this year. Comments are invited on the content of the overall plan, the priority set for each initiative, and projected publication targets. They should be addressed to: Administrator, HCFA, HHS, P.O. Box 17082, Baltimore, Maryland 21235. A copy of the notice on the regulations plan may be obtained from the AAMC's Department of Teaching Hospitals.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) WILL UNDERTAKE A TWO-YEAR, $2 MILLION STUDY ON THE MEDICAL, SOCIAL, ECONOMIC, AND ETHICAL CONSEQUENCES OF HEART TRANSPLANT SURGERY in order to determine whether Medicare should continue to fund this costly operation, according to an announcement made by HHS Secretary Patricia Harris on June 12. Medicare has been paying for a limited number of these transplants at Stanford University. Except for those operations performed as part of the new study, HCFA will now stop such funding because, as Secretary Harris stated, "we were financing transplants before we had policy on whether or not we should do it." In conjunction with the study, which will be jointly undertaken with the Center for Health Care Technology, HCFA will for the first time develop a generic definition of all "reasonable and necessary" medical services to serve as a guide for future Medicare coverage. This is expected to be issued in September as a Notice of Proposed Rulemaking (NPRM), offering an opportunity for public comment.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) PROPOSES TO AMEND THE MEDICARE REGULATIONS ON REASONABLE CHARGES TO SET FORTH THE PROCESS AND CRI-

TERIA BY WHICH IT WILL ESTABLISH SPECIAL REASONABLE CHARGE RULES AND PAYMENT LIMITS FOR INDIVIDUALLY IDENTIFIED HIGH-TECHNOLOGY ITEMS REIMBURSED UNDER PART B OF THE MEDICARE PROGRAM, according to a notice of decision to develop regulations published in the May 29 *Federal Register*. Currently, the reasonable charge for an item or service is computed as the lowest of (1) the actual charge, (2) the customary charge made by the particular physician or supplier, and (3) the prevailing charge (the 75th percentile in the range of customary charges for similar services in the locality). HCFA believes that under unusual market conditions (e.g., when the federal government is the primary payor for an item; when there is a rapid spread of new, expensive technology; or when an item is furnished by only one supplier), these rules may result in excessive or unreasonable levels of payment. The regulations to be proposed by HCFA would establish a special rule for these situations. It would state general criteria for determining when a limit is appropriate for a specific item, set forth a process for public participation in subsequently establishing a limit on that specific item, and provide for exceptions when a supplier or beneficiary submits acceptable justification. The item HCFA has under review for the initial application of this regulation is the computerized tomography scanner. It will be issuing a notice, shortly after publication of the proposed regulations, setting forth proposed limits on scanner services and its basis for developing them. Copies of the HCFA notice of decision to develop regulations may be obtained from the AAMC's Department of Teaching Hospitals.

REGULATIONS HAVE BEEN PROPOSED THAT WOULD PROHIBIT THE USE OF FEDERAL FUNDS UNDER THE MEDICARE AND MEDICAID PROGRAMS TO PAY FOR CERTAIN DRUGS THAT THE FOOD AND DRUG ADMINISTRATION (FDA) HAS CONCLUDED ARE NOT EFFECTIVE FOR ANY INDICATED USE. The point of termination of payment for "less-than-effective" drugs under the proposed regulations, which were issued by the Health Care Financing Administration (HCFA) in the June 5 *Federal Register*, would be the point at which the FDA classifies a drug as "less than effective for any treatment" in a final determination (i.e., without regard to court orders permitting the continued sale of the drug pending appeal of the FDA's determination). Two other categories of drugs would also be excluded under the proposed regulations: (1) so-called "me-too" drugs, which are identical, related, or similar to "less-than-effective" drugs but are marketed under different names or by different firms, and (2) drugs, such as Laetrile, that are subject to pre-market approval but that have been introduced onto the market without FDA's approval having been sought. Comments on the proposed regulations are invited until August 4, 1980, and should be addressed to: Administrator, HCFA, HHS, P.O. Box 17073, Baltimore, Maryland 21235.

IN THE JUNE 10 *FEDERAL REGISTER*, THE BUREAU OF HEALTH PROFESSIONS ANNOUNCED THAT APPLICATIONS FOR FISCAL YEAR 1981 GRANTS FOR GRADUATE TRAINING IN FAMILY MEDICINE ARE NOW BEING ACCEPTED. In funding of approved applications, preference will be given to projects in which: (1) substantial training experience is in settings which exemplify interdependent utilization of physicians and physician assistants and/or nurse practitioners; and/or (2) substantial portions of the project are conducted in a health manpower shortage area; and/or (3) for osteopathic post-doctoral education projects, there is coordination of training with an affiliated school of osteopathic medicine. Approximately $5-6 million is expected to be available in fiscal year 1981 for these competitive grants. To be considered for fiscal year 1981 funding, applications must be received by August 1, 1980.

In the same *Federal Register*, the Bureau of Health Professions also announced that

applications for fiscal year 1981 grants for faculty development in family medicine are now being accepted. A funding preference may be accorded to approved applications with emphasis on increasing the number of new faculty who will be teaching on a full-time basis in family medicine. Approximately $25 million is expected to be available for these competitive grant awards in fiscal year 1981. Completed applications must be received by September 4, 1980.

For both grant programs, requests for application materials should be directed to: Grants Management Officer (D15), Bureau of Health Professions, Health Resources Administration, Center Building, Room 4-27, 3700 East-West Highway, Hyattsville, Maryland 20782.

PHILIP CAPER, M.D., VICE-CHANCELLOR FOR HEALTH AFFAIRS AND PROFESSOR OF MEDICINE IN COMMUNITY MEDICINE AT THE UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER, WAS RECENTLY ELECTED BY THE NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT TO BECOME ITS NEXT CHAIRMAN. He succeeds Sally Berger, Chairperson of the Chicago Health Systems Agency, whose council term expires July 31.

STAFF CHANGES AT THE DEPARTMENT OF TEACHING HOSPITALS: Recently completing a very successful administrative residency was Charles (Chip) Kahn, III, who received his masters degree in May from the Health Systems Management Program at Tulane University. While with the Department, Chip authored the well-received annotated bibliography on "The Costs of Medical Education in Teaching Hospitals." Aside from other staff support duties, Chip also produced the *1979 COTH Executive Salary Survey*. We wish him the best of luck in his new position as Director, Office of Financial Management Education of the Association of University Programs in Health Administration. He will be missed.

Joining the Department as its new administrative resident for 1980-81 is Mary Eng, who recently earned a masters degree from Duke University's Graduate Program in Health Administration. She received her B.A. degree in Biology from Brown University in 1976. Mary will be responsible for the *1980 COTH Executive Salary Survey*, as well as numerous other special projects developed during the year in response to constituent needs and requests. In addition, she will assist staff in addressing regulatory and legislative issues as they arise. We welcome Mary to what we hope will be a rewarding and enjoyable learning experience.

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# COTH report

COUNCIL OF TEACHING HOSPITALS ASSOCIATION OF AMERICAN MEDICAL COLLEGES

CONTENTS:



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## ● GMENAC REPORT COMPLETED

On September 30, the Graduate Medical Education National Advisory Committee (GMENAC) submitted its long-awaited final report to HHS Secretary Patricia Harris. After more than three years of work on it, the report consists of seven volumes and makes 106 recommendations which are directed at solving GMENAC's identification of three major problems—(1) a projected oversupply of 69,750 physicians by 1990, (2) surpluses or shortages within individual medical specialties, and (3) the uneven geographic distribution of physicians. Earlier drafts of the report had estimated that there would be an excess of 59,000 or 75,000 physicians by 1990 and 130,000 by the year 2000. Explaining the variation, GMENAC advises that the numerical size of the aggregate estimates is considered tentative until the methodology it developed has undergone critical evaluation.



A summary document condenses the 106 recommendations into 39 major and 25 supportive proposals. Major recommendations include:

*ADDRESSING THE PROJECTED PHYSICIAN SURPLUS*—Allopathic and osteopathic medical schools should *reduce entering class size* in the aggregate by a minimum of *10 percent by 1984* relative to the 1978 enrollment. *No new* allopathic or osteopathic *medical schools* should be established beyond those with first year students in place in 1980-81. No increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981 should occur. The number of graduates of foreign medical schools entering the United States yearly, an estimated 4,100 by 1983, should be severely restricted. Federal and state loans and scholarships to U.S. medical students initiating study abroad after the 1981 academic year should be terminated. The "fifth pathway" for entrance to approved programs of graduate medical education should be eliminated.

*ADDRESSING PROJECTED SHORTAGES/SURPLUSES IN MEDICAL SPECIALTIES—No specialty* or subspecialty should be expected to *increase or decrease* the number of *first year trainees* in residency or fellowship training programs *more than 20 percent by 1986,* compared to 1979. Medical school graduates in the 1980s should be strongly encouraged to enter those specialties where a shortage of physicians is expected. Among those medical specialties projected to have the greatest shortages in 1990 are general psychiatry, child psychiatry, emergency medicine, nuclear medicine, preventive medicine, and anesthesiology. Those forecasted for the largest surpluses include general surgery, obsterics/gynecology, radiology, general internal medicine, cardiology, and general pediatrics.

*INTEGRATION OF REQUIREMENTS FOR NON-PHYSICIAN PROVIDERS INTO PHYSICIAN MANPOWER PLANNING*—GMENAC concludes that nurse practitioners (NPs), phy-

*Continued on next page*

sician assistants (PAs), and nurse midwives (NMWs) make positive contributions to the health care system when working in close alliance with physicians. It predicts that the supply of these *non-physician health care providers will double by 1990 to 40,000* and potentially add further to the surplus capability. It recommends that extensive research on the requirements for NPs, PAs, NMWs, and other non-physician providers be undertaken as soon as possible. Until this research is completed, GMENAC believes that the number of PAs, NPs, and NMWs in training for child medical care, adult care, and obsterical/gynecological care should remain stable at their present levels.

*LAWS, REGULATIONS AND PROGRAMS PERTAINING TO NPs, PAs AND NMWs SHOULD BE MADE MORE CONSISTENT*—GMENAC recommends that state laws and regulations should not impose requirements for physician supervision of NPs, NMWs, and PAs, beyond those needed to assure quality of care. More specifically, GMENAC suggests that states *provide PAs, NPs, and nurse-midwives with limited power of prescription,* taking what precautions are necessary to safeguard the quality of care. Medicare, Medicaid, and other insurance programs are called upon to recognize and *provide some form of reimbursement for the services of these non-physician practitioners.* Moreover, it is believed that NPs, PAs, and NMWs should be eligible for all federal incentive programs directed at improving the geographic accessibility of services, including the National Health Service Corps scholarship program.

*MECHANISMS TO ACHIEVE A MORE FAVORABLE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS—Alternative data systems for monitoring the geographic distribution of physicians should be developed* and evaluated, the report states. Medical students should be encouraged to select a location for practice in underserved rural and urban areas by several approaches: (1) expanded urban and rural preceptorships, (2) governmentally sponsored loan and scholarship programs should be evaluated to determine their effectiveness in improving geographic distribution, (3) use of loan foregiveness programs modeled after those with proven success, and (4) the National Health Service Corps scholarship program should be supported because its impact has been favorable. Areawide programs of decentralized medical education and service such as WAMI (Washington, Alaska, Montana, and Idaho) and some AHECs (Area Health Education Centers) should be evaluated for replicability elsewhere. GMENAC further recommends that the basic unit for medical manpower planning should be a small geographic area within which most of the population receives a specified medical service. These functional medical service areas, service by service, are recommended as the geographic units for assessing the adequacy of manpower supply.

*THE ROLE OF MEDICAL SCHOOLS AND TEACHING HOSPITALS IN SPECIALTY AND GEOGRAPHIC DISTRIBUTION*—Medical education in medical schools and in the early phase of graduate medical education in teaching hospitals should *provide a broad-based clinical experience with emphasis on the generalist clinical fields.* A portion of graduate medical training should occur in ohter than tertiary care medical centers. A *more* vigorous and imaginative *emphasis* should be placed *on ambulatory care training* experiences. Greater diversity among the medical students should be accomplished by

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promoting more flexibility in the requirements for admission, by broadening the characteristics of the applicant pool, and by providing specific loans and scholarships. Information relative to physician manpower needs in the various specialties and in different geographic settings should be disseminated broadly to applicants, medical schools, medical students, faculty and administrators.

*FINANCING MECHANISMS FOR UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION, AND REIMBURSEMENT FOR PHYSICIAN SERVICES—Capitation* payments to medical schools *for* the sole purpose of *increasing class size* or for influencing specialty choice *should be discontinued* in view of the impending surplus of physicians in most specialty areas. The *special purpose grants* to medical schools and other teaching institutions *for primary care training* in family medicine, general internal medicine, and general pediatrics should be continued in order *to emphasize ambulatory care.*

The true costs of graduate medical education should include the compensation for residents and teaching personnel. All of the ancillary and indirect costs should distinguish the cost of education and the cost of patient care by a uniform recognized reporting system, and should be borne equitably by all payers as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided. Public and private reimbursement policies, when being adjusted, should: emphasize ambulatory care services and training, encourage practice in underserved areas, consider the implications of the change for physician choice, explore the concept of shared risks among physicians and pay professional fees to teaching physicians when their services have been identifiably discreet and necessary.

*CONTINUATION OF THE ACTIVITIES OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE*—The committee believes that health manpower planning would be advanced through a *continuation of GMENAC for at least two more years.* The report recommends that a successor to GMENAC be established by statute and be an advisory body without regulatory functions.

Complimentary copies of the GMENAC report will become available in early December from the Office of Graduate Medical Education, Health Resources Administration, Room 1030, Center Building, 3700 East-West Highway, Hyattsville, Maryland 20782, (301) 436-6430. A formal comprehensive AAMC response to the report is now being developed for review by the Association's various councils at their next quarterly meetings in January 1981.

## ● APPROVAL OF BUDGET RECONCILIATION BILL IN DOUBT

While the Congress appeared determined several weeks ago to adopt an omnibus budget reconciliation bill prior to the national elections, it had yet to occur as the election recess began October 2. The individual Senate and House versions (S. 2885 and H.R. 7765) were passed on June 30 and September 4 respectively and a 100-member Conference Committee was appointed to iron out differences in the bills. Approximately 35 of these conferees have been assigned responsibility for the health issues in question. Agreement has been reached on some of the non-controversial provisions. However, many of the more serious issues have yet to be resolved.

On September 19, the Association of American Medical Colleges (AAMC) wrote to each of the Conferees, expressing its views on six issues addressed in the proposed legislation. The **Association supported a provision** (Section 865) in the House bill **that would, in effect, repeal Section** 227 of the Social Security Act, the highly controversial Medicare provision dealing with teaching physician reimbursement. The Association has contended that Section 227 inherently discriminates against physicians caring for patients in teaching hospitals and has noted that two sets of draft implementing regulations have been unworkable, inequitable and harmful to existing patterns of medical education.

**Five** of the **provisions** in the Senate bill were **opposed by the AAMC:** (1) Section 551 which establishes a retroactive **limitation on hospital reimbursement** using a mandated, inflexible statistical formula **with a "ratcheting" effect;** (2) Section 554 which undermines the authority of fiscal intermediaries to establish equitable apportionment of costs by **limiting all payments**

**to the Medicare patient's proportional share** and by requiring federal review of the justifications for a higher payment rate; (3) Section 555 which penalizes hospitals financially under Medicare for the absence of adequate long-term care facilities in their community by paying **lower long-term care reimbursement rates when acute care beds may be in use necessarily**; (4) Section 560 which requires the HHS Secretary to implement **outpatient cost limitations prior to appropriate Congressional examination** of the implications of such specific limitations; and (5) Section 562 which **permits Medicaid programs to limit a beneficiary's choice of hospitals on behalf of cost effectiveness** and thereby potentially creating a two-class system for medical care.

The House-Senate conferees responsible for the health service components of the budget reconciliation bills adjourned October 1 for the Congressional recess having addressed two of the conference issues of major interest to the AAMC and its members. The conferees agreed in principle to accept the House provision which would repeal Medicare Section 227. Congressional staff are presently drafting statutory language to accomplish their "in principle" agreement. AAMC staff will be following these activities closely to help ensure that the bill contains a clear and complete repeal.

The conferees also reached an "in principle" agreement on the proposal to pay hospitals at nursing facility rates for patients that require skilled nursing level care but are utilizing acute care beds and services. While no definitive language is yet available, the agreement essentially combines the Senate's general methodology with the House provision excepting hospitals having an 80% or greater occupancy level and those demonstrating they are unable to obtain a certificate of need for long-term care beds.

Since this is, in effect, the first Congressional attempt to reconcile the federal budget, predicting the eventual outcome of the deliberations is difficult. The process is complicated by a major election recess which will at least temporarily arrest any momentum the bill may have gathered before Congress adjourned. However, the conferees will have an opportunity for further work on the legislation during Congress' "lame duck" session which is scheduled to convene on November 12.

## ● CONGRESS APPROVES CONTINUING FUNDING RESOLUTION FOR FY 1981

On October 1, under pressure to assure continued funding for the Department of Health and Human Services (HHS) and most other Federal agencies, both the House and Senate approved a compromise Continuing Appropriations Resolution for FY 1981 one day after the end of the federal government's fiscal year. The Senate had initially threatened to reject the proposal because of disagreements with the House of Representatives over the House's more restrictive language prohibiting Medicaid-funded abortions. However, the two chambers worked swiftly to effect an acceptable compromise because failure to enact an FY 1981 Continuing Resolution prior to September 30 (the end of the 1980 fiscal year) left the federal government officially out of money, with the mandate to spend only what would be required to close itself down. As adopted, the bill authorizes Medicaid payments for abortions when the life of the mother is threatened and in cases of incest and promptly reported rape. Moreover, the bill specifically provides that states may adopt more restrictive anti-abortion rules than those the Congress has approved.

In terms of funding levels, the compromise Continuing Resolution **provides funding through December 15** for authorized health programs at the lower of their present 1980 appropriations levels or those that the House approved earlier this year in its fiscal 1981 Labor/HHS Appropriations measure. Unauthorized health programs (those approved too late to be included in the Approriations bill) would be continued at their present funding levels. However, their budgets could be adjusted in an eventual Appropriations bill or through a supplemental appropriation. The only execption is the National Health Service Corps program which, thanks to an amendment offered by Senator Warren Magnuson, will be funded at the President's revised budget request of $87 million, an increase of more than $5 million over its present appropriation.

## HOUSE PASSES HEALTH RESEARCH LEGISLATION

H.R. 7036, "The Health Research Act of 1980," introduced by House Commerce Health Subcommittee Chairman Henry Waxman (D-Cal.) was approved by the House of Representatives on August 28 by a vote of 292-48. The Senate version, S. 988, introduced by Human Resources Health Subcommittee Chairman Edward Kennedy (D-Mass.), had been previously passed on June 19, 1980, by a vote of 82-0. While Congressional staff meetings on compromise legislation are apparently continuing, the official House-Senate conference on H.R. 7036 and S. 988 will not take place until the Congress' "lame duck" session after the national elections.

Although the goals of the two bills as stated by their sponsors **are similar**—strengthening the Congressional role in planning and overseeing the national biomedical research effort—the **approaches** taken to accomplish these goals are **markedly different.** *S. 988* would (1) establish a national research planning council, (2) strengthen the role and flexibility of the Director of the National Institutes of Health (NIH), and (3) return the Cancer and Heart, Lung, and Blood Institutes to the permanent open-ended authority of Section 301 of the Public Health Service Act now provided for the rest of NIH. On the other hand, *H.R. 7036* would (a) establish limited authorizations and spending ceilings for all of the Institutes, (b) require that these authorizations be renewed every three years, and (c) repeal the Section 301 authority entirely.

The Executive Committee of the Association of American Medical Colleges (AAMC), after careful consideration, concluded that S. 988 **is the preferred legislation.** The Association recently urged its Council of Deans, Council of Teaching Hospitals and Council of Academic Societies to actively support the key provisions of S. 988.

Prior to the vote by the full House on H.R. 7036, Rep Waxman persuaded his colleagues to **incorporate** into the language of the Health Research Act, his **"Health Planning Technical Amendments,"** H.R. 7911, which were previously approved by the House (see August *COTH Report*). Waxman thought that such an action would expedite passage of the Planning Act amendments through the Congress. The technical amendments include: exemption of certain health research capital expenditures from certificate of need review; extension of the deadline for states to conform their laws to federal certificate of need requirements; provision of an additional two years for health systems agencies (HSAs) to complete their first appropriateness reviews; clarification that a person serving on one or more health facility boards should not automatically be considered a provider for purposes of membership on health planning agency governing bodies; and modification of the HHS method of allocating federal grants to planning agencies.

## MANPOWER LEGISLATION WILL GO TO JOINT CONFERENCE

Both the House of Representatives and Senate now have **passed** their versions of health manpower legislation, H.R. 7203 and S. 2375, on September 3 and 19 respectively, **with virtually no debate or controversy.** The joint conference on these two measures is scheduled to be undertaken during the Congress' "lame duck" session after the national elections. AAMC staff is in the process of examining the differences between the two proposals in regard to medical education and is developing the Association's views for submission to the conferees. Disparities exist in the areas of:

- *Institutional Support*—H.R. 7203 continues the traditional system of capitation grants but provides for its phase down and eventual termination. In contrast, S. 2375 would establish a new form of institutional support—The National Priority Incentive Grant Program—at higher authorization levels than those proposed by the House. The Senate proposal appears to be politically palatable to many in Congress who oppose the continuation of the present capitation program.
- *Student Assistance*—Each bill proposes a different student aid program. H.R. 7203 would reauthorize, at generous levels, the current assistance structure with modifications designed to eliminate some of the

problems that have arisen in the implementation of these programs. S. 2375, on the other hand, proposes one new program which contains stricter service requirements than those currently in operation and discontinues another program that has been functioning since 1963.

- *Eligibility for Schools of Chiropractic*—The Senate bill contains a series of controversial provisions that would extend eligibility for selected special project grants and student aid programs to schools of chiropractic. The House measure does not contain such provisions.

- *Foreign Medical School Graduates*—The provisions in the original House bill that affected foreign medical graduates (FMGs) were reported out by the full House Interstate and Foreign Commerce Committee as a separate bill, H.R. 7204. This measure was then referred to the House Judiciary Committee, where it and a related FMG proposal (H.R. 7118) have been incorporated into an omnibus immigration bill. S. 2375 has maintained its FMG-related provisions which involve: extending the duration of stay in this country for J-visa holders; waiving of the Visa Qualifying Examination (VQE) requirement; and, placing National Health Service Corps (NHSC) physicians in certain hospitals and locations designated as manpower shortage areas in order to reduce the dependency of these areas on alien FMGs.

## HOUSE COMMITTEE TABLES DISTRESSED HOSPITAL BILL

As reported in last month's *COTH Report*, the House Ways and Means Health Subcommittee unanimously approved the "Hospital Financing Experiment and Demonstration Act," H.R. 7776, on August 26. However when taken up by the full Committee on September 16, the bill was **set aside indefinitively** and is not expected to be considered again by the Committee during this session of Congress. The bill, sponsored by Health Subcommittee Chairman Charles Rangel (D-N.Y.), would expand existing demonstration authority under Titles XVIII and XIX of the Social Security Act to enable the Department of Health and Human Services to experiment with reimbursement and related policies to foster the restructuring of the health care delivery system in a community in order to result in more economical delivery of health services under these Titles.

Specifically, H.R. 7776 would authorize studies and demonstration projects on whether Medicare and Medicaid should be used to pay for: a portion of a hospital's bad debts; hospital closure, conversion, renovation, or physical improvements needed for compliance with safety standards; establishing outpatient primary care facilities; and management improvements. Additionally, studies would be authorized on the more economic and efficient use of Medicare-Medicaid funds and on improvements in program administration.

One of the stumbling blocks for the bill before the full Committee was Committee Chairman Al Ullman's (D-Ore.) inability to see the need for the HHS Secretary to have the proposed statutory authority if HHS is already undertaking such experimental programs. In the August 29 *Federal Register*, the Health Care Financing Administration (HCFA) published a notice **soliciting applications** from state Medicaid agencies **for "demonstration projects to improve the efficiency of services and management in financially troubled hospitals** in medically underserved rural and inner-city areas, so that they can better serve the Medicare, Medicaid, uninsured and inadequately insured populations."

According to HCFA, these grants will provide funds for demonstration projects that "insure access to services for federal beneficiaries and address the financially troubled hospital problems through system reforms." Particular interest is expressed for "projects that test the way in which changes in health care delivery and reimbursement and changes in Medicaid eligibility rules will affect the ability of financially distressed hospitals to provide health care for federal beneficiaries, the uninsured and inadequately insured while achieving fiscal viability." The demonstration program also encourages potential grant recipients to study a variety of approaches to improving access to quality care.

While no specific limit on either the number or size of the grants has been established, HHS Secretary Patricia Harris has stated that the Department is hoping to fund up to eight demonstration projects during the fiscal year and would particularly be examining the cost of proposed projects in determining which would be selected for the program. September 30 was established as the application deadline for these special grants, which could be applied for only by the single state Medicaid agency, which would in turn identify appropriate hospitals for participation. Besides the unusually short application submission cycle provided, many hospitals are also finding their state Medicaid agencies reluctant to submit applications due to lack of required state Medicaid matching funds.

For further information on the grants program, contact: Steven A. Pelovitz, HCFA, Office of Research, Demonstrations and Statistics, Office of Demonstrations and Evaluations, Area 1-E-6, Oak Meadows Building, 6340 Security Blvd., Baltimore, Maryland 21207, (301) 597-1821.

## ● VA PHYSICIANS SPECIAL PAY BILL ENACTED

On August 26, the Congress voted by an overwhelming majority—401 to 5 in the House and 85 to 0 in the Senate—to override the President's veto of legislation designed to revise and make permanent the authority of the Veterans Administration (VA) to enter into special pay agreements with physicians and other health professionals employed by its Department of Medicine and Surgery (DM&S). The enactment of P.L. 96-330 marks **only the second time a Democratic Congress has overruled a Democratic President's veto since 1952.** The new statute represents a compromise of the major elements of the original House and Senate proposals. While several of its provisions affecting part-time physicians employed on a half-time or greater basis are somewhat disappointing, the newly adopted law represents a considerable improvement over current statutes and resolves a number of the AAMC's concerns regarding the initially proposed bills.

P.L. 96-330 creates **incentives for full-time employment** while providing **lesser benefits for part-time service.** Major provisions of the law include:

- Increases in incentive special pay, amounting to approximately an 80 percent increase over current levels for full-time physicians and 30 percent for part-timers. Based on the time worked, part-time physicians will be eligible for only a proportional share of yearly special pay benefits not to exceed slightly more than three-quarters of the amount allotted to those employed on a full-time basis.

- More favorable retirement benefits for full-time physicians. Special pay will be regarded as basic pay for the purpose of computing requirement credits for full-time physicians with a minimum of 15 years of service.

- A requirement that Chief of Staff positions be filled on a full-time basis. However, the law does include a grandfather clause under this provision.

- Permanent exemption of DM&S personnel from the requirement of the Senior Executive Service (SES).

- A VA Health Professions Scholarship Program for the purposes of: providing DM&S with adequate health care personnel, particularly physicians and nurses; reducing the Department's dependence on foreign medical graduates; and decreasing the VA's use of contract physicians.

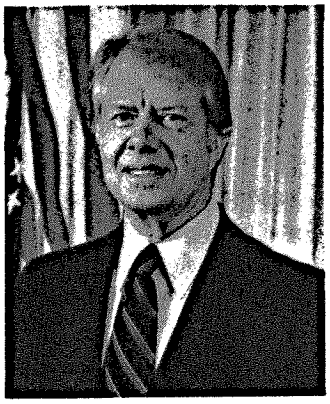
- A statutory program of 15 geriatric research, clinical, education centers (GRECCs) at VA health care facilities.

Effective January 1, maximum annual salaries for VA physicians will be increased to $76,200 from the present level of $58,700. President Carter called the increase an "unwarranted salary bonus" and asserted that it would do little to actually assist veterans. The President has consistently opposed physician pay raises except for those in the military. He vetoed a military pay bonus bill earlier this year because it included Public Health Service physicians and some non-physicians.

# FACES IN THE NEWS

## ● MENTAL HEALTH SYSTEMS ACT ENACTED

On October 7, President Jimmy Carter signed into law as P.L. 96-398, the "Mental Health Systems Act of 1980." The new law authorizes total spending of $796 million in fiscal years 1981-84 to be used primarily for funding of existing community mental health centers and for grants targeted at certain segments of the population such as the chronically mentally ill, the elderly, severely disturbed children and adolescents, and other underserved populations.



PRESIDENT CARTER

The passage of the Mental Health Systems Act was particularly pleasing to First Lady Rossalyn Carter, who chaired the President's Commission on Mental Health. Numerous recommendations made in the four-volume Commission report to the President of April 1978 were incorporated into the provisions of the newly enacted legislation. In addition, two controversial provisions were included in the final bill. The first was a recommended **mental patients' "bill of rights"** strongly pushed by Senate Human Resources Health Subcommittee Chairman Edward Kennedy (D-Mass.) and Senator Jacob Javits (R-N.Y.), sponsors of the provision. Implementation of the provision, which sets forth a listing of 12 rights to which persons admitted to a program or facility for the purpose of receiving mental health services are entitled, would be optional and **non-binding on the states.** P.L. 96-398 generally strengthens the states' authority over mental health programs and though it also recommends that states establish programs independent of their mental health systems to advocate the rights of the mentally ill, it does not make such programs mandatory.

The second controversial provision included in the new law is one that **gives Public Health Service doctors and dentists comparable special pay increases** to those recently authorized for military physicians. By incorporating the special pay raise in the Mental Health Bill strongly endorsed by the President, Congress was able to achieve passage of the special pay bonuses that were vetoed earlier in the year by him in separate legislation (see April *COTH Report*).

Specifically, the Mental Health Systems Act of 1980:

- extends the Community Mental Health Centers Act through fiscal 1981, authorizing $85 million for programs under the Act;
- continues grants for new community mental health centers, allowing centers in poverty areas to make up a larger proportion of total operating costs with grants;
- allows states with approved mental health services systems to determine which programs would receive grants;
- authorizes a series of new federal mental health grant programs beginning in fiscal 1982 to include those for the chronically mentally ill, priority populations (those with limited access to adequate mental health services), walk-in health care centers, children and adolescents, continuing grants for services in facilities no longer eligible for center grants, innovative projects, improved state administration of mental health programs, mental illness prevention, and for rape victim services and prevention demonstration projects;
- limits most grants to the first eight years of operation of a new program and provides that the percentage of total operating costs that could be funded by grants would be reduced at a designated rate during that period;
- requires compliance by states to protect the rights and interests of employees impacted by the shift in emphasis from institutionalized care to outpatient care;
- provides a model mental health patients' "bill of rights" for states to adopt voluntarily;

- authorizes grants for public or non-profit private programs to advocate the rights of the mentally ill;
- provides that commissioned medical and dental officers of the Public Health Service be paid at rates equal to the special pay paid to commissioned medical and dental officers of the Armed Forces; and
- requires states to establish mechanized systems for processing Medicaid claims and information.

## NATION SPENT $212 BILLION ON HEALTH CARE IN 1979

On August 25, HHS Secretary Patricia Harris announced the results of the latest comprehensive health spending estimates compiled by the Health Care Financing Administration (HCFA), reporting that the nation spent an estimated $212.2 billion for health care in 1979. This amount is **equal to nine percent of the gross national product and an increase of 12.5 percent in actual dollars expended** from 1978, according to HCFA.

SECRETARY HARRIS

On a per capita basis, 1979 health spending from all sources was reported at an estimated **$943 per person.** Of this amount, $406 or 43 percent represented public spending. **Medicare and Medicaid** outlays for health care benefits **paid 27 percent of all personal health care** in the nation, amounting to $29.3 billion and $21.7 billion respectively, including hospital care benefits of $29.7 billion for both programs. Overall, $85.3 billion (or 40 **percent** of the 1979 total **expended** on health care from all sources) was **solely for hospital care.** Medicare paid nearly $20 billion in benefits under its hospital insurance (Part A) program during fiscal 1979. Inpatient hospital care, the report states accounted for 96 percent of the Part A payments.

The HCFA report of the latest tabulation of money spent for health care in the United States continues a series of annual reports begun in 1964. The 1979 estimates are published in the current (Summer) issue of HCFA's quarterly journal, the *Health Care Financing Review.* Highlights among other figures in the report include:

- The estimated $85.3 billion bill for hospital care represents a 12.5 percent rate of increase over 1978 levels. At the end of 1979, there were 6,801 hospitals participating in Medicare, with slightly more than 1.1 million beds.
- Expenditures for health care in 1979 included $54.4 billion in premiums to private health insurance, $60.9 billion in federal payments and $30.5 billion in state and local government funds.
- Spending for physician services rose 13.4 percent to $40.6 billion—19 percent of all health care spending in 1979.
- All third parties combined—private health insurers, government, philanthropy and industry—financed 68 percent of the $188.6 billion in 1979 personal health care spending (as opposed to outlays for research, construction, and administration), ranging from 92 percent of hospital care services to 64 percent of physicians' services and 39 percent of the remainder. Direct payments by consumers reached $60 billion in 1979. This represented 32 percent of all personal health care expenses.
- As of January 1, 1979, 24.6 million aged and 2.9 million disabled persons under 65 (12 percent of the U.S. civilian population) were covered by Medicare.

Complimentary copies of the report may be obtained from HCFA, Printing and Publications Branch, 1710 Gwynn Oak Avenue, Room D-3, Baltimore, MD 21235. To obtain a subscription to *Health Care Financing Review,* write to

ORDS Publications, Room 1E9, Oak Meadows Bldg., 6340 Security Blvd., Baltimore, Maryland 21235.

## ● MEDICARE REGS PROPOSE INCENTIVE REIMBURSEMENT FOR OUTPATIENT AND SELF-CARE DIALYSIS

In the September 26 *Federal Register*, the Health Care Financing Administration (HCFA) *proposed* regulations providing for reimbursement of the cost of outpatient maintenance renal dialysis and self-care dialysis training treatments furnished to Medicare patients dialyzing in a hospital or independent facility. The regulations implement Section 1881(b)(2)(B) of the Social Security Act, which provides for an incentive reimbursement method to encourage economies in the delivery of these treatments. Under the method proposed, Medicare would **set national rates in advance,** according to type and location of the facility, then **provide prospective payment of 80 percent of that rate.** Facilities furnishing treatments more economically than the specified rate could keep the difference between their actual cost and the national rate, which would be adjusted periodically. In addition, a one-year transition period will be provided for those facilities with costs significantly above the rates, and an **exception** to the established national rate **for facilities with an atypical patient mix** or other circumstances warranting a higher rate would be authorized.

The End-Stage Renal Disease program, which began in 1973, provides Medicare coverage to more than 45,000 people currently dependent on dialysis. It authorizes Medicare reimbursement for services in a hospital, including kidney transplants; for maintenance dialysis furnished on an outpatient basis in approved facilities or in the home; and it pays for training patients to dialyze themselves. **Medicare,** under Part B, **now pays 80 percent of the average cost of outpatient treatment in a hospital and 80 percent of reasonable charges for independent facilities up to a limit of $138 per treatment,** unless an exception is granted.

Announcing the proposed regulations, HCFA Administrator Howard Newman stated, "Although our kidney program has been successful in protecting renal disease patients against the catastrophic costs of needed care, expenditures have skyrocketed from some $160 million in 1974 to about $850 million in 1979. We feel that the method of reimbursement we are proposing today would slow the increasing costs by promoting more efficient and cost-effective delivery of services through financial incentives." The new methodology would apply to outpatient dialysis in a hospital or free-standing facility, and to programs that train patients to dialyze themselves at home. Although the proposed regulations provide an explanation of the proposed methodology by which HCFA plans to establish the first set of national rates, if the regulation is adopted, it does not include the actual rates to be proposed. HCFA now is conducting extensive audits on a statistically selected sample of facilities. The rates to be included in the final regulations will be based on the results of these audits.

HOWARD NEWMAN

Under the proposed regulations, facilities will be required to report their costs as they do under current Medicare regulations. The reports will be used to monitor the program and to establish future rates. **Four national classifications of facilities** are proposed: (1) urban hospitals, (2) urban independent facilities, (3) rural hospitals and (4) rural independent facilities. The rate for each facility would be composed of a portion covering salaries which would be adjusted by an area wage index and a portion covering other operating expenses. HCFA Administrator Newman expressed the belief that facilities should be able to achieve economies by shopping for the best prices and supplies and doing bulk buying when possible. He also contended that the regulations should encourage improvement in administrative and management services and promote efficiencies in all types of operating costs.

HCFA will receive comments (in duplicate) on these proposed regulations until **November 25, 1980.** They should be addressed to: Administrator, Health Care Financing Administration, DHHS, P.O. Box 17073, Baltimore, Maryland 21235. In commenting, please refer to file code OSP-2-P. Copies of these proposed regulations may be obtained from the AAMC's Department of Teaching Hospitals.

## ● HOSPITAL-BASED PHYSICIAN PAYMENT REGS REMAIN BLOCKED

Implementation of the Health Care Financing Administration's (HCFA) **March 11 Notice** of change in Medicare reimbursement of hospital-based physicians **remains blocked by an injunction.** On August 26, a Federal District Court judge in Little Rock, Arkansas, rejected a motion by HHS to dismiss a preliminary court injunction blocking the Medicare reimbursement changes. HHS had argued that the Court lacked jurisdiction in the matter. The nationwide **injunction was issued June 4** on the basis of a suit brought by the Arkansas Hospital Association, state and national pathologist associations, three hospitals located in the state, and three pathologists practicing in the state. It was contended that the Medicare reimbursement changes would have seriously impacted existing agreements between hospitals and hospital-based physicians in the state. The HCFA **Notice would require that Medicare payments to hospital-based physicians be made on a reasonable charge basis only if the services rendered** required performance by a physician **in person or directly contributed to diagnosis or treatment of the patient.** Otherwise, payment to hospital-based physicians would be made on a reasonable cost basis.

HCFA has now filed a motion requesting the federal district court to "clarify or modify" the preliminary injunction on the grounds that its intended scope "is unclear and overly broad." HCFA wants the injunction changed so that it does not compel payment under Part B for professional component billing "by pathologists *not paid on this basis prior to the March 11 Notice.*" It is contended by HCFA that Medicare administrative costs will be increased substantially if additional pathologists, those not on direct billing before March 11, are permitted to alter their billing as a result of the injunction.

## ● REGS PROPOSED TO EXPAND MEDICARE AMBULANCE SERVICE COVERAGE

In the August 27 *Federal Register,* the Health Care Financing Administration (HCFA) proposed regulations that would expand Medicare Part B coverage of ambulance services. **Round trips to non-hospital destinations** (e.g., clinics, physicians' offices, therapy centers) **would be covered** for hospital inpatients who require special diagnostic or therapeutic services not available at the hospital in which the beneficiary is a patient. Under current regulations, such round trip ambulance transportation is covered only when the beneficiary travels to the nearest institution with appropriate facilities for the specialized services.

The proposed regulations would also **add the availability of a physician or physician specialist capable of providing the needed care** or treatment **to the criteria for deciding whether an institution had appropriate facilities** to provide the care needed by the beneficiary. The *Medicare Intermediary Manual* and the *Medicare Carriers Manual* currently deny coverage of ambulance service to a more distant hospital solely to avail a patient of the services of a physician in a specific specialty.

According to HCFA Administrator Howard Newman, "This proposal represents a program improvement that would make the Medicare ambulance service benefit more responsive to patient needs and consistent with developments in medical care that have tended to centralize certain diagnostic and therapeutic services. Although we are not proposing to extend the ambulance benefit other than for hospital inpatients, we are soliciting comments and suggestions on the need that may exist in other situations." Such comments should refer to file code BPP-31 and be addressed to: Administrator, HCFA, DHHS, P.O. Box 17076, Baltimore, Maryland 21235. Comments must be received by *October 27, 1980.*

## STUDY FINDING MANDATORY STATE RATE-SETTING SUCCESS DISPUTED

The findings of a study reported in a September 13 *New England Journal of Medicine* article, entitled "Hospital Cost Inflation Under State Rate-Setting Programs," have been strongly challenged by the American Hospital Association (AHA). The study, authored by Biles, Schramm, and Atkinson of the Johns Hopkins Center for Hospital Finance and Management and the Maryland Health Services Cost Review Commission, found that the states with mandatory rate-setting programs—Connecticut, Maryland, Massachusetts, New Jersey, New York, and Washington—**had an 11.2 percent average annual rate of increase in hospital costs during the period of 1976-78,** while the average annual rate of increase in states **without such programs was 14.3 percent.** The authors conclude that "much of the initial pessimism regarding the effectiveness of hospital rate-setting programs, based on studies that covered earlier reporting periods, may be unwarranted." However, they look upon such regulation as a short-run solution to inflation that should be seen as a transitory step in creating a competitive health market.

Calling the study incomplete and misleading, the AHA has argued that **use of old data led the researchers to false conclusions.** The AHA claims that using 1979 data results in entirely different conclusions. **The Association's 1979 data show that the sharpest acceleration in the rate of increase between 1978 and 1979 occurred in the regulated states.** In states with mandatory regulation, the rate of increase in hospital expenses rose from 8.8 percent in 1978 to 11 percent in 1979, while expenses in the nonregulated states rose from 14.3 percent to 14.4 percent. Morevoer, the AHA noted, the **impact** of such regulation **on the quality of care** was **not addressed** by the investigators. In New York State, for instance, savings have come at the expense of many hospital closings and cutbacks in services, with 77 percent of the state's hospitals operating at a deficit in 1978.

Supportive of the findings presented by Biles, et al., the **U.S. General Accounting Office** (GAO) issued a report on September 19 which **claims** that states which have adopted hospital prospective rate-setting programs *"have been effective in restraining rising hospital costs."* Initiated in mid 1978, the GAO study **focused on 9 of the 26 states which use various prospective rate-setting programs** and found that they "were more successful in controlling the growth rate in expenditures per case **during 1975-77."**

Examining the principle factors contributing to higher hospital costs, the GAO contends that a major influence "appears to be the (traditional) cost-based retrospective method of determining the amount hospitals will be paid by third party payors," which is labeled by GAO as "inherently inflationary since it provides little, if any, incentive to contain costs." The nine states upon which the GAO study is based were: Arizona, Connecticut, Florida, Indiana, Maryland, Massachusetts, New Jersey, Virginia, and Washington. The report explains that the programs in these states make payments based on rates determined before the services are provided by establishing "an external authority to regulate the prices that hospitals may charge and/or that third parties must pay for specified services." It is the **presence of** such an **outside review authority,** GAO argues, that **forces hospital managers to closely review, and be prepared to justify, planned expenditures.** Despite this pressure, however, GAO concludes that the hospitals in the nine prospective rate-setting states "generally have not yet adopted cost containing management techniques," such as shared services, energy conservation techniques, and individualized testing procedures.

On the basis of its findings, the GAO recommends that Congress *"amend the Social Security Act to permit the full participation of the Health Care Financing Administration's Medicare program in existing prospective rate-setting programs."* Should this occur, GAO further recommends that the Secretary of HHS should: (1) increase the number of prospective rate-setting programs in which HCFA is actively participating by making Medicare, and permitting Medicaid, payments based on program determined rates; (2) promote and encourage the greater use of cost containment management techniques to help contain hospital cost increases; and (3) monitor the impact of pros-

pective rate-setting programs on hospital cost increases and periodically report the results to the Congress.

The **AHA also criticized the GAO report.** As stated in the report, AHA felt that the study "failed to address (1) the major impact the federal government has on rising hospital costs (through excessive laws and regulations) and (2) the impact of prospective rate-setting programs on the financial stability of hospitals or the quality of patient care provided." More specifically, the AHA took exception to the GAO's data on use of energy conservation techniques, and comments that GAO "overestimated the ease with which sharing arrangements can be developed and implemented."

A complimentary copy of the 210-page GAO report, entitled *"Rising Hospital Costs Can Be Restrained by Regulating Payments and Improving Management"* HRD-80-72, dated September 19, 1980, may be obtained from the U.S. General Accounting Office, Documents Handling and Information Services Facility, P.O. Box 6015, Gaithersburg, Maryland 20760.

## GAO EXAMINES HOSPITAL MANAGEMENT SERVICE CONTRACTS

In a letter to the Health Care Financing Administration (HCFA) dated June 30, 1980, the U.S. General Accounting Office (GAO) reported the results of its review of hospital use of contract management services. The **GAO found that the use of such contracts, designed to arrange for the day-to-day management of the hospital by an outside management firm, is increasing.** The GAO also found that many **fees seemed excessive** (particularly those based on a percentage of gross revenue), that **inadequate records were kept** of the actual services rendered under these contracts, and that Medicare **intermediaries were generally not reviewing the reasonableness of the fees charged.**

In particular, GAO examined those arrangements where the management firm provides "full service management" and assumes responsibility for management of the day-to-day operation of the hospital. The study included the review of the provisions of 66 contracts. Common contract features included: the hospitals' Board of Directors retained ultimate control and responsibility; fees were based on factors not related to the contractors' cost of providing the services; and many, although not all, of the hospitals were in serious financial condition. Common problems that hospitals have and that management firms attempt to address included excess hospital beds, under-utilization of facilities, overstaffing, excessive inventories, and untimely collection of receivables.

There were a number of concerns GAO noted in connection with the use of these contracts:

- *The contracts frequently covered excessively long periods.* GAO found contracts ranging from one to 27 years, with the average falling at three years. By installing management firm employees in top hospital management positions, many contracts assured continued client dependence.
- *The fees for many of the contracts were often based on a percentage of gross revenues.* Of the 66 contracts reviewed, 24 involved percentage arrangements; 35 involved fixed amounts; and seven involved fixed amounts per day per bed. Thirty contracts required the hospitals to pay the salaries and benefits of management firm employees in addition to the management fee. The problems cited by GAO with regard to percentage arrangements included: (1) the total dollar amount cannot be foretold; (2) they are disincentives to holding down costs—the incentive is to maximize revenues and thus maximize fees; and (3) the relationship between the fee charged and services performed can be widely disparate.
- *The fees varied widely.* Reasons which would account for or explain the wide differences in fees found were not evident from reviewing the contracts, which were very general and did not break out specific services and related fees. One 412-bed hospital paid $1,647,233 in management fees in fiscal year 1978, while another 405-bed hospital paid only $250,000 for the same period.
- *The documentation of the services actually provided was inadequate.* The hospitals visited did not maintain, or provide GAO,

records in sufficient detail to show what services were actually performed. Essentially, GAO was unable to make an assessment of reasonableness of management fees because it was unable to relate fees charged to the specific services actually provided.

- *The adequacy of controls over payments to the firms was questionable.* Contracts often did not specify controls over disbursements to management firms. Since the controller and administrator usually were management firm employees, improprieties could occur.
- *Medicare intermediaries generally were not reviewing the reasonableness of the fees charged.* As a standard procedure, officials at one intermediary visited stated that they would only make a "related organization" assessment and not evaluate the reasonableness of fees claimed. Intermediaries generally were concerned with whether the management fee was negotiated at arm's length and/or whether the management firms and the hospitals were related parties. Intermediary officials stated that Medicare has not provided adequate guidelines or criteria for evaluating the reasonableness of management fees.
- *HCFA has not developed adequate standards and instructions governing reimbursement for the costs of hospital management contracts.* Intermediaries did not have a complete inventory of which providers were being managed under contract. Providers were not required to submit copies of the contracts and intermediaries usually identified such contracts only when a field audit was made of the provider hospital. On February 6, 1980, HCFA's Bureau of Program Policy issued for comment a proposed revision to the *Provider Reimbursement Manual* which clarifies Medicare policy regarding reasonable cost evaluation of purchased management and administrative support services. Among other things, the proposed issuance requires that hospitals keep records of the services provided and the time spent by management firm employees on hospital business. GAO believes this proposed action is the only practical way to establish a basis for assessing the reasonableness of management fees claimed for Medicare reimbursement.

To provide greater control over Medicare reimbursement for the costs of the increasing number of hospital management contracts, GAO recommended that the proposed revision to the *Provider Reimbursement Manual* include provisions requiring that providers:

- establish appropriate controls over payments to management firms;
- maintain strict management firm accountability for the use of the firm's specialists; and
- forward a copy of all new contracts and renewals to intermediaries as soon as they are consummated.

In addition, **GAO recommended that providers be prohibited from using percentage arrangements** as a basis for calculating the amount of management fees claimed for Medicare reimbursement, and that it be emphasized to intermediaries that the **reasonableness of these fees be addressed as part of the cost report settlement process.**

A copy of the complete text of GAO's June 30 letter to HCFA may be obtained from the AAMC's Department of Teaching Hospitals.

## ● OTA REPORTS ON IMPLICATIONS OF COST-EFFECTIVENESS ANALYSIS IN HEALTH CARE

Cost-effectiveness analysis (CEA) and cost-benefit analysis (CBA) *"cannot serve as the sole or primary determinant of a health care decision,"* according to a study conducted by the Congressional Office of Technology Assessment (OTA) to assess the implications of cost analyses of medical technology. The 219-page report, issued August 15, presents findings of a study conducted in response to a request made back in September 1978 by the Senate Finance and Labor and Human Resources Committees. The major conclusion of the report is that contrary to some expectations, *"it is unrealistic . . . to expect that CEA/CBA, in itself, would be an effective tool for reducing or controlling overall expenditures for medical care."*

The study defines CBA and CEA as "formal analytical techniques for comparing the positive and negative consequences of alternative ways to allocate resources. *In CBA*, all costs and all benefits are valued in monetary terms. Thus, conceptually, CBA can be used to evaluate the worth of a project and would allow comparison of projects of different types (such as dams and hospitals). *In CEA*, the health-related effects of programs or technologies are not valued in monetary terms but rather are measured in some other unit (such as years of life gained). A CEA, therefore does not result in a net monetary value for a project. Instead it produces a measure of the cost involved in attaining some desirable health-related effect. Conceptually, CEA permits direct comparison of only those programs or technologies that share similar objectives."

The study report explains that "most of the specific findings of this report relate to **two major general findings:** (1) performing an analysis of costs and benefits has potential to be very helpful to decision-makers, because the process of analysis structures the problem, allows open consideration of all relevant effects of a decision, and forces the explicit treatment of key assumptions, and (2) CEA/CBA exhibits too many methodological and other limitations to justify relying solely or too heavily on the results of formal CEA/CBA studies in making a decision." The assessment found two methodological weaknesses—"those that are inherent in this form of analysis and those that are due to the lack of maturity in the state-of-the-art of CEA/CBA and to the lack of analysis expertise and experience with CEA and CBA in health care."

CEA/CBA is **generally ill-suited to the National Institutes of Health** (NIH) biomedical decision-making process," the OTA concludes. However, "NIH may be able to incorporate some form of efficiency-based analysis in its center, contract, and intramural research efforts." Examining the potential for use of CEA/CBA **in third-party reimbursement** coverage decisions, OTA reports that such potential **use is "severely tempered" by limitations** of current state-of-the-art methods for such analysis and health policy makers' unfamiliarity with them. In addition, OTA cautions, "the economic efficiency value embodied in cost-effectiveness information may **conflict with a number of other values prevalent in our health care system:** (1) the practitioner's obligation to do the most for the patient; (2) the patient's desire to receive a full range of medical care, regardless of ability to pay; (3) society's desire to encourage innovation in order to ultimately improve care; and (4) society's goals in terms of equity and other non-economic values." The implications of CEA/CBA for health planning agencies, health maintenance organizations and professional standards review organizations are also considered in the study. The **basic conclusion,** however, was that **"very little formal use"** of these analytical techniques is occurring **in health care decision-making now.**

In response to the OTA report, Senator Edward Kennedy (D-Mass.), Chairman of the Senate Human Resources Subcommittee on Health stated, "The report underscores my belief that the simplistic use of cost-effectiveness analysis will not resolve many of basic dilemmas in health care delivery." Representative Henry Waxman (D-Cal.), Chairman of the House Commerce Subcommittee on Health said: "The report reinforces my concern that we don't know how to measure the benefits of programs accurately, nor do we have a valid method of measuring the true costs of death and disease. I have long felt that the most pernicious aspect of cost benefit and cost-effectiveness analysis is that it conceals difficult moral questions under a comforting pretense of mathematical objectiveness." The OTA report concludes, however, that the process of analyzing costs and benefits can lead to better decisions in health care, with the results that **"interest in the use of CEA/CBA is likely to increase substantially."**

The OTA report, titled *"The Implications of Cost-Effectiveness Analysis of Medical Technology,"* may be purchased for $6.50 from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Reference should be made to GPO Stock No. 052-003-00765-7.

# NEWS BRIEFS

THE NEW COUNCIL FOR MEDICAL AFFAIRS, WHICH REPLACED THE COORDINATING COUNCIL ON MEDICAL EDUCATION, HELD ITS FIRST MEETING SEPTEMBER 24 IN WASHINGTON, D.C. The new Council is part of a plan to restructure the system for accrediting medical education in the United States. Like its predecessor, the new Council will be composed of representatives from five parent bodies: the Association of American Medical Colleges, the American Medical Association, the American Hospital Association, the American Board of Medical Specialties and the Council of Medical Specialty Societies. Each of the parent groups will be represented by its two chief elected officers and the chief executive officer. The Liaison Committee for Graduate Medical Education was renamed the **Accreditation Council for Graduate Medical Education** and will be comprised of four representatives from each of the parent organizations, a public member, a resident in training and a federal representative (who would not be a voting member). The agenda for the September 24 meeting also included adoption of a proposal for creation of a single accrediting body for continuing medical education. Accreditation of continuing medical education had been conducted by both the Liaison Committee for Continuing Medical Education and the AMA-sponsored Committee for the Accreditation of Continuing Medical Education. The newly created body will be called the **Accreditation Council on Continuing Medical Education.**

THE RECIPIENTS OF THE 1980 FLEXNER AND BORDEN AWARDS WERE RECENTLY ANNOUNCED BY THE AAMC. **William G. Anlyan, M.D.,** Vice President for Health Affairs at Duke University Medical Center and Professor of Surgery, Duke University School of Medicine, is the recipient of the 1980 Abraham Flexner Award for distinguished service to medical education. Anlyan served as chairman of the AAMC Executive Council in 1970-71 and was the first chairman of the Coordinating Council on Medical Education. He is recognized for his substantial contributions as an educator and an administrator, and for his professional activities to advance the cause of medical education on the national scene. **Donald F. Steiner, M.D.,** Pritzker Professor of Biochemistry in Medicine and Associate Director of the Diabetes and Research Training Center at the University of Chicago, will receive the 1980 Borden Award for outstanding research in medicine by a member of a medical school faculty. Steiner is honored for his discovery that insulin is made by way of a single chain precursor and for the impact of this discovery on biology and medicine. **The awards will be presented at the AAMC's Annual Meeting Plenary Session on Tuesday, October 28 at 9:30 a.m.** in the International Ballroom of the Washington Hilton Hotel.

DATA ON SUBSTANTIAL DISRUPTION WAIVERS HAS BEEN RELEASED BY HHS. During the past few years, health manpower legislation (P.L. 94-484 and 95-83) amended the Immigration and Nationality Act by applying stringent requirements for the issuance of J-1 (exchange visitor) visas to alien physicians. Congress then provided for the waiver of certain portions of these requirements, if rigorous implementation of all of the provisions of these sections of the law would cause a "substantial disruption in health services." Data on the numbers of substantial disruption waiver applications requested and approved in 1978, 1979 and 1980 were recently released by the Division of Medicine of the Health Resources Administration. On the basis of location, the **demand for FMGs through the waiver mechanism was by far highest in New York** in each of the years. New York received 11 of the 19 applications approved in 1978, 94 of the 108 approved in 1979, and 183 of the 229 approved in 1980. On the basis of specialty programs, the **highest number of applications** approved in 1978 was for psychiatry (with six), and **for pediatrics in both 1979 and 1990** (with

53 and 97 respectively). Overall, the ratio of applications approved to those requested looked as follows:

*SUBSTANTIAL DISRUPTION WAIVERS*
1978-1980

| YEAR | NUMBER REQUESTED | NUMBER APPROVED |
|---|---|---|
| 1978 | 35 | 19 |
| 1979 | 140 | 108 |
| 1980 | 243 | 229 |

ON AUGUST 13, THE COST EFFECTIVENESS OF PSROs WAS REPORTED ON BY HCFA in its third annual report to Congress evaluating the Professional Standards Review Organization (PSRO) program for the calendar year 1978. For that year, according to HCFA, **PSROs saved the Medicare program $21 million more than it cost to administer the review** of care given Medicare beneficiaries. This compares to an estimated $5 million for the previous year. The report also states that for the second consecutive year **Medicare hospital use** has been **reduced in areas that have active PSROs. Nationally** the **net reduction** in days of care per thousand patients was reported to be **1.7 percent.** The greatest savings in hospital use—a 4.8 percent decrease in the days of care per thousand patients —was found in the northeast section of the country, where PSROs have been in operation for the longest time.

In addition to presenting numerous tables and charts evaluating the performance of PSROs in calendar year 1978, the 214-page report also provides an overview of the PSRO program and discusses significant program events of fiscal year 1979. Single copies of the report, entitled, *"Professional Standards Review Organization 1979 Program Evaluation,"* are available free from HCFA Publications, Room D-3, 1710 Gwynn Oak Avenue, Baltimore, Maryland 21235.

THE NUMBER OF HOSPITALS IN THE UNITED STATES DECREASED LAST YEAR TO 6,988 FROM 7,015, according to data in the 1980 edition of the American Hospital Associations (AHA's) "Hospital Statistics." Based on AHA's 1979 annual survey of all hospitals, the data also show that the number of hospital beds decreased. **Admissions,** however, **continued to increase** along with the number of surgical operations and births. All hospitals received the annual questionnaire. The response rate was 89.8 percent. Community hospitals grew in bed capacity but not in number. Community hospitals are defined as all non-federal, short-term general and other special hospitals, excluding hospital units of institutions whose facilities are available to the public. So defined, community hospitals represent more than three-fourths of the nation's hospitals.

Admissions into community hospitals continued to increase in 1979, up 1.7 percent from 1978 to 35,099,000. This represents a 24.2 percent increase in one decade. The **average length of stay** in these hospitals **remained the same** as in 1978—7.6 days. The average number of patients in community hospitals on any given day in 1979 rose 1.3 percent from 1978 to 727,000, while **births rose 4.1 percent** to 3,287,012 and **surgical operations increased by 6.5 percent** to 18,268,581. Total community hospital expenditures were $66 billion, a 13.4 percent increase from 1978. The **average expenditude per inpatient day in 1979 was $217.34,** an increase of 11.8 percent from 1978. The AHA's annual survey also, for the first time, collected data on CT scanners. Though distinctions were not made between head and body scanners, it was found that **948 of the nation's hospitals had CT scanning equipment.**

KAISER-PERMANENTE HAS ACQUIRED THE GEORGETOWN UNIVERSITY HEALTH PLAN, a 54,000-member health maintenance organization (HMO) in the Washington, D.C. metropolitan area. Under the acquisition agreement, **effective August 1,** the non-profit Kaiser Foundation Health Plan (the administrative arm of the Kaiser-Permanente Medical Care Program, the nation's largest private health care delivery system) will assume managerial responsibility for the **newly named Kaiser-Georgetown**

**Community Health Plan.** Kaiser Foundation Hospitals, a non-profit and charitable corporation, will be responsible for hospitalization arrangements. The Georgetown physicians, salaried employees, plan to establish themselves as a professional corporation, in line with the other Permanente Medical Groups in the nation.

THE MEDICARE HOSPITAL INSURANCE DEDUCTIBLE WILL INCREASE ON JANUARY 1, 1981, FROM $180 TO $204. This represents **a 13.3 percent increase over the current deductible rate,** a rate that is adjusted by the Secretary of HHS annually to account for changing economic conditions. In addition to the deductible change, Medicare patients will have to begin contributing $51 per day from the 61st day to the 90th days of hospitalization, up from the current figure of $45. These changes were announced in the October 10 *Federal Register.*

FINAL REGULATIONS DEFINING "RADIOLOGICAL SERVICES" FOR WHICH THE MEDICARE PROGRAM PROVIDES FOR PAYMENT AT 100 PERCENT OF REASONABLE CHARGES were published by the Health Care Financing Administration (HCFA) in the August 22 *Federal Register.* Section 1833(a)(1)(B) of the Social Security Act provides for the 100 percent reimbursement for "radiological services" when furnished to hospital inpatients by physicians in the field of radiology. Current administrative guidelines restrict the 100 percent reimbursement to services in which X-rays or rays from radioactive substances are used. Proposed regulations published on January 25, 1979 would have extended the 100 percent reimbursement to other diagnostic imaging services such as ultrasound. On the basis of information acquired through public comment on the proposed regulations, **HCFA has concluded that there is not sufficient reason at this time to extend the 100 percent reimbursement to services not already so reimbursed.** Accordingly, these final regulations follow current operating instructions and define "radiological services" as ionizing radiation used for diagnostic or therapeutic purposes. Copies of these final regulations may be obtained from the AAMC's Department of Teaching Hospitals.

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) INTENDS TO *PROPOSE* REGULATIONS TO CLARIFY THE RULES GOVERNING MEDICARE REIMBURSEMENT OF REASONABLE COST ON THE BASIS OF PRUDENT PRACTICES, according to a notice published in the August 18 *Federal Register.* The prosoed regulations would explicitly state that providers must apply sound management principles to their day-to-day business transactions, thus assuring that their actual operating costs do not exceed what a prudent cost-conscious business manager would have incurred for similar transactions. While current regulations provide that Medicare payment of a provider's reasonable cost is intended to meet the costs actually incurred, a limit applies when a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors, or the costs are otherwise not reasonable. This limitation has been interpreted in various program manuals and instructions as a "prudent buyer" concept. The proposed amendment would explain the "prudent buyer" concept in regulations. **The intent of this change is to clarify HCFA's existing authority to disallow costs that are unreasonable.**

REVISED *FINAL* REGULATIONS TO IMPLEMENT THE PROGRAM OF FINANCIAL DISTRESS GRANTS TO HEALTH PROFESSIONS SCHOOLS were issued by the Public Health Service in the August 21 *Federal Register.* These **grants are designed to assist schools in meeting their cost of operations,** if they the in serious financial distress and threatened by closure; in meeting **accreditation requirements,** if there is need of special assistance to address the potential loss of accreditation; and in car-

**rying out operational, managerial and financial reforms.** Until the publication of these final regulations, the program had been operating under an interim-final rule. The **major change** under the new set of procedures is **an acceleration of the grant cycle** allowing grant funds to be awarded at the federal level and budgeted at the grantee level before the school year begins. Thus, federal funds could be awarded at the beginning of the fiscal year, rather than during the year as under the former regulations. The regulations would **also permit transfer of grant funds from the health professions schools to the university** or other parent organization for services provided to the school when the viability of the two entities is linked. Additionally, a provision stipulating that the size of the grant may not exceed 75 percent of the amount awarded in the previous fiscal year has been deleted.

Almost 90 percent of the $6.9 million awarded in financial distress grants in fiscal 1980 went to four minority health profession schools: Meharry Medical College's Schools of Medicine and Dentistry, Tuskegee Institute of Veterinary Medicine and Copies of these final regulations may be obtained from the AAMC's Department of Teaching Hospitals.

APPLICATIONS FOR RESIDENCY TRAINING GRANTS IN GENERAL INTERNAL MEDICINE OR GENERAL PEDIATRICS ARE NOW BEING ACCEPTED BY THE BUREAU OF HEALTH PROFESSIONS, according to an announcement in the September 15 *Federal Register*. Under Section 784 of the Public Health Service Act, authorization is given for the award of grants to **assist in meeting the costs of planning, developing, and operating approved residency training programs in internal medicine or general pediatrics** and to **provide financial assistance** in the form of traineeships and fellowships **to residents who** are participants in these types of programs and **plan to practice in these medical specialties.** In funding of approved applications, preference will be given to projects in which: (1) substantial training is experienced in settings where physician assistants or nurse practitioners, or both, are used as part of the health care team; (2) coordination is undertaken between administrative and education resources to be used by a program in general internal medicine and a program in general pediatrics within a single project; and (3) substantial portions of a project are conducted in a primary medical care manpower shortage area(s).

Requests for application materials and questions regarding grants policy should be directed to: Grants Management Officer (D-28), Bureau of Health Professions, HRA, Center Building Room 4-27, 3700 East-West Highway, Hyattsville, Maryland 20782, (301) 436-6564. Eligible applicants are public or private nonprofit schools of medicine or osteopathy. To receive support, **programs must meet the requirements of final regulations published in the *Federal Register* on August 1, 1980.** Copies of these final regulations, as well as those appearing in the same issue for grants to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, and podiatry for capitation support of their educational programs, may be obtained from the AAMC's Department of Teaching Hospitals.

FINAL REGULATIONS SETTING FORTH THE REQUIREMENTS FOR GRANTS FOR TRAINING PROGRAMS IN EMERGENCY MEDICAL SERVICES, under Section 789 of the Public Health Service Act, were issued in the September 12 *Federal Register*. These grants would go to schools of medicine, dentistry, osteopathy, and nursing; training centers for allied health professions; hospitals; and other appropriate educational and public entities. The regulations become **effective on October 30, 1980,** and address such questions as: To what programs do these regulations apply?; What are the general policies and definitions pertaining to this grant program?; Who is eligible to apply for a grant?; What should grant applications contain and how

will they be evaluated?; What are the project requirements and how is the amount and duration of grant support determined?; For what purposes may grant funds be spent?; and What health planning, audit and inspection requirements must be met by grantees? Copies of these final regulations may be obtained from the AAMC's Department of Teaching Hospitals.

FINAL REGULATIONS GOVERNING THE AWARDING OF NATIONAL HEALTH SERVICE CORPS (NHSC) SCHOLARSHIPS were issued by the Public Health Service in the August 20 *Federal Register*. The regulations, which became **effective with their publication,** are intended to allow greater flexibility in use of selection criteria. These criteria include consideration of work experience, community background, career goals, faculty recommendations and academic performance. The **time period is increased from two to three years for repayment of scholarship funds by persons who either failed to perform acceptably in school or were dismissed or asked to leave school voluntarily.** Deferment of the service obligation for students of medicine, osteopathy and dentistry is authorized beyond the existing three-year period to permit completion of residency training in certain specialties needed by the National Health Service Corps. Veterinary, optometry, podiatry and pharmacy students also may be given deferments for at least one year for advanced clinical training.

Copies of these final regulations may be obtained from the AAMC's Department of Teaching Hospitals.

A PROGRAM PROVIDING UP TO $100,000 IN GRANTS-IN-AID WAS ANNOUNCED BY THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) RECENTLY. Grants will be awarded for projects that will improve the communications skills of FMGs; enhance FMGs' understanding of education, economics and the political process in the U.S.; improve the understanding of the American people about FMGs' contribution to American medicine; and sponsor research on the effects of availability of graduate medical programs in the U.S. for FMGs. Eligible applicants are not-for-profit agencies, organizations and institutions. For information and application forms, contact: Ray L. Casterline, M.D., Executive Director, Educational Commission for Foreign Medical Graduates, 3624 Market Street, Philadelphia, Pennsylvania 19104.

THE HOSPITAL RESEARCH AND EDUCATIONAL TRUST HAS ANNOUNCED IT WILL RECEIVE APPLICATIONS THROUGH DECEMBER 1, 1980 FOR NINE FELLOWSHIPS FOR 1981. Two Edwin L. Crosby Memorial Fellowships and seven W. K. Kellogg Foundation Fellowships of $12,000 each will be awarded to individuals in the early stages of their health care careers for nine-month projects that promise to have practical and widely applicable results toward improving the organization and delivery of health care. Application forms are available from: Hospital Research and Educational Trust, 840 N. Lake Shore Drive, Chicago, Illinois 60611.

DECEMBER 15, 1980 IS THE DUE DATE FOR APPLICATIONS TO THE VETERANS ADMINISTRATION (VA) ADMINISTRATIVE SCHOLARS PROGRAM. The program, which was initiated in 1977, provides a two-year opportunity for midcareer health professionals to prepare for leadership positions in large health systems by focusing on the management and policy issues related to such systems through self-directed and self-initiated studies. Competition for the Program is national and open to all health professionals. Five scholars will be selected for next year's entering class. Financial support will equal present compensation up to certain limits. For further information, call or write: Executive Director, VA Administrative Scholars Program, VA Ceneral Office, 810 Vermont Avenue, N.W., Washington, D.C. 20420, (202) 389-3588.