ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1432 SHESS 1982 INTERIM: HEALTH REPOPT 1982

PROSPECTIVE REIMBURSEMENT
(SB 698)

The current method of reimbursement to hospitals and nursing home facilities for Medicaid and General Relief-Medical (GRM) services has no incentive system for cost efficient health care. The State of Alaska presently reimburses health care facilities for costs which arise from the treatment of a Medicaid or GRM patient. Many critics of the present cost reimbursement system believe that, in many instances, more tests and more expensive procedures are used than may be necessary since the government is paying for the services. As the Battelle Study points out, by changing the incentives, Medicaid services can become more efficient and cost effective.

One alternative to the present payment system was proposed in Senate Bill 698 which called for prospective reimbursement to health care facilities. With prospective reimbursement, a budget or rate is established prior to the beginning of the fiscal year and approved by the state. The major difference with this form of reimbursement is that the price is fixed at the beginning of the year prior to the services being performed. The incentive is built in to perform all Medicaid and GRM services as efficiently as possible because if a hospital can keep costs below the accepted budget, it may accrue extra revenues. If there are higher costs, the hospital, under SB 698, could have the option of proposing an amended budget which would have to be reviewed and accepted or rejected by the State.

According to data in the Battelle Study, prospective reimbursement could save Alaska 2.5% to 4.6% in Medicaid hospital payments or approximately $270,000 to $500,000 per year. The state could save even a larger amount from nursing home reimbursement payments, approximately $1.15 million or 11% per year.

SB 698 provides a framework which would be used in setting a reimbursement rate. The reimbursement rate to a health facility would be based on a "fair rate for reasonable costs that are incurred by the facility." The facility could reflect in its proposed budget a reasonable return on its investment. The budgets would be examined and approved by a newly created Medical Assistance Budget Review Commission which would consist of five non-paid members.

The rate system developed in SB 698 is only one method of prospective reimbursement. Alternative programs can differ in specific details as to what costs may be reimbursed, method of budget review, whether the program is voluntary or mandatory, legal sanctions, if any, and mode of setting the rates. The main point, however, in prospective rate setting, is that the rate is set prior to the beginning of the period.

One important question which did not seem to be addressed in the studies cited in the Battelle Study was whether the savings and reductions in costs on Medicaid services resulted from more efficient efforts or from a reduction in the quality of care. There may need to be a quality control mechanism developed to ensure cost effectiveness

without a significant reduction in the quality of health care provided to the Medicaid and GRM patient.

The Alaska Hospital Association and the Department of Health and Social Services' Advisory Committee to the Alaska Comprehensive Health Care and Financing (Battelle) Study both expressed support for a prospective reimbursement program. Savings in Medicaid and General Relief-Medical payments could help to facilitate the continuation of many health care benefit programs which the state is now being forced to provide because of the Federal budget cuts.

STATE HEALTH INSURANCE
(CS HB 41)

According to the Battelle Study, approximately 29,000 Alaskans or 9% of the non-Native population are not covered by some type of health insurance (all Natives are covered through the Alaska Area Native Health Service-AANHS). Of these 29,000 Alaskans, approximately 59% are employed, 8% are unemployed and 33% are not in the labor force. Dependent children comprise 43% of uninsured Alaskans. Studies have indicated that, of those employed, certain kinds of workers are less likely to have insurance of some type. They are hourly workers, part-time employees, non-union laborers, non-office workers, the very young and old in the labor force, employees in a small business, and individuals with a low income.

The Battelle Study lists five reasons in support of the need to provide insurance for the uninsured:

1. Many cannot afford the expense of individual health plans.
2. These persons and their families do not receive adequate health care.
3. Illness in these families can cause extreme financial hardship.
4. The state sometimes ends up paying for their care through catastrophic illness or other public health service programs.
5. Bills unpaid by people who cannot afford to pay them raise the cost of health care for everyone else.

In order to provide access to adequate health care for all Alaskans, the State may wish to intervene in order to cover the uninsured residents. Two basic options the State has for making insurance available to the uninsured are to provide incentives for an employment-based program or to have a state-sponsored health insurance plan. Problems, both conceptual and philosophical, can be found in either option.

The employment-based insurance plan would provide a state subsidy to employers to extend their current coverage to employees who in the past were not covered and to encourage an employer with no insurance package to purchase one. Many of the uninsured, employed population are working for employers who do offer an insurance plan; however, because of the type of work or type of worker involved, they are not included in the insurance program (e.g., a part-time or temporary workers). Under this option, the state would subsidize or provide incentives to employers so that these workers would be covered under the currently available insurance programs.

The employment-based option, although it would cover much of the targeted population, would not necessarily address the unemployed and those not in the work force. A state-sponsored insurance program could be made available to all Alaskans who do not have an insurance program or some type of coverage available to them. They would have an option to purchase a policy. In the case of those who could not financially afford the premiums (the very poor are already covered through Medicaid and GRM), portions of the premiums could be subsidized by the state with a sliding scale according to income.

The Senate HESS Committee's amended version of House Bill 41 provided for a state health insurance program to be established through the Department of Administration. The program would be underwritten by a contracted firm and the administration of the program could also be contracted out. The state would pay all or part of the premium cost for those residents who qualified according to their adjusted gross income.

Problems occur in both options. There may be some concern as to whether a state-sponsored insurance program will be in competition with private insurance companies. In the employment-based option, the cost of insuring those who were not previously covered is expensive, especially since this type of program would try to extend to those employed by businesses which do not have an insurance program (e.g. small, independent businesses with one or two employees) which is difficult and also includes an additional expense on the employer.

If the method proposed by SCS HB 41 is not adopted, the legislature should look into some system which will guarantee that all Alaskans, including the 29,000 individuals now without health insurance, have reasonable access to health care.

REGIONAL HEALTH PLANNING
(SB 754)

In 1974, Congress believed that health care in the U. S. was wasteful, inefficient, short of efforts to prevent disease, unevenly distributed and not meeting the needs of the citizens. For these reasons they established a planning mechanism, Health Systems Agencies (HSAs), to deal with the problems found in health care. Three HSAs were formed in Alaska in 1976. Their mandate was to offer direct technical assistance, identify problems and offer solutions, provide a regional center to disseminate current health data, emphasize health promotion and preventive medicine, coordinate the development of services among the various providers in the state (AHNS, state, military, non-profit corporations, etc.) and address unmet and future needs while containing the cost of health services.

In an effort to assist the regional HSAs in their endeavors, Alaska established the State Health Coordinating Council (SHCC) and the State Planning and Development Agency. HSAs were also partially funded by the state with 27.3% of the total funding coming from the state government, 70.2% from federal funds and 2.5% from other sources. The Federal government, however, established the regulations which defined the goals and guided the actions of the HSAs. Critics of the HSAs believed that these Federal guidelines where not always adequate to provide solutions for some unique state problems.

Recently, the Federal government drastically cut funding to the HSAs which means that either the HSAs will be dissolved or funding must come from other sources. Twenty-seven states have reported that they are contemplating an HSA phase-out and many are replacing the HSAs with a state system of health planning, funded by the state and controlled by state regulations which, they believe, will produce more of a local planning scheme appropriate to the individual state needs.

Presently, Alaska is in a phasing-out stage with respect to the Federal HSAs. In a letter to the Governor, Dr. Charles M. Kaltenbach, Chairman of the Alaska Health Coalition, states that the Department of Health and Social Services has proposed to eliminate all funding for the HSAs in the FY84 budget. This, without any additional legislation, would in effect leave Alaska without regional input in the health care planning field.

Senate Bill 754 would have established a regional health resource system funded and regulated by the state. Since much of the opposition to HSAs was because, by law, they administered the Certificates of Need (CON) which had to be approved prior to major expansion or purchase of equipment by health facilities, the three new Regional Health Resource Organizations (HROs) would not perform this function. The HROs would provide technical assistance and health planning services to the same HSA service areas which now exist. The state would contract the services of non-profit organizations to operate the HROs and each HRO would be governed by a board of directors with representation from each borough, municipality and regional nonprofit Native corporation within the health

service area. In addition, the board would consist of members of the public representing consumers as well as providers of health services in the area.

The question as to whether or not regional health planning agencies should be totally eliminated has not been settled. The success of the HSAs in Alaska, as Dr. Kaltenbach states, can be documented in "savings to the State of several hundreds of thousands of dollars each year by preventing duplication of services, increasing continuity of care, and preventing the development of unneeded services." If HSAs are eliminated, would the Department of Health and Social Services continue to provide the technical guidance and health planning services on a statewide basis? By providing an alternative viewpoint, the HSAs (or any regional agency) help to decentralize the health planning process and no longer leave everything up to the Department of Health and Social Services in the capital.

CERTIFICATES OF NEED
(SB 760)

The Certificates Of Need (CON) program, which is set forth in sec. 1527 of P.L. 93-641, provides a method of controlling and regulating the development of health care facilities' capital projects. A CON must be authorized before a group may construct a health care facility, alter bed capacity, add or eliminate a category of service, or acquire major medical equipment. The CON was formed to alleviate duplication in services in local areas and to help maintain affordable as well as quality health care to residents.

When Alaska, under the threat of losing Federal funds, established CONs in 1976, the Federal government strictly regulated the dollar thresholds above which a CON was necessary and required that the Health System Agency (HSA) was to be the agency which reviewed the CON applications. Since the legislation was adopted, six years of inflation have made the original dollar amounts unreasonably low; opponents to CONs state that health care facilities have to get approval for almost any equipment purchase or minor expansion which they need. Therefore, the Federal government has recently amended P.L. 93-641 to allow for higher CON thresholds and to authorize other agencies to administer the program.

Senate Bill 760 was drafted to bring the state statutes regulating CONs in compliance with the Federal laws. The bill would not only raise the minimum dollar amount needed for a CON to match the federal threshold but also place the CON program under the auspices of the State Health Planning and Development Agency. Since the HSAs are being phased out, this legislation in conjunction with SB 754 would separate the CON function from the regional health planning function. Both functions had previously been found in the HSA.

In order to make the CON program more responsive to the rising cost of health care capital expenditures, the State should utilize the new Federal thresholds. Without legislation such as SB 760 and in light of the fact that HSAs are being phased out in Alaska, the CON program will not only be very burdensome with the low thresholds, it will soon be without an administering agency. The future of the CON program needs close attention in the next legislative session.

Long Term Hospital Capital Plan
(SCS HB 844)

Health care is too essential to be subjected to the shifting political balance of power. Presently, funding for construction of health care facilities is in the political arena; funding for major projects depends on the political clout of the elected official representing the respective area. In order to have a truly integrated and equitable health care system, a comprehensive, statewide plan relating to health facility improvements and maintenance should be developed by an apolitical group. Current legislative methods of funding health care facilities results in a fragmented and many times inefficient statewide health care system.

To continue in efforts toward the development of a comprehensive health care plan, House Bill 844 was amended by the Senate HESS Committee to provide for a long term hospital capital plan. As stated in the "Findings and Purpose" section of the bill, "health facilities constitute an integral part of the health services of the state..." and the act was designed "to assist health facilities in securing the capital necessary to improve and maintain their physical plants so that they can continue to provide quality health care."

The bill originated in the House and, in its original form, only provided a plan for financing rural health facilities. However, the health system in Alaska is too integrated and interdependent to have health planning only in non-urban areas of the state. Patients may originally be served by a village health clinic, sent to an inpatient facility in a neighboring city for stabilizing and then transported to one of the hospitals in the larger cities for major medical procedures. A more comprehensive, statewide plan was needed to effectively facilitate the fulfillment of the objectives of the legislation; therefore, the Senate HESS Committee amended the bill to provide for such a plan. This statewide plan for financing health facility improvements and maintenance then passed both houses of the legislature.

The legislation would have established a health facility improvements and maintenance fund in the Department of Health and Social Services. Following the guidelines set forth in the bill, the Statewide Health Coordinating Council would compile and submit a list of recommended priorities of health care facilities needing a state grant or loan. The Council's itemized priority list would be divided into four categories depending on the bed capacity of the facility and community size. The legislation required the four categories to ensure that all areas of the state are considered in the prioritization. After receiving the prioritized list, the commissioner of the Department of Health and Social Services could make changes in the list if these changes were submitted to the Council in writing. The commissioner would then provide the governor with the finalized priority list for appropriations from the health facility improvement and maintenance fund. In this manner, the priority list is not subjected to the radical changes which the proposed executive budget routinely undergoes in the legislature.

One of the reasons for the veto cited in the Governor's message was that the he found direct grants to non-profit agencies unacceptable. Legislative authority to appropriate money to non-profit organizations has been a bone of contention between the executive branch and the legislature for the past few years. It is entirely possible that the new governor will not have these problems with direct grants. If this continues to be a matter at issue between the two branches, a compromise can be worked out similar to that in existence for the past few years where the appropriation is given to the municipality to be passed on the the health facility.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

file

Alaska State Legislature

Senate

Office of the President

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

November 9, 1982

Senate Charles H. Parr
950 Cowles, Rm. 224
Fairbanks, Ak 99701

Dear Chan[illegible]

Thank you for your recent letter concerning the health activities of the Senate HESS Committee. I have noted your concerns and will consider your ideas when the legislature addresses this and related topics during the next session.

I would like to express my sincere appreciation for the dedication to service you have demonstrated as chairman of the Senate HESS Committee.

Best wishes for your future.

Sincerely,

Senator Jay Kerttula
Senate President

JK/st

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Health file

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 0599
Fairbanks, Alaska 99701
(907) 456-5029

Fairbanks Interim Office
545 Third Avenue, Suite D
Fairbanks, Alaska 99701
(907)456-8925

Pouch V
Juneau, Alaska 99811
(907) 465-4907

DATE: August 18, 1981

TO: All interested parties

FROM: Senator Charlie Parr, Chairman CP
Senate Health, Education and Social Services Committee

SUBJ: Forthcoming public hearings

* *

The Senate Health, Education and Social Services Committee will conduct public hearings in the following communities during the interim to consider aspects of health care and health care delivery systems within Alaska.

All interested parties are invited to attend and present testimony.

For further information, please contact Sandra Stringer in Fairbanks at 456-8925 or Nancy Deitrick in Juneau at 465-4907.

FAIRBANKS	Saturday, September 12, 1981 9:00 a.m. - 5:00 p.m.	Borough Assembly Chambers 520 Fifth Avenue
KENAI	Saturday, September 26, 1981 9:00 a.m. - 5:00 p.m.	Borough Building
NOME	Saturday, November 7, 1981 9:00 a.m. - 5:00 p.m.	City Hall
BETHEL	Saturday, November 14, 1981 9:00 a.m. - 5:00 p.m.	Legislative Information Office
ANCHORAGE	Thurs., Friday, December 9-10, 1981 9:00 a.m. - 5:00 p.m.	Committee work sessions only Legislative Information Office
	Saturday, December 11, 1981 9:00 a.m. - 5:00 p.m.	Public hearing Legislative Information Office 1024 W. 6th Avenue

CHP:dm

LEADING CAUSES OF DEATH BY REGION	RATE PER 100,000
KETCHIKAN	
1. Heart disease and hypertension	157.1
2. Accidents	107.6
3. Malignant neoplasms	82.9
4. Vascular lesions of CNS	44.5
5. Degenerative diseases	21.0
WRANGELL-PETERSBURG	
1. Heart disease and hypertension	173.0
2. Accidents	150.0
3. Malignant neoplasms	110.4
4. Suicide	29.4
5. Vascular lesions of CNS	22.1
SITKA	
1. Heart disease and hypertension	114.2
2. Accidents	108.3
3. Malignant neoplasms	93.7
4. Vascular lesions of CNS	32.2
5. Alcoholism/diseases of early infancy	23.4
JUNEAU	
1. Heart disease and hypertension	122.0
2. Accidents	104.1
3. Malignant neoplasms	75.1
4. Vascular lesions of CNS	32.4
5. Respiratory/ill-defined	17.1
CHUGACH	
1. Accidents	173.8
2. Heart Disease and hypertension	120.8
3. Malignant neoplasms	108.1
4. Influenza pneumonia/Respiratory	21.2
5. Vascular lesions of CNS/Cirrhosis	17.0
AHTNA	
1. Accidents	160.9
2. Malignant neoplasms	47.3
3. Heart disease and hypertension	42.6
4. Diseases of early infancy/Ill-defined	23.7
5. Suicide	14.2
COOK-INLET	
1. Accidents	125.5

2. Heart disease and hypertension	103.7
3. Malignant neoplasms	81.3
4. Vascular lesions of CNS	24.3
5. Ill-defined	22.4
ANCHORAGE	
1. Accidents	74.9
2. Heart disease and hypertension	54.6
3. Malignant neoplasms	46.2
4. Suicide	16.5
5. Cirrhosis	13.1
KONIAG	
1. Accidents	191.8
2. Heart disease and hypertension	93.7
3. Malignant neoplasms	56.7
4. Alcoholism	26.1
5. Vascular lesions of CNS	21.8
ALEUTIANS	
1. Accidents	81.4
2. Heart disease and hypertension	65.1
3. Malignant neoplasms	32.5
4. Vascular lesions of CNS	24.4
5. Diseases of early infance/Ill-defined	10.8
BRISTOL BAY	
1. Accidents	204.0
2. Heart disease and hypertension	61.9
3. Malignant neoplasms	51.0
4. Ill-defined	32.8
5. Vascular lesions CNS/Respiratory	25.5
CALISTA	
1. Accidents	181.7
2. Heart disease and hypertension	43.7
3. Influenza Pneumonia	31.0
4. Ill-defined	29.6
5. Diseases of early infancy	26.8
BERING STRAITS	
1. Accidents	258.0
2. Heart disease and hypertension	105.0
3. Malignant neoplasms	96.0

4. Suicide	57.0
5. Homocide/Ill-defined	30.0
NANA	
1. Accidents	149.2
2. Suicide	78.8
3. Heart disease and hypertension	66.3
4. Ill-defined	45.6
5. Malignant neoplasms	51.5
DOYON	
1. Accidents	142.1
2. Heart disease and hypertension	72.9
3. Malignant neoplasms	37.1
4. Homocide	27.2
5. Suicide	21.0
FAIRBANKS	
1. Accidents	76.8
2. Heart disease and hypertension	68.7
3. Malignant neoplasms	54.5
4. Vasculer lesiona of CNS	20.0
5. Diseases of early infancy	17.3

Average annual rate 1974-1977 per 100,000 from DHEW statistics

1977 LEADING CAUSES OF DEATH - UNITED STATES	RATE PER 100,000
1. Diseases of the heart	331.3
2. Malignant neoplasms	183.5
3. Cerebrovascular disease	76.9
4. Accidents	47.9
5. Pulmonary disease	22.7
6. Pneumonia/Influenza	20.0
7. Diabetes mellitus	15.0
8. Chronic liver disease	13.6
9. Atherosclerosis	13.0
10. Suicide	12.6

CAUSE OF DEATH	RATE/100,000 ALASKA	RATE/100,000 U.S.
Congenital Abnormalities		6.0
1. Nana	12.4	
2. Sitka	11.7	
3. Calista	11.3	
4. Bristol Bay	10.9	
5. Doyon	9.9	
Vascular Lesions of CNS		3.4
1. Ketchikan	44.5	
2. Juneau	32.4	
3. Sitka	32.2	
4. Bristol Bay	25.5	
5. Aleutians	24.4	
Accidents		47.7
1. Bering Straits	258.0	
2. Bristol Bay	204.0	
3. Koniag	191.8	
4. Calista	181.7	
5. Chugach	173.8	
6. Ahtna	160.9	
Homocide		9.1
1. Bering Straits	30.0	
2. Doyon	27.2	
3. Calista	19.7	
4. Nana	16.6	
5. Arctic Slope	13.1	
Suicide		13.3
1. Nana	78.8	
2. Bering Straits	57.0	
3. Wrangell-Petersburg	29.4	
4. Calista	23.9	
5. Doyon	21.0	
Alcoholism		2.4
1. Koniag	26.1	
2. Sitka	23.4	
3. Nana	20.7	
4. Ketchikan	19.8	
5. Bering Straits	18.0	

MALE 1976-1977	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	FEMALE	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	TOTAL BOTH SEXES Rate per 100,000 Two Year Average 1977 and 1978
	1976	1977	1978			1976	1977	1978		
Tuberculosis	3	1	0	0.2*	Tuberculosis	1	1	3	1.1*	0.6
Other Infections	8	5	27	7.1	Other Infections	*	10	16	6.9	7.0
Inflammatory Diseases of CNS	8	4	2	1.3	Inflammatory Diseases of CNS	3	3	4	1.9	1.6
Gastritis and Enteritis	0	0	0	0.0*	Gastritis and Enteritis	2	0	0	0.0*	0.0*
Influenza and Pneumonia	30	20	35	12.2	Influenza and Pneumonia	18	8	20	7.4	10.0
Other Respiratory	18	17	18	7.8	Other Respiratory	10	15	15	7.9	7.9
Maternal	-	-	-	-	Maternal	0	1	1	0.5*	0.2*
Congenital Abnormalities	19	12	10	4.9	Congenital Abnormalities	18	21	19	10.6	7.5
Diseases of Early Infancy	31	27	37	14.2	Diseases of Early Infancy	16	15	15	7.9	11.4
Ill-Defined	38	41	33	16.5	Ill-Defined	23	27	25	13.8	15.2
Heart Disease and Hypertension	212	222	210	96.0	Heart Disease and Hypertenston	100	91	99	50.3	75.2
Malignant Neoplasms	133	133	159	64.9	Malignant Neoplasms	100	116	117	61.7	63.4
Diabetes	8	3	6	2.0	Diabetes	4	5	5	2.6	2.3
Vascular Lesions of the CNS	29	34	30	14.2	Vascular Lesions of CNS	37	27	36	16.7	15.3
General Arteriosclerosis	6	18	7	5.6	General Arteriosclerosis	5	9	4	3.4	4.6
Chronic Nephritis	0	0	2	0.4*	Chronic Nephritis	1	1	0	0.3*	0.4*
Cirrhosis of Liver	33	17	26	9.6	Cirrhosis of Liver	18	20	13	8.7	9.2
Other Degenerative	16	22	23	10.0	Other Degenerative	11	20	18	9.5	9.8
Accidents	336	287	357	143.2	Accidents	95	78	94	45.5	98.6
Suicide	51	73	50	27.3	Suicide	16	16	9	6.6	17.9
Homicide	43	28	42	15.6	Homicide	8	8	18	6.9	11.6
Other External Causes	13	32	22	12.0	Other External Causes	4	12	5	4.5	8.6
Alcoholism	15	21	8	6.4	Alcoholism	12	10	9	5.0	5.8
All Other Causes	38	43	22	14.5	All Other Causes	18	32	29	16.1	15.2
TOTAL	1,088	1,040	1,126	486.0	TOTAL	529	546	572	295.9	399.2

*Rate based on number less than 5.

Source: Office of Information Systems, Alaska Dept. of Health and Social Services, Alaska Vital Statistics, 1976 and 1977; and Unpublished Data, 1979. Population by sex derived by applying 1970 sex ratio to 1977 and 1978 total population.

RESIDENT DEATHS BY CAUSE BY RACE

Alaska Natives

1976-1978

	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978
	1976	1977	1978	
Tuberculosis	2	2	2	2.9*
Other Infections	8	6	16	16.0
Inflammatory Diseases of CNS	7	5	0	3.6
Gastritis and Enteritis	1	0	0	0.0*
Influenza and Pneumonia	26	8	25	24.1
Other Respiratory	9	7	10	12.4
Maternal	0	0	0	0.0*
Congenital Abnormalities	9	6	4	7.3
Diseases of Early Infancy	21	10	13	16.8
Ill-Defined	26	27	17	32.1
Heart Disease and Hypertension	69	57	65	89.0
Malignant Neoplasms	55	60	54	83.2
Diabetes	2	1	1	1.5*
Vascular Lesions of CNS	15	19	13	23.3
General Arteriosclerosis	3	4	2	4.4
Chronic Nephritis	1	0	1	0.7*
Cirrhosis of Liver	19	10	12	16.0
Other Degenerative	7	15	6	15.3
Accidents	131	110	122	169.2
Suicide	21	25	13	27.7
Homicide	20	11	25	26.3
Other External Causes	9	23	7	21.9
Alcoholism	22	17	10	19.7
All Other Causes	14	24	16	31.4
TOTAL	497	447	437	644.8

	NON-NATIVES				TOTAL ALL RACES
	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	Rate per 100,000 Two Year Average 1977 and 1978
	1976	1977	1978		
Tuberculosis	2	0	1	0.1*	0.6
Other Infections	9	8	26	4.9	7.0
Inflammatory Diseases of CNS	4	2	6	1.2	1.6
Gastritis and Enteritis	1	0	0	0.0*	0.0*
Influenza and Pneumonia	22	20	29	7.1	10.0
Other Respiratory	19	25	23	7.0	7.9
Maternal	0	1	1	0.3*	0.2*
Congenital Abnormalities	28	26	25	7.4	7.5
Diseases of Early Infancy	26	32	39	10.3	11.4
Ill-Defined	34	41	40	11.7	15.2
Heart Disease and Hypertension	243	256	244	72.4	75.2
Malignant Neoplasms	178	188	222	59.4	63.4
Diabetes	10	7	10	2.5	2.3
Vascular Lesions of CNS	51	42	53	13.8	15.3
General Arteriosclerosis	8	23	9	4.6	4.6
Chronic Nephritis	0	1	1	0.3*	0.4*
Cirrhosis of Liver	32	27	27	7.8	9.2
Other Degenerative	20	27	33	8.7	8.8
Accidents	298	255	328	84.4	98.6
Suicide	46	64	46	15.9	17.9
Homicide	31	25	35	8.7	11.6
Other External Causes	10	21	20	5.9	8.6
Alcoholism	5	14	7	3.0	5.8
All Other Causes	40	51	32	12.0	15.2
TOTAL	1,317	1,156	1,257	349.6	399.2

*Rate based on number less than 5.

Source: Office of Information Systems, Alaska Dept. of Health and Social Services.

PROFESSION	RATE PER 100,000 POPULATION BY YEAR							
	1950	1965	1970		1975	1979		1981
	U.S.	U.S.	U.S.	AK.	U.S.	U.S.	AK.	AK.
PHYSICIAN	134.0	139.9	148.7		166.7	185.1	113.0	140.0
PHYSICIAN ASS'T								12.0
R.N.	218.1	317.6	363.9		448.1	520.8	689.6	831.0
L.P.N.						252.0		238.3
PSYCHOLOGIST							5.1	15.2
CHIROPRACTOR						10.0	8.0	11.0
OPTOMETRIST	9.6	8.8	8.9	5.5	9.3	9.7	6.2	6.3
DENTIST	49.8	46.5	47.1	42.0	50.3	54.0	47.3	49.1
PHARMACIST	56.6	52.5	54.4	46.0	56.2	62.4	56.4	43.1

All figures from DHEW Statistics except 1981 Alaska statistics which I took from the Division of Occupational Licensing(removing all non-residents from figures).

Figures seem to be besed on all licensed professionals, including those residing out of state and those not in active service.

RESIDENT DEATHS BY ACCIDENT

Alaska 1974-1978

(Rate per 100,000)

TYPE OF ACCIDENT	1974	1975	1976	1977	1978	U.S. 1977
Other Transport	0.0*	0.0*	0.2*	0.2*	0.2*	0.4
Motor Vehicle	20.5	29.4	27.6	32.3	29.1	22.9
Water Transport--Drown	8.3	12.1	7.7	7.5	14.4	0.6
Water Transport--Other	0.6*	0.5*	1.0*	0.2*	0.5*	0.0
Aircraft	14.5	16.8	14.5	10.2	23.8	0.8
Poisoning	4.0	?	5.1	2.7	3.6	2.2
Falls	6.3	3.0	5.6	5.8	4.1	6.4
Fire	10.5	5.4	5.6	5.4	4.8	2.9
Exposure	1.1*	2.5	3.6	2.9	1.7	0.3
Other Environment	6.8	3.0	1.5	1.0*	2.2	0.5
Drown--Non-transport	13.7	9.1	10.6	8.8	8.2	2.8
Suffocation	2.8	2.5	1.7	0.5*	1.2	1.4
Firearms	8.3	4.0	5.8	2.4	4.1	0.9
Other Accidents	13.4	7.9	13.8	8.8	9.6	5.5
TOTAL ALL ACCIDENTS	110.8	101.3	104.3	88.8	108.3	47.7

Source: Office of Information Systems, Alaska Department of Health and Social Services, Unpublished Data.

ALASKA			RESIDENT DEATHS BY CAUSE 1976 (Rate per 100,000)				RESIDENT DEATHS BY CAUSE 1977 (Rate per 100,000)				RESIDENT DEATHS BY CAUSE 1978 (Rate per 100,000)		
			HSA				HSA				HSA		
1974	1975	CAUSE OF DEATH	SE	SC	N	PERCENT DIFFERENCE U.S.	SE	SC	N	PERCENT DIFFERENCE U.S.	SE	SC	N
2.3	1.5	Tuberculosis	2.0*	0.7*	1.2*	Alaska 33% lower	1.9*	0.4*	0.0*	Alaska 64% lower	0.0*	1.1*	0.0*
1.7	2.7	Other Infections	9.8	2.5	5.9	Alaska 35% lower	1.9*	3.9	4.1*	Alaska 45% lower	5.5*	10.0	14.6
1.1*	1.5	Inflammatory Disease of CNS	0.0*	3.2	2.4*	Alaska 27% lower	0.0*	1.8	2.7*	Alaska 50% lower	0.0*	1.1*	3.6*
0.3*	0.7*	Gastritis and Enteritis	0.0*	0.7*	0.0*	N/A	0.0*	0.0*	0.0*	N/A	0.0*	0.0*	0.0*
12.2	11.6	Influenza and Pneumonia	19.5	10.4	10.7	Alaska 60% lower	13.2	4.6	10.8	Alaska 71% lower	11.0	11.8	19.4
10.0	10.9	Other Respiratory	11.7	7.2	2.4*	N/A	11.3	8.1	4.1*	N/A	16.5	6.4	7.3
0.0*	0.0*	Maternal	0.0*	0.0*	0.0*	Alaska 100% lower	1.9*	0.0*	0.0*	No difference	0.0*	0.4*	0.0*
5.7	5.4	Congenital Abnormalities	9.8	9.0	8.3	Alaska 48% higher	11.3	6.7	10.8	Alaska 33% higher	7.4*	7.9	3.6*
19.1	12.6	Diseases of Early Infancy	5.9*	12.6	10.7	Alaska 2% lower	5.6*	9.9	14.9	Alaska 6% lower	18.4	12.5	8.5
14.0	12.6	Ill-Defined	9.8*	13.7	21.4	Alaska 3% higher	20.7	12.3	29.7	Alaska 11% higher	5.5*	14.3	18.2
83.7	64.7	Heart Disease and Hypertension	156.3	63.0	67.7	Alaska 78% lower	131.7	68.7	64.9	Alaska 77% lower	136.0	61.9	75.3
51.0	52.9	Malignant Neoplasms	95.8	50.0	52.5	Alaska 68% lower	88.4	58.1	50.0	Alaska 66% lower	90.1	65.4	53.5
4.3	3.5	Diabetes	5.9*	1.4*	5.9	Alaska 82% lower	1.9*	2.1	1.4*	Alaska 88% lower	3.7*	1.8	4.9*
27.1	18.3	Vascular Lesions of CNS	50.8	11.2	10.7	Alaska 82% lower	26.3	11.6	18.9	Alaska 82% lower	31.2	13.2	14.6
2.8	3.5	General Arteriosclerosis	17.6	0.7*	0.0*	Alaska 80% lower	26.3	2.5	8.1	Alaska 50% lower	5.5*	1.4*	4.9*
0.6*	0.5*	Chronic Nephritis	0.0*	0.4*	0.0*	Alaska 94% lower	0.0*	0.4*	0.0*	Alaska 94% lower	1.8*	0.4*	0.0*
10.5	12.1	Cirrhosis of Liver	19.5	13.7	3.6*	Alaska 16% lower	9.4	8.8	9.5	Alaska 37% lower	14.7	7.5	12.2
8.5	7.9	Other Degenerative	11.7	6.5	3.6*	N/A	18.8	9.5	6.8	N/A	20.2	8.2	6.1
110.8	101.3	Accidents	103.6	108.7	90.3	Alaska 122% higher	75.2	83.8	117.5	Alaska 86% higher	119.5	111.5	89.9
12.2	18.3	Suicide	15.6	18.0	10.7	Alaska 30% higher	22.6	21.5	21.6	Alaska 62% higher	16.5	13.7	7.3
9.7	6.4	Homicide	2.0*	15.1	9.5	Alaska 37% higher	0.0*	9.5	12.2	Alaska 3% lower	9.2	12.5	24.3
5.7	2.2	Other External Causes	3.9*	0.7*	15.4	Alaska 86% higher	11.3	8.1	20.3	Alaska 410% higher	3.7*	0.7*	27.9
10.0	11.4	Alcoholism	13.7	5.8	4.8*	Alaska 183% higher	18.8	4.2	12.2	Alaska 212% higher	7.4*	4.3	1.2*
14.8	13.6	All Other Causes	25.4	10.8	15.4	N/A	28.2	15.5	21.6	N/A	18.4	11.1	12.2
418.0	376.1	TOTAL	590.2	365.9	354.1	Alaska 66% lower	526.7	351.7	441.8	Alaska 56% lower	542.3	381.1	409.5

LEADING CAUSES OF DEATH BY AGE

Alaska and U.S. 1976 & 1977

(Average Annual Rate* per 100,000)

	Alaska	U.S.	% Difference
UNDER AGE 1			
1. Diseases of Early Infancy	546.3	778.6	Alaska 30% lower
2. Ill-Defined	362.2	174.3	Alaska 108% higher
3. Congenital Abnormalities	319.2	271.0	Alaska 18% higher
4. Influenza and Pneumonia	73.7	59.0	Alaska 25% higher
5. Accidents	55.2	39.2	Alaska 41% higher
All causes	1,540.8	1,540.3	Alaska <1% higher
AGE 1-4			
1. Accidents	56.5	27.6	Alaska 105% higher
2. Homicide	9.2	2.6	Alaska 254% higher
3. Congenital Abnormalities	6.1	8.9	Alaska 32% lower
3. Ill-Defined	6.1	2.6	Alaska 135% higher
All causes	109.9	69.4	Alaska 58% higher
AGE 5-14			
1. Accidents	23.9	17.2	Alaska 39% higher
2. Malignant Neoplasms	3.9	4.9	Alaska 20% lower
3. Homicide	2.2	1.2	Alaska 83% higher
3. Suicide	2.2	0.4	Alaska 450% higher
3. Congenital Abnormalities	2.2	2.0	Alaska 10% higher
3. Inflammatory Diseases of CNS	2.2	0.3	Alaska 633% higher
All causes	43.3	34.7	Alaska 25% higher
AGE 15-24			
1. Accidents	149.1	61.2	Alaska 144% higher
2. Suicide	32.1	12.6	Alaska 155% higher
3. Homicide	11.9	12.6	Alaska 6% lower
4. Malignant Neoplasms	7.1	6.5	Alaska 9% higher
5. Heart Disease & Hypertension	2.4	2.6	Alaska 8% lower
All causes	218.0	115.3	Alaska 89% higher
AGE 25-34			
1. Accidents	151.9	43.8	Alaska 247% higher
2. Suicide	36.6	16.8	Alaska 118% higher
3. Homicide	13.6	16.5	Alaska 17% lower
4. Malignant Neoplasms	9.5	14.5	Alaska 34% lower
5. Heart Disease & Hypertension	8.1	8.7	Alaska 7% lower
All causes	253.6	136.2	Alaska 86% higher
AGE 35-44			
1. Accidents	90.0	37.4	Alaska 141% higher
2. Heart Disease & Hypertension	36.0	50.7	Alaska 29% lower
3. Malignant Neoplasms	23.7	51.2	Alaska 54% lower
4. Cirrhosis of Liver	16.4	16.1	Alaska 2% higher
5. Homicide	14.7	11.4	Alaska 2% higher
All causes	243.0	250.8	Alaska 3% lower
AGE 45-54			
1. Malignant Neoplasms	127.8	182.2	Alaska 20% lower
2. Heart Disease & Hypertension	125.1	198.4	Alaska 37% lower
2. Accidents	125.1	40.1	Alaska 212% higher
3. Cirrhosis of Liver	46.2	34.4	Alaska 34% higher
4. Suicide	20.4	19.0	Alaska 7% higher
4. Homicide	20.4	9.9	Alaska 106% higher
All causes	589.9	627.8	Alaska 6% lower
AGE 55-64			
1. Heart Disease & Hypertension	469.5	544.9	Alaska 14% lower
2. Malignant Neoplasms	389.7	439.4	Alaska 11% lower
3. Accidents	168.3	47.8	Alaska 252% higher
4. Cirrhosis of Liver	67.9	46.5	Alaska 46% higher
5. Vascular Lesions of CNS	47.2	82.6	Alaska 43% lower
All causes	1,491.0	1,455.2	Alaska 3% higher
AGE 65+			
1. Heart Disease & Hypertension	1,801.9	2,383.3	Alaska 24% lower
2. Malignant Neoplasms	1,097.3	983.8	Alaska 12% higher
3. Vascular Lesions of CNS	433.2	676.2	Alaska 36% lower
4. Accidents	196.4	103.5	Alaska 90% higher
5. General Arteriosclerosis	179.0	119.3	Alaska 50% higher
All causes	4,880.2	5,357.7	Alaska 9% lower

AGE-SPECIFIC DEATH RATES

ALASKA & THE U.S. 1970

Age-Specific rate per 100,000

Age	Alaska	U.S.	Percent Difference In Age-Adjusted Rate
0 - 4 years	635.8	494.7	Alaska 29% higher
5 - 14 years	56.4	41.4	Alaska 36% higher
15 - 24 years	221.2	126.7	Alaska 75% higher
25 - 34 years	217.5	159.8	Alaska 36% higher
35 - 44 years	391.9	314.1	Alaska 12% higher
45 - 54 years	785.1	724.9	Alaska 8% higher
55 - 64 years	1657.1	1662.4	Alaska 1% lower
65 + years	5340.4	5890.1	Alaska 9% lower
All age groups	476.4	940.4	Alaska 49% lower

Alaska & U.S. 1977

(Age-Specific Rate per 100,000)

Age	Alaska	U.S.	
<1	1,480.1	1,485.6	Alaska <1% lower
1 - 4	106.3	68.8	Alaska 55% higher
5 - 14	39.4	34.6	Alaska 14% higher
15 - 24	207.4	117.1	Alaska 77% higher
25 - 34	268.5	136.2	Alaska 97% higher
35 - 44	255.8	247.5	Alaska 3% higher
45 - 54	549.4	620.7	Alaska 11% lower
55 - 64	1,450.1	1,434.9	Alaska 1% higher
65+	5,003.4	5,288.1	Alaska 5% lower
All Age Groups	390.6	878.1	Alaska 56% lower

Source: Office of Information Systems, Alaska Department of Health and Social Services, Alaska Vital Statistics for Health Systms Agencies, 1977. Office of State Health Planning and Development, Alaska Department of Health and Social Services, Unpublished Data, 1979. National Center for Health Statistics, U.S. DHEW, Monthly Vital Statistics Report, Final Mortality Statistics, 1977.

RESIDENT DEATHS BY CAUSE

ALASKA 1950 - 1978

SELECTED CAUSES OF DEATH	1950	1951	1952	1955	1956	1957	1960	1961	1962	1965	1966	1967	1970	1971	1972	1975	1976	1977	1978
Tuberculosis	177.0	145.7	97.4	24.4	22.7	24.6	8.8	8.1	7.8	5.3	3.7	3.6	3.0	1.6	1.5	1.5	1.0	.5	0.7
Other Infectious	31.1	18.9	17.3	7.7	19.1	7.4	6.1	12.7	14.4	9.4	6.2	5.3	3.6	3.9	5.6	2.7	4.1	3.6	10.3
Inflammatory Diseases of CNS	6.7	6.7	5.1	2.3	2.7	4.8	3.9	5.5	6.6	3.4	3.3	5.3	1.3	1.3	1.5	1.5	2.7	1.7	1.4
Gastritis and Enteritis	5.2	3.7	4.1	3.6	6.8	6.6	10.5	5.5	6.2	9.8	1.5	3.2	1.6	.0	.9	.7	.5	0.0	0.0
Influenza and Pneumonia	57.0	40.2	25.5	29.4	36.8	39.5	43.4	31.0	27.1	25.9	22.7	13.9	17.9	17.0	11.8	11.6	11.6	6.8	13.2
Other Respiratory	9.6	13.4	12.8	18.6	14.5	15.8	12.7	6.4	14.0	14.7	9.5	8.5	13.2	13.8	6.8	10.9	6.8	7.8	7.9
Maternal	6.7	2.4	2.6	1.8	2.3	1.8	0.4	1.3	2.1	1.1	0.4	0.7	.7	.0	.0	.0	0	.2	0.2
Congenital Abnormalities	10.4	12.8	13.3	12.2	10.9	12.7	17.5	12.3	9.5	15.8	12.4	11.4	12.9	6.4	8.7	5.4	9.0	8.0	7.0
Diseases of Early Infancy	45.2	63.4	50.0	57.0	64.5	64.0	63.1	59.8	49.7	40.2	34.3	34.1	25.5	22.8	19.6	12.6	11.4	10.2	12.5
Ill Defined	34.8	41.5	32.1	25.3	21.4	21.1	19.7	21.2	18.5	12.0	18.6	22.8	14.2	8.8	13.3	12.6	14.8	16.5	13.9
Heart Disease and Hypertension	169.6	139.0	111.2	106.3	103.6	96.0	107.4	103.5	109.3	103.7	87.7	94.6	87.3	86.5	99.0	64.7	75.5	76.1	74.2
Malignant Neoplasms	66.7	43.9	42.3	39.4	47.7	50.0	50.9	54.7	50.6	62.8	54.4	54.4	61.5	65.3	65.8	52.9	56.4	60.6	66.3
Diabetes	3.0	2.4	3.1	2.7	3.6	3.5	3.9	3.8	3.3	2.6	3.7	3.9	2.6	3.5	2.2	3.5	2.9	1.9	2.6
Vascular Lesions of CNS	48.1	44.5	38.8	29.9	27.7	32.0	29.8	23.3	44.0	28.6	24.1	30.9	26.1	27.0	30.4	18.3	16.0	14.8	15.9
General Arteriosclerosis	5.9	8.5	4.1	3.6	2.7	6.1	8.3	12.7	11.5	9.4	8.0	9.6	7.6	3.2	6.2	3.5	2.7	6.6	2.6
Chronic Nephritis	3.7	4.3	4.1	5.9	3.2	4.4	2.2	3.8	3.3	1.1	1.1	2.8	1.6	.6	1.2	.5	.2	.2	0.5
Cirrhosis of Liver	5.2	9.1	8.7	5.4	5.9	7.0	6.1	3.4	9.9	7.9	8.0	5.7	11.2	13.5	11.8	12.1	12.3	9.0	9.4
Other Degenerative	12.6	11.0	12.2	12.2	10.0	12.7	10.5	10.2	9.9	16.5	9.1	11.0	13.9	10.9	12.1	7.9	6.6	10.2	9.4
Accidents*	155.6	149.4	117.3	129.9	109.1	103.9	100.4	107.3	95.4	104.5	125.7	90.7	116.7	128.6	104.9	103.5	108.4	99.5	114.8
Suicides	24.4	16.5	16.3	16.3	14.5	11.8	14.0	16.5	16.0	17.7	17.7	16.4	13.2	15.4	11.2	18.3	16.2	21.6	14.2
Homicides	12.6	9.1	6.6	7.2	10.5	8.8	8.8	10.2	4.5	8.6	9.5	10.0	10.6	8.4	9.6	6.4	12.3	8.8	14.4
Alcoholism	8.1	15.2	10.2	6.8	5.5	5.3	7.0	6.8	4.1	6.4	5.5	6.8	10.9	14.5	11.8	11.4	6.6	7.5	4.1
ALL OTHER CAUSES	40.7	39.0	24.0	18.1	17.7	21.1	18.9	24.2	20.1	18.8	20.1	15.6	15.9	15.4	19.2	13.6	13.5	18.2	12.2
TOTAL	940.0	840.0	659.2	566.1	563.6	561.0	544.6	544.3	537.6	526.1	487.0	461.1	473.3	467.7	455.4	376.1	391.3	390.6	407.8

Source: Office of Information Systems, Alaska Department of Health and Social Services, Alaska Vital Statistics, 1966, 1974-1977 and unpublished data 1977, 1978, 1979.

*Because Accidents and Other External Causes are grouped together in early Alaska mortality data, Accidents and Other External Causes are grouped together in this table.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Prevention

COMMUNICABLE DISEASE BULLETIN
SECTION OF COMMUNICABLE DISEASE CONTROL
STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Room 313 - MacKay Building
338 Denali Street
Anchorage, Alaska 99501
(907) 272-7534

COMMUNICABLE DISEASE BULLETIN
WEEK ENDING SEPTEMBER 3, 1982 - NUMBER 16

RECOMMENDATIONS - INFLUENZA VACCINE FOR 1982-1983

Influenza vaccine for 1982-1983 will consist of an inactivated trivalent preparation of antigens representative of the influenza viruses expected to be prevalent. The specific antigens and their potency in the vaccine will be the same as in 1981-1982: 15 µg each of hemagglutinin of A/Brazil/78 (H1N1), A/Bangkok/79 (H3N2), and B/Singapore/79 viruses per 0.5 ml dose.

Adults and children greater or equal to 13 years old will require only one dose. Children less than 13 years old should receive two doses of vaccine. However, children who have already had at least one of the influenza vaccines recommended for use from 1978 to 1982 will require only one dose of the 1982-1983 vaccine. The influenza vaccine dosage schedule for 1982-83 is summarized in Table 1.

TABLE 1. Influenza vaccine* dosage, by age, 1982-1983

Age group	Product	Dosage	Number of doses
≥13 years	Whole virion (whole virus) or sub-virion (split virus)	0.5 ml	1
3-12 years	Sub-virion (split virus)	0.5 ml	2†
6-35 months	Sub-virion (split virus)	0.25 ml‡	2†

*Contains 15 µg each of A/Brazil/78(H1N1), A/Bangkok/79(H3N2), and B/Singapore/79 hemagglutinin antigens in each 0.5 ml

†Four weeks or more between doses, both doses recommended for good protection. However, if the individual received at least 1 dose of any influenza vaccine recommended from 1978-79 to 1981-82, one dose is sufficient

‡Based on limited data. Since the likelihood of febrile convulsions is greater for this age group, special care should be taken in weighing relative risks and benefits

Vaccine Usage

Influenza vaccine is strongly recommended for all individuals at increased risk of adverse consequences from infections of the lower respiratory tract. Such conditions include: (1) acquired or congenital heart disease, (2) any chronic disorder with compromised pulmonary function, (3) chronic renal disease, (4) diabetes mellitus and other metabolic diseases, (5) chronic severe anemia, (6) conditions which compromise the immune mechanism, (7) older persons, particularly those over age 65.

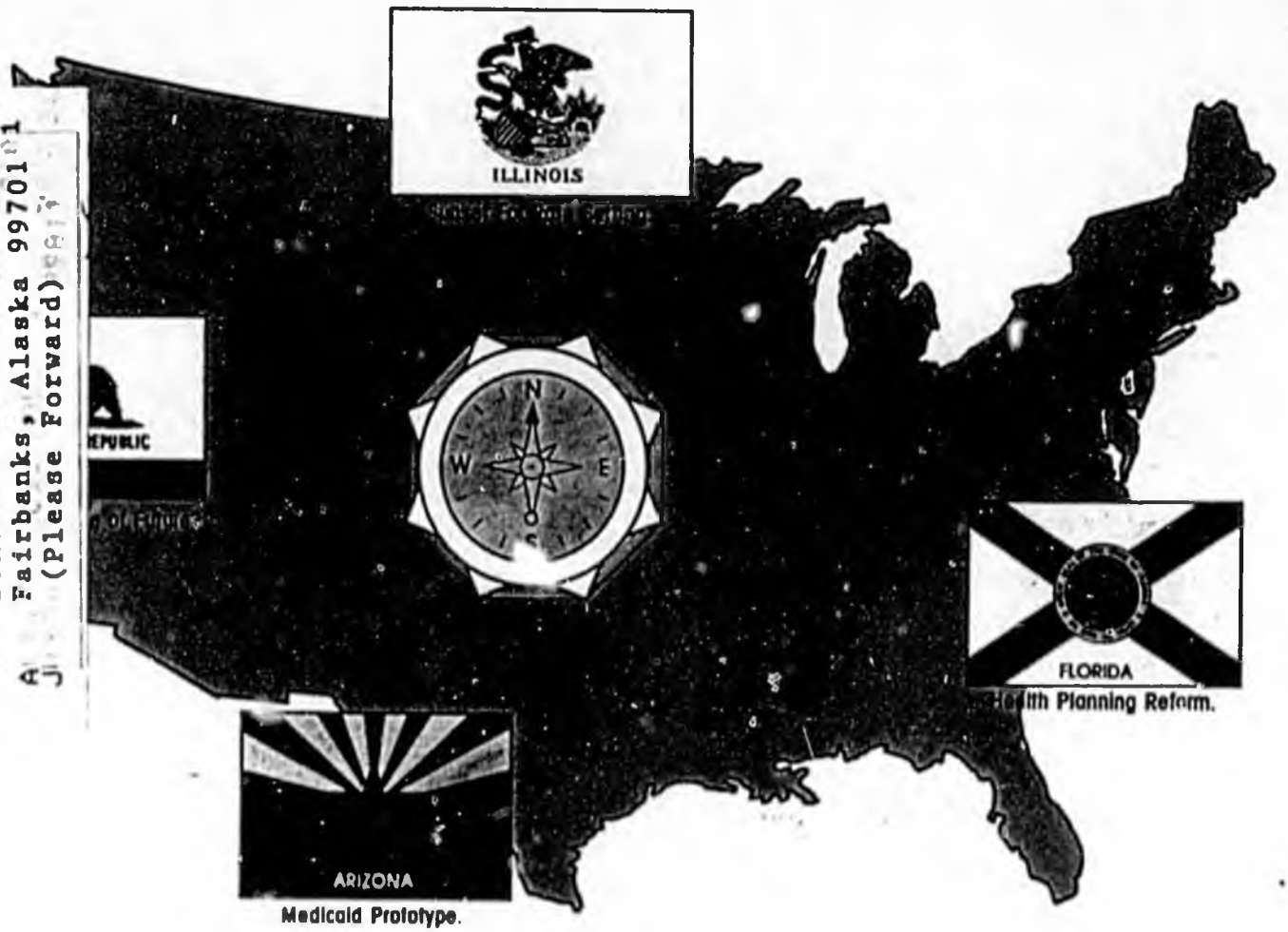
Vaccine Information

As in past years, influenza vaccine is available to all physicians and other health care providers from the State Immunization Program. In order to simplify distrubution, only split virus vaccine will be stocked. The vaccine will be available in 5.0 ml, 10-dose vials. Orders should be submitted through regular supply channels.

During the 1981-1982 winter, influenza activity was widespread in Alaska although it was generally low in the United States. The current vaccine contains antigens identical to the antigens in the vaccine used in the past two years: 1980-81, 1981-82. There is little data on the persistence of immunity from influenza vaccination beyond one year. However, there is great likelihood that individuals who have received influenza vaccine for the past two years will be protected for this year from influenza infection with the same influenza virus strains.

While the Centers for Disease Control still recommends annual influenza vaccination in high risk individuals, we feel that the benefit will be maximal in individuals who have not previously been vaccinated and that efforts should be concentrated among this group. While some additional benefit may be conferred on individuals who have previously received the vaccine, we anticipate that the benefit will be minimal in 1982-83 compared with the protection conferred to those individuals in past years. Individuals who have had influenza vaccine in the past two years who still request it should be vaccinated, but major efforts to seek out these individuals for a repeat immunization this year are not necessary.

Federation of American Hospitals
Review
September/October 1982



Health Planning Reform.

Medicaid Prototype.

The States
New Directions In Health

Introducing the stand-alone Color Trend monitor from Burdick. It has its own computing ability and memory. So it doesn't need to be linked to a costly central computer.

In fact, the new Burdick M565 needs only an electrical outlet to give you computerized, intensive-care monitoring wherever you need it.

The M565 measures all these critical parameters: ECG with heart rate, respiration with apnea alert, three pressures, two temperatures, plus cardiac output and trending. It displays them simultaneously in individual colors with vivid clarity on its high-resolution screen.

In addition, the M565 stores trend data on all parameters for 3, 9 or 27 hours and displays it in graphic or numeric form. It can also compute and display a full range of hemodynamic profiles.

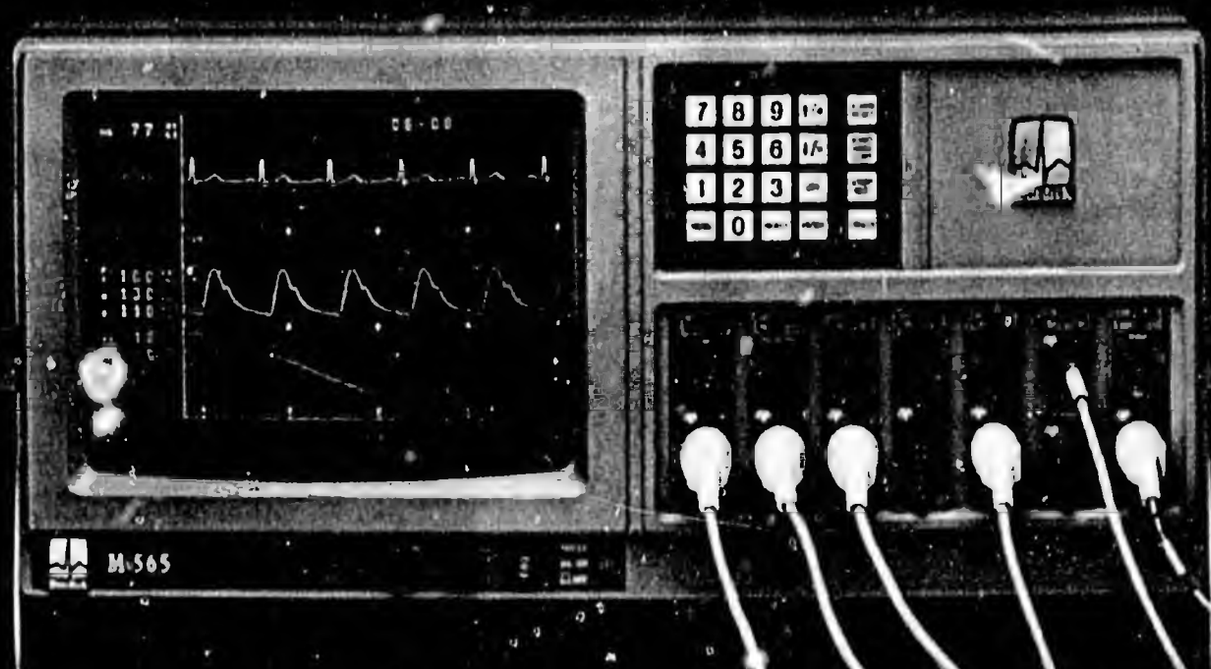
The operator chooses the information, type of display, and alarm limits by using menus and simple instructions that appear on the screen. With freeze-frame ability and printer, the M565 can provide hard copy of any display. It even has a self-contained power source to assure 40 hours of data retention in the event of interrupted service.

Best of all, you get all these unmatched features for a surprisingly low investment. That's the Burdick commitment to deliver the latest technology for critical care at affordable prices.

Call or write for more information.

Our new bedside monitor doesn't need a central computer.

It is one.



THE BURDICK CORPORATION, MILTON, WISCONSIN 53563

Burdick

TOLL-FREE 800-356-0701, IN WISCONSIN 608-868-7631

New directions in health become goal for many states

Budget reductions, changing times leading to increase in innovations

Pages 10-39

New contracting system holds health attention in California

Medi-Cal "czar" Guy gearing up for role as negotiator

Page 12

Illinois hospitals triumph in 'sunset' demise of rate control

President of IHA O'Leary tells story behind the IHA stand

Page 19

State-by-state survey cites issues affecting the hospitals

Five categories of concern are covered in the summary

Pages 32-39

Owned and Published by the Federation of American Hospitals

The Association of Investor-owned Hospitals

Volume 15, Number 5, September/October 1982

Staff

W. Campbell Thomson, Dir. of Publications
John R. Walker, General Manager
Maurice Moore, Editor
Garren E. Hagemeier, Marketing Manager
Dorothy McAllister, Administrator

The **REVIEW** (ISSN 0148-9496) is published bimonthly at 1405 N. Pierce, Suite 311, Little Rock, Arkansas 72207. Telephone AC 501/661-9555

All manuscripts submitted are subject to editing or rewrite if found necessary to conform to policy or style of magazine

The **REVIEW** is completely indexed in Hospital Literature Index, American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611

Microfilm copies are available from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48013

Subscription rate
$15 – One Year Subscription
$25 – Directory issue only
$35 – One year subscription and Directory issue

Overseas Subscription
Add $3.00 for surface delivery
A30 $10.00 for air delivery
Remit to 1405 N. Pierce, Suite 311, Little Rock, Arkansas 72207

Second class postage paid at Little Rock, Arkansas and additional offices

Member of Business Publications Audit of Circulation Inc. BPA

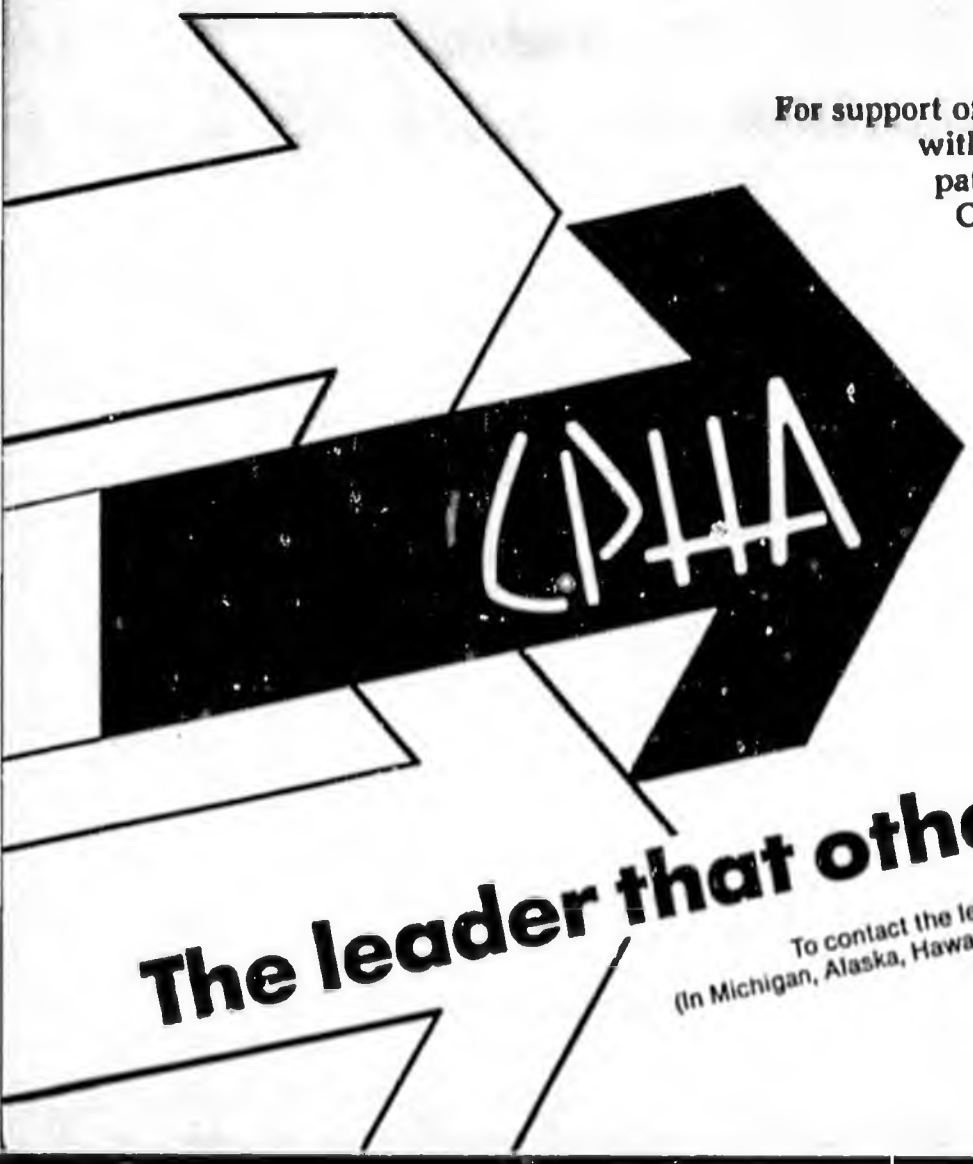
Change of Address – Please notify our offices immediately if you change your address. If possible include your old mailing label along with the new address and mail to The REVIEW, 1405 N. Pierce, Suite 311, Little Rock, Arkansas 72207

Postmaster: Send Form 3579 to 1405 N. Pierce, Suite 311, Little Rock, Arkansas 72207

FROM PATIENT TO PAYMENT, CPHA SUPPORTS YOUR REIMBURSEMENT NEEDS

- Documenting your reimbursement appeals with **CASE MIX ANALYSIS**, using multiple case mix measures such as DRGs to describe the expected resource intensity of your hospital's case mix.
- Legitimizing your prospective reimbursement claims with **STUDY OF PATIENT CHARGES**, case mix adjusted charge information on your hospital's patient groups for accurately linking the patient's care to the charges.
- Preventing dollars lost through inaccurate diagnosis and procedure coding with **CODEFINDER***, the revolutionary interactive computerized system for *ICD-9-CM* disease and procedure coding.

**CODEFINDER*, a product of Code 3 Corporation.*



For support of your reimbursement needs with accurate case mix adjusted patient care information, bring CPHA's powerful PAS System into your hospital.

Commission on Professional and Hospital Activities
1968 Green Road
P.O. Box 1809
Ann Arbor, Michigan 48106

The leader that others follow.

To contact the leader, call CPHA toll-free 800-521-6210
(In Michigan, Alaska, Hawaii, or Canada, please call 313-769-6511)

Dateline Washington

By Michael D. Bromberg
Executive Director of
the Federation of American Hospitals

Medicare incentives — A new direction in policy

Congress has just enacted a major change in Medicare payment policy. The growth in Medicare revenues will be substantially slowed from recent levels, but, under certain conditions, hospitals with below average costs could receive payments greater than their allowable Medicare costs.

Under this new cost containment program, hospitals would receive bonus payments from Medicare if they hold per admission cost increases below a pre-set target based on a hospital market basket price index (prices paid for goods and services), plus 1 percent. To qualify for the bonus payment, a hospital not only must have costs below 120 percent of average costs per admission, but also its cost per admission increase must not exceed a pre-set allowable increase from its own base cost of the prior year.

For the first time since Medicare became law, the link between cost and payment has been partially severed. Depending on the details of the program — especially the allowable percent increase — the payment system will recognize, encourage and reward efficiency.

The new system, effective October 1, 1982, will allow hospitals to keep 50 percent of the difference between their costs and the target up to a maximum of 5 percent of the target. Hospitals with cost increases above the target will only receive 25 percent of excess costs.

In addition to incentive payments, Congress also mandated the development of a prospective payment system by the Secretary of Health and Human Services (HHS) in consultation with congressional committees. This next step (one or two years from now), in all likelihood, will include a total incentive by allowing hospitals to retain the entire difference between their costs and the prospective or target rate while receiving no costs above that rate.

To underscore the significance of this new policy direction and the impact on hospital management, let's look at a few managerial options under the old and new payment systems:

(1) Staffing Patterns: The option of reducing FTEs or restraining the growth of FTEs is not a pleasant chore for a hospital executive officer. Under the old system, Medicare reimbursement covers the cost of staff salaries and benefits so that the manager receives less income if payroll expenses are reduced and more income if these costs are increased. Under the new system, if FTE growth is restrained so that total costs are below the target rate, the manager receives 50 percent of the difference between his actual cost and the target cost or the full difference under a future prospective rate.

(2) Utilization of Ancillary Services and Length of Stay: Under the old cost reimbursement system, a shorter length of stay or restrained use of ancillary services per stay result in lower Medicare reimbursement. Under the new system, it may mean bonus payments.

New system incentives

For the first time since 1965, the Medicare program is willing to permit hospitals to keep some part of the rewards of cost reducing management practices and innovations. The details of a prospective payment plan are all important and could scuttle the promise of greater reward for greater efficiency. But the key point is that a prospective payment system will discriminate in favor of good management.

These new general directions in public policy are in line with recommendations offered by the Federation of American Hospitals (FAH) for the last dozen years or longer. The explosion of Medicare costs since 1965 has largely been the result of two policy errors (1) the absence of hospital copayments during the second through 60th day of care which has removed consumer and provider restraint in the use of benefits, and (2) the cost reimbursement system which removed economic incentives and rewards for restraint in expenditures.

Finally, there is a willingness by the Administration and Congress to try to correct at least one of these policy mistakes through incentive reimbursement followed by prospective payment.

We support the general change in direction, but serious questions remain about the details of the prospective payment system. It would be disappointing if the new system is cumbersome or based on inaccurate data resulting in another arbitrary regulatory system which is not a true test of economic incentives.

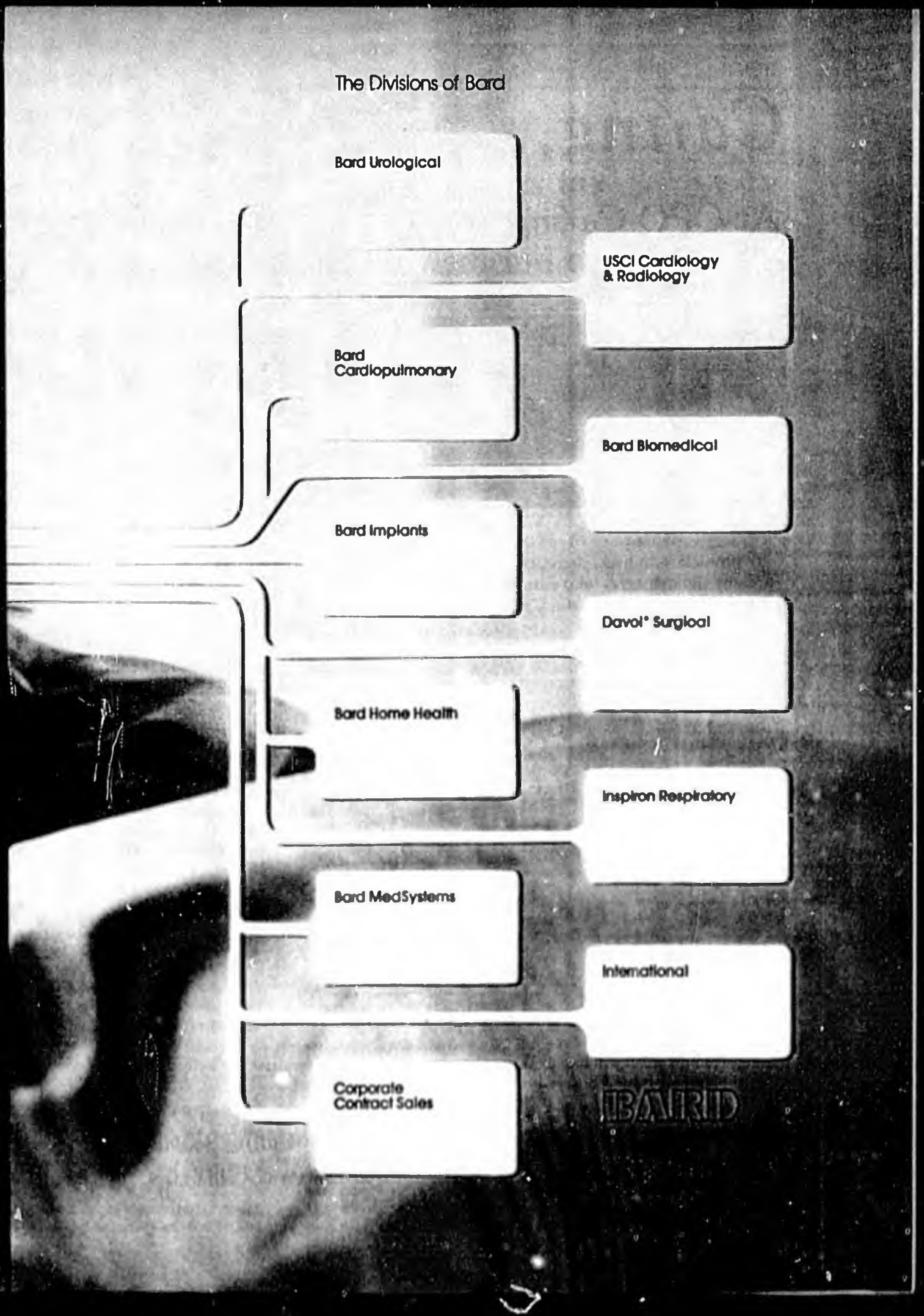
Finally, we must not fall into the trap of believing that payment reform is the full answer to Medicare's budget problem. Until beneficiary cost sharing is addressed in a bipartisan manner, there can be no satisfactory restraint in expenditure increase. □

In Urology...

Bard is the leading manufacturer of urological products in the world and has maintained this position since the introduction of the Foley catheter more than 40 years ago. Ever striving ...never complacent...and in keeping with the Bard corporate philosophy of developing well-designed, quality, cost-effective products that serve the world's health-care needs, Bard Urological Division pursues the development of new concepts while improving and refining existing products.

A total resource for the urologist, Bard provides a broad range of specialty and custom products designed to meet individual needs. Widely accepted by health-care professionals are Foley trays and sterile procedure kits, a concept pioneered by Bard.

Bard scientists focused on [illegible] sophisticated devices for [illegible] and improved products that will aid in the advancement of infection control for urological procedures.

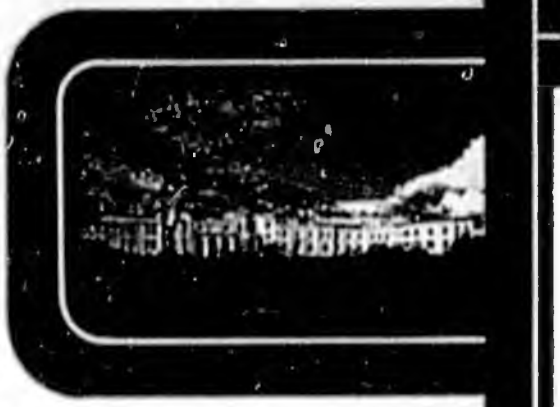

The Divisions of Bard
Bard Urological
USCI Cardiology & Radiology
Bard Cardiopulmonary
Bard Biomedical
Bard Implants
Davol® Surgical
Bard Home Health
Inspiron Respiratory
Bard MedSystems
International
Corporate Contract Sales
BARD

Caring...

At CPC *Caring* is our business.

Caring... for our patients and their loved ones, guaranteeing quality treatment and understanding to those who come to us for help.

Caring... about our over 4000 skilled physicians, nurses, therapists, technicians and managers who ensure quality in every area of a CPC center.



Caring... internationally as CPC initiates European operation of two premier treatment centers in London, England.

CPC owns and operates 20 acute psychiatric hospitals and treatment centers in the United States and London, England and 39 dialysis centers throughout the United States. CPC provides experienced management and consultation services to the investor-owned hospital industry.

Community Psychiatric Centers...*Caring People Caring*

2204 East Fourth Street, P.O. Box 15140, Santa Ana, California 92705
(714) 835-4535

Congress approves tax hike, $14.4 billion Medicare/Medicaid cut

Congress has approved H.R. 4961, the Tax Equity and Fiscal Responsibility Act of 1982, which includes a total of $98.3 billion in tax increases and cuts totalling $14.4 billion in Medicare and Medicaid.

Of the total of $2.9 billion in Medicare cuts for Fiscal Year 1983, about $700 million will impact hospitals.

Major changes

The new law makes these key changes in Medicare reimbursement:

Expansion of 223 Limits: Ancillary service operating costs will now be included. The limit is set at 120 percent of group mean per discharge for FY 1983, 115 percent for FY 1984, and 110 percent thereafter. Appropriate adjustments will be required for psychiatric hospitals and those serving a disproportionate number of low income or Medicare patients. Rural hospitals under 50 beds are exempted. This provision is effective for cost reporting periods beginning on or after October 1, 1982.

Establishment of a Three-year Target Rate: Each hospital will have a target for increased Medicare cost per admission over its prior year beginning with reporting periods on or after October 1, 1982. The target will equal the previous year's allowable operating costs per case (or after the first year, the previous year's target) plus an increase in the hospital wage and price index, plus 1 percent for intensity.

The incentive payment is 50 percent of the difference between costs and the target – up to 5 percent of the target. The penalty is a disallowance of 75 percent of costs above the target.

Prospective Payment: This provision requires the Secretary of Health and Human Services (HHS) to submit a prospective payment plan for Medicare reimbursement to hospitals, SNFs and other feasible providers within five months of the enactment of the bill.

Nursing Differential: This provision eliminates the 5 percent inpatient routine nursing salary cost differential.

PSRO: The existing PSRO program is repealed, and the Secretary of HHS is required to enter into performance contracts for review services.

Hospice Care: Medicare reimbursement for hospice care is granted for a demonstration period ending September 30, 1986.

Prohibition of Payment: This applies to Hill-Burton free care and anti-unionization activities.

The Medicare voucher proposal, sponsored by Congressmen Richard Gephardt (D-Mo) and Willis Gradison (D-Ohio), was rejected by the Senate and House conferees. However, they did approve a provision permitting Medicare beneficiaries to enroll in HMOs. The federal government will pay premiums equal to 95 percent of the AAPCC directly to the HMO.

An attempt by Congressman Henry Waxman (D-Calif), chairman of the House Energy and Commerce Subcommittee on Health and Environment, to expand Medicaid incentive payments for state hospital rate setting also was rejected by the conferees. States that had approved mandatory state rate setting programs in effect by July 1, 1981, qualify for a Medicaid bonus payment if they meet certain performance criteria. Waxman wanted to include all states by eliminating the July 1, 1981, date. Since the effort failed in the Conference Committee, incentive payments are limited to the current seven states with mandatory rate setting programs.

Medical expense deductions for individuals are affected by some of the several important tax measures approved by Congress. Here are some of the tax bill highlights in this category:

(1) The deductible medical expenses floor is raised from 3 percent to 5 percent of adjusted gross income.

(2) The $150 deduction for one-half of health insurance premiums is eliminated.

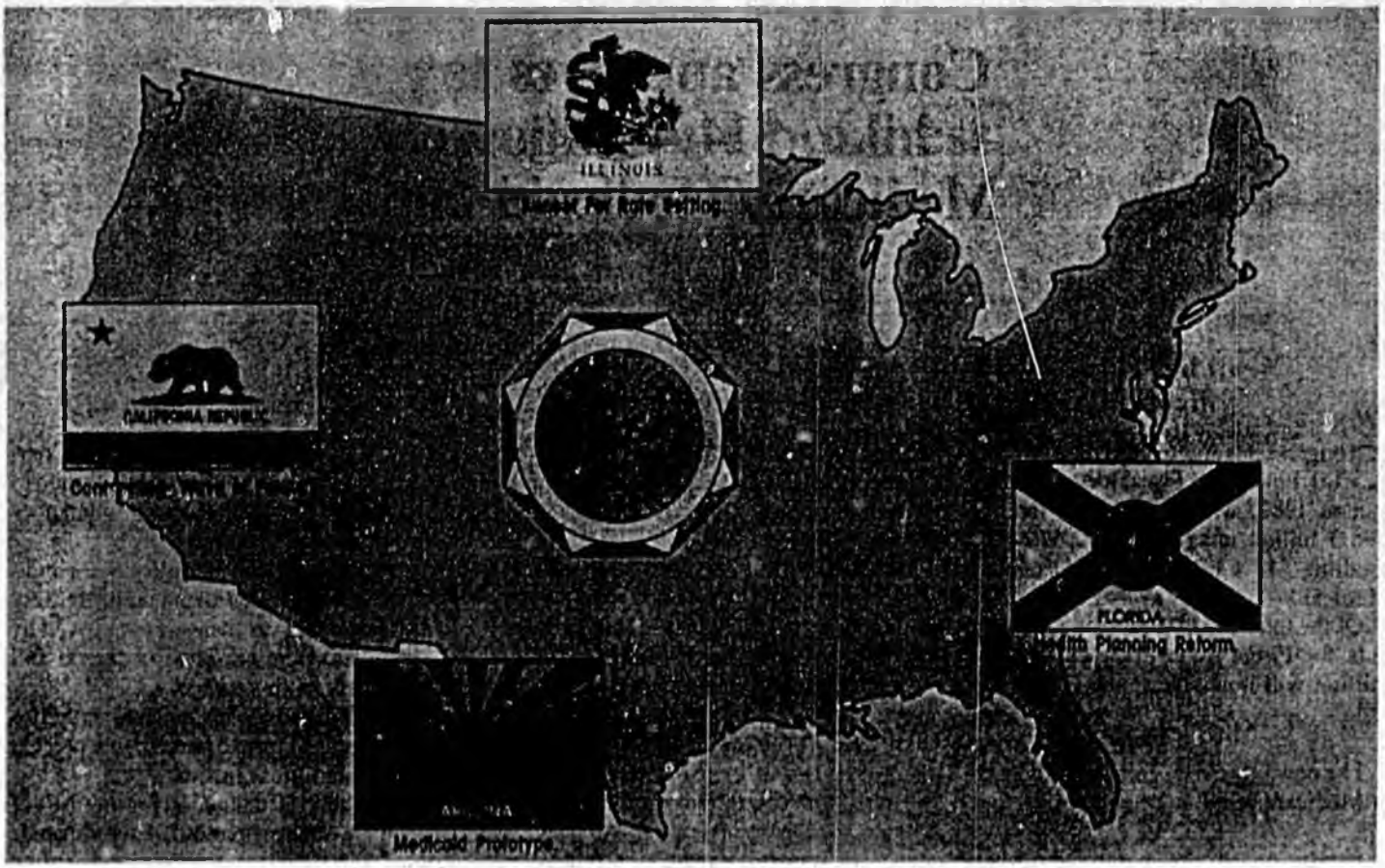
(3) The 1 percent deduction for drug expenditures is eliminated after December 31, 1983, except for prescription drugs.

(4) Several restrictions are imposed on the use of tax exempt bonds for private activities such as public hearings, straight line (rather than accelerated) depreciation for the property finance, and periodic reporting to the Internal Revenue Service (IRS) on bonds issued. Bonds for 501(c)(3) non-profit organizations and government units, however, must comply only with reporting requirements, unless used for unrelated trade or business. Small issue IDBs will be sunsetted on December 31, 1986.

(5) The accelerations of depreciation, scheduled for 1985 and 1986, are repealed.

(6) Businesses are required to reduce the basis of assets by 50 percent of the amount of regular, energy and certified historic rehabilitation investment tax credits.

(The final tax bill and conference report are printed in the *Congressional Record*, Part II, of August 17, 1982. To order the publication, send $1.00 to the Superintendent of Documents, Government Printing Office, Washington, D.C.) □



The States
New Directions In Health

Belt-tightening budget cuts at both the federal and state level, coupled with some strong winds of political change, have led — and in certain cases, virtually have forced — various states to seek more economical and innovative ways of financing and providing health care.

This *Review* Special Report, *The States: New Directions in Health*, takes a comprehensive look at new systems in a number of states. (Some of the innovations have generated considerable controversy, both in their formative and implemental stages.) Also, there are reports on what is happening to a few of the old systems — for example, the demise of hospital rate-setting in Illinois, legislatively-mandated in 1978 but never operational.

The focal point of the Special Report is a State-by-State Survey (see Pages 32-39), which highlights legislative and regulatory issues affecting the nation's hospitals in 1982 — and beyond.

The *Review* sent questionnaires to all state hospital associations, seeking information in these special categories: Medicaid, Contracting, Freedom of Choice, Health Planning and State Rate-Setting.

This brief statistical summary provides an insight into what is happening in the states: (Note: Totals may exceed the number of states because some states are taking more than one approach in certain categories:

Medicaid: 25 states are cutting programs; 4 states by federal waiver; 18 states by administrative plan change; 11 states by legislative enactment. Areas affected include: Benefits: 12 states; Eligibility: 13 states; and Reimbursement: 16 states.

Contracting: 17 states are either developing or considering the development of a program for contracting for Medicaid hospital and/or physician services.

Freedom of Choice: 25 states report that their state insurance code or Medicaid statute currently have a Freedom of Choice requirement. Five states report that efforts are under way, or will be made, to remove restrictions on the Blues or health insurers' ability to contract for alternative payment plans.

Health Planning: 27 states report HSA phase-outs are either under way or contemplated. Also, 15 states either have gone, or are planning to go, to a single state planning authority; 21 states have raised, or plan to raise, the thresholds to current federal levels, and 10 states have raised, or plan to raise, the thresholds to other levels.

State Rate-Setting: The majority of the states indicated that there are no current or expected legislative or administrative proposals for mandatory rate-setting.

Looking at some of the state innovations individually, there is considerable interest in California's unique but controversial contracting law, a revolutionary program that is expected to bring quick and dramatic changes in the way that health care is financed in the state. (See Page 12)

The plan, which became effective on July 1, 1982, but won't become operational until, and unless, federal waivers are granted, (1) provides that the exclusive way of participating in Medi-Cal programs for inpatient hospital services is by contract, and (2) allows Blue Cross and commercial insurance companies to contract with hospitals and physicians to provide care at a low cost option for policyholders.

Critics of the contracting program claim that it will result in a two-tier health care system in the state.

William A. Guy, who has been appointed by Governor Edmund Brown, Jr. to be the chief Medi-Cal negotiator for the first year of the program, says, in an exclusive interview starting on Page 13, that the new contracting system "represents one of the most massive and challenging changes in health care financing in the state's history."

Guy, who retired earlier this year as president of Blue Cross of Southern California, acknowledges that "we are treading in uncharted waters." He expresses confidence, however, that the basic objectives of the new system can be accomplished "but in a mold that is new for most of us who have dealt with the health care field over a number of years."

He said that contract negotiations with hospitals could start as soon as the federal waivers are granted. He concedes that "the biggest job at this point is working with the Feds to obtain the necessary waivers under the Medicare/Medicaid programs."

While California prepares to encounter the unknown, Illinois hospitals are rejoicing over the demise of the state's rate-setting program, which will "sunset" by statute on October 1, 1982.

The Illinois Hospital Association (IHA), led by its president, Robert O'Leary, marked up a notable political victory by leading the opposition against Governor James Thompson's legislation to extend the life of the Illinois Health Finance Authority (IHFA) for five years past the scheduled "sunset" deadline.

The IHA supported the original legislation in 1978 but withdrew that support and started campaigning for an end to the program on its "sunset" date. A brief account of the IHA's role in halting the program before it was ever activated starts on Page 19.

In an exclusive interview (beginning on Page 22), President O'Leary reveals the story behind IHA's position change on rate-setting.

Noting that "hindsight is such a great provider of wisdom," O'Leary says that "there were signs of trouble ahead almost immediately upon signing of the rate-setting legislation." He explains that it took nine months for the governor to get around to appointing the board of the authority.

"From February, 1979, to June, 1982, the authority went through the process of studying and researching, educating, drafting regulations, deciding what sort of computer forms they wanted for data, etc.," O'Leary recalled. "Essentially, they strung out for nearly three years a process that was supposed to last a year. By the time June, 1979, rolled around, they barely had appointed some of their staff and decided where their office was going to be."

O'Leary also discloses in the interview that IHA did not support an attempt to repeal the rate control program in the 1981 legislative session because of its "commitment to support this activity from the beginning, and that commitment included the bill as it was passed — which provided for a 'sunset' provision on October 1, 1982."

Switching to the Sunbelt from the Midwest, the focus is on Arizona, which is ready to begin an innovative health experiment featuring competitive bidding, contracting and prepaid, capitated services. The article starts on Page 26.

Adding to the uniqueness of the three-year experiment is the fact that Arizona, the only state without a Medicaid program, will use Title XIX funds for the first time in implementing the program.

Arizona Governor Bruce Babbitt says in an interview with the *Review* that "the premise of the system is that we will introduce some competition, and we will ask for predetermined prices on a captation basis."

Babbitt notes, "There is an enormous amount of interest among governors of other states in our new system for obvious reasons. State Medicaid costs have been going out of sight at the very time that the federal government Administration is attempting to scale back its level of commitment. This has put states in a very difficult position.

"It is the feeling on the part of many that some kind of competitive cost containment is the only alternative to massive reduction in coverage. I believe that everybody understands that the escalation of costs, given the fiscal realities in this country, cannot continue."

The article also takes a look at some of the potential problem areas of the so-called Arizona Health Care Cost Containment System, (AHCCCS) as seen by Ronald D. Krause, president of the Arizona Hospital Association, and Sandra Spellman, who heads the association's activities related to the program. The association has mounted a $200,000 information and technical assistance campaign to help hospitals prepare for the new system.

Speaking of Medicaid, Governor Lamar Alexander of Tennessee, (in an article on Page 25) expresses the viewpoint that the program should be federalized under President Reagan's proposed New Federalism plan because "the program is so big that only the national government can afford to operate it."

Alexander, who is a member of the National Governors Association (NGA) New Federalism team negotiating with the White House, noted that there were still a number of persons in the Administration — not the President — "who are reluctant for the federal government to assume all of the responsibility of the Medicaid program." These people, he notes, believe that Medicaid "is a so-called welfare program and more properly belongs with state and local governments."

For hospitals in Florida, health planning reform was one of their legislative highlights of 1982.

Special features of the new planning system are discussed in an article, starting on Page 30. The law authorizes (1) replacement of Health Systems Agencies (HSAs) with local Health Planning Councils, and (2) placement of Certificate-of-Need (CON) responsibilities at the state level, with the State Department of Health and Rehabilitative Service.

Florida Governor Bob Graham explains in an interview, "What Florida has done in reaction to the retreat of the federal government from Health Systems Agencies is to set up a state planning mechanism, particularly with responsibility for carrying out Certificate-of-Need requirements. There will continue to be a local initial point of contact, but more of the final decision will be made at the state level."

In addition to the Special Report, some of the *Review's* regular columns are devoted to commentaries on state level legislative and regulatory activities. □

California hospitals girding for the start of state's new contracting plan

California's unique and controversial contracting law, designed to bring reforms to a financially-strapped Medi-Cal (Medicaid) system, has produced a quandary for the state's hospital industry.

The revolutionary program is expected to bring quick and dramatic changes in the way that health care is financed in the state.

The law became effective on July 1, 1982, after the legislation won speedy approval in the State Legislature in what one critic described as "under very unusual and undemocratic conditions, in haste and without the usual hearings by policy and fiscal committees." However, the program will not become operational until federal waivers are approved by the Department of Health and Human Services (HHS). This could come at any time — or not for quite a while. For example, the Health Care Financing Administration (HCFA) recently requested more details on certain items in the program.

Meanwhile, hospital executives are watching and waiting — and their questions about the system are piling up. There are few answers because program officials are in the process of setting up the machinery and haven't finalized their start-up plans. The California Hospital Association (CHA), a leading critic of the new law, has been conducting regional meetings to acquaint members with the intricacies of the contracting concept and advise them on potential problems.

Actually, there are two parts of the contracting law. The first (which is included in the State Budget Act) provides that the exclusive way of participating in a Medi-Cal program for inpatient hospital services is by contract, which will be negotiated by the chief Medi-Cal negotiator, working out of the Office of the Governor. He will continue to do this until the nine-member California Medical Assistance Commission (yet to be appointed) assumes those duties on July 1, 1983.

The second part of the law is an amendment to the State Insurance Code, which allows Blue Cross and commercial insurance companies to contract with hospitals and physicians to provide care at a low cost option for policyholders.

The process of "cleaning up" the legislation has started in the State Legislature. The CHA, for example, is urging its hospital members to push for the passage of at least 17 safeguards, including (1) mechanisms for an orderly transition from cost reimbursement to contracting; (2) definitions of emergency services and procedures for non-contracting hospitals, and (3) immunity from state and federal antitrust liability for group negotiations and contracts.

William A. Guy, who retired earlier this year as president of Blue Cross of Southern California, has been appointed by Governor Edmund Brown, Jr. to the key position of chief negotiator — or Medi-Cal "czar" as the job has been labeled. (Guy discusses his views on the program in an interview, starting on the opposite page.)

The state Hospital Association has described the program as "the dismantling of mainstream medical care for the poor by shifting medically indigent adults to the counties by moving toward a system of Medi-Cal contracts," and "thus, the state is firmly committed to two separate systems of health care and freedom of choice of provider will soon be a memory for the poor."

"The two bills," the CHA noted, "will have more impact upon hospitals and physicians than any other legislation since the enactment of the Medi-Cal program in 1965. Our health care financing system has been fundamentally altered. No longer is the primary motivation to provide all the services needed by the patient, within medical judgment, with secondary concern for cost."

Paul D. Ward, the CHA president who has been a sharp critic of the new plan, has been urging hospitals "to examine the state's contract terms in minute detail and to satisfy all ambiguous or questionable terms before signing," because "the health of our institutions and our patients is at stake."

Ward recently wrote to Secretary of HHS Richard Schweiker, expressing the CHA's concerns over the program. He said:

"Contrary to various reports in the media and press, CHA did not 'bitterly oppose' Medi-Cal contracting, and, in fact, supported the implementation of a contracting program. Our concern has always been that a hastily implemented and poorly designed contracting system would result in a chaotic, patchwork Medi-Cal program. Such a scheme would be bad not only for hospitals, but for beneficiaries and government payors, resulting in the possible collapse of a promising new payment methodology."

Carl Weissburg, executive director of the United Hospital Association (UHA), representing investor-owned hospitals, said:

"We have not opposed Medi-Cal contracting as a concept. What we were opposed to was the full-blown manner in which it was proposed and is now being blanketed across the state. It all came into being with a stroke of the pen rather than being phased-in. We were not successful in getting a number of our proposed safeguards in the original bill. We are trying now to rectify some of those omissions in the clean-up bill."

Weissburg commented: "The only thing that is safe to predict right now is that things are going to be different, but we are not certain to what extreme." □

Chief negotiator gearing up for the "czar" role in California's new contracting program

California's bold, new contracting program represents one of the most massive and challenging changes in health care financing in the state's history, according to William A. Guy, who, as chief negotiator, has been labeled the Medi-Cal (Medicaid) "czar."

Guy, who retired earlier this year after a long tenure as president of Blue Cross of Southern California, is credited with being a leading architect of the controversial plan in which health care coverage for Medi-Cal recipients will be negotiated and contracted with hospitals and later with physicians and others in the provider community.

Guy, who operates directly from the Office of the Governor, is charged with the responsibility of organizing and running the program until July 1, 1983, when a nine-member California Medical Assistance Commission (to be appointed after January 1, 1983) assumes control under the law.

Conceding that "we are treading in uncharted waters," Guy expresses confidence that the basic objectives of the new system can be accomplished but "in a mold that is new for most of us who have dealt with the health care field over a number of years."

The Medi-Cal "czar" told the *Review* recently in an exclusive interview:

"My message to hospitals is that change is absolutely necessary, and I personally would like to see them enter this era of change in a positive way — a proactive way rather than a reactive way. I believe that the whole method of financing health care is going to be changed substantially. Therefore, we must learn how to look at and assess the total financial picture in a way that we have never had to before."

Guy said that contract negotiations with hospitals could begin within 30 days after federal waivers are granted by the Health Care Financing Administration (HCFA) — a task that is yet to be accomplished.

"The biggest job at this point is working with the Feds to obtain the necessary waivers under the Medicare/Medicaid programs," he explained. "I wish I knew how long this process will take. The federal government has 90 days from the time that the waivers are requested. However, if additional information is requested, this could stretch it out for another 90 days.

"We are gearing up to be able to actually start negotiations as soon as we receive the federal waivers. I hope that we will have our first contract with hospitals within 30 days thereafter. Of course, that doesn't mean with everybody because we obviously can't cover the entire state that fast."

Guy made these comments in his question-and-answer session with the *Review:*

Question — How do you perceive your role as Medi-Cal czar?

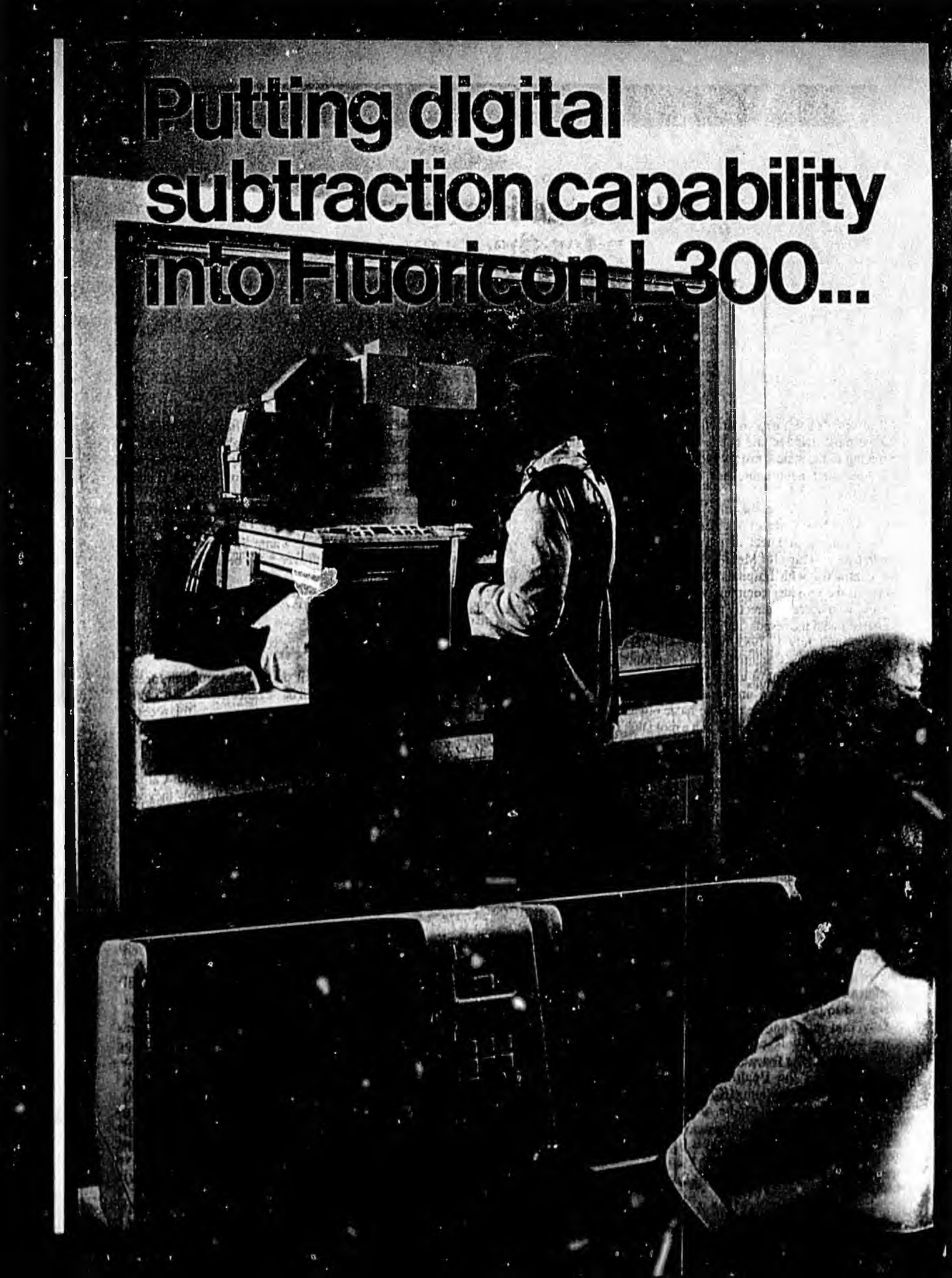
Answer — I see it as a role of putting this program together within the framework of several basic objectives. I don't intend to create Medi-Cal hospitals. I intend to improve the access of care for Medi-Cal recipients. I intend to maintain the quality of that care and try to make it cost effective for the state. By the time I wind up my job, I hope to have in place a program through which we can offer Medi-Cal recipients a choice as to how they wish their health care delivered. In other words, I want to set in motion a base by which each Medi-Cal recipient in an area could opt out of the state program that I am putting together and opt into a Kaiser program, another HMO program, or a program that is insured by an insurance company or a group of insurance companies. We want to have a system in which Medi-Cal recipients have a choice.

William A. Guy (left) (shown here in an appearance before his retirement earlier this year as president of Blue Cross of Southern California) says California's new contracting program is one of the most massive and challenging changes in health care financing in the state's history.

Question — What major problems do you anticipate in implementing the new Medi-Cal contracting program?

Answer — The major problems that I foresee simply involve the negotiating process necessary to get the program into effect. We have 600 hospitals in California, and it is

Putting digital subtraction capability into Fluoricon L-300...



Now you can perform the latest digital procedures on a General Electric RFX/Fluoricon® L300 system, with no compromise in digital quality or in R & F system performance. By adding the integrated Digital Fluoricon 3000 system you can increase your range of clinical applications to include such digital studies as vascular screening and a wide variety of post-surgical follow-up evaluations. And with the use of less invasive SVC and antecubital injection sites, outpatient exams and the study of some higher risk patients are now a real possibility.

Image small vessel detail with higher contrast sensitivity.

The sophisticated imaging chain of the Digital Fluoricon system dramatically expands image dynamic range. With signal-to-noise ratio of 1000:1 and 10 bit A/D conversion, you can visualize 1 mm vessels at 1% contrast with 1 mR exposures. GE's progressive TV readout allows variable exposure times (4-500 msec) at high frame rates (1-10 fps), without compromising radiographic techniques, so you can utilize dosage more efficiently while minimizing motion blurring. High frame rate capability and reprocessing functions—such as contrast enhancement, remasking and time interval differencing (TID)—can greatly increase your imaging accuracy and flexibility. And, GE is developing hybrid imaging,* which will further augment diagnostic accuracy by eliminating soft tissue motion.

*combining temporal and dual energy subtraction

Maintain maximum room utilization with the classical RFX system.

When you are not performing digital exams, you can keep your R & F room active with upper GIs, myelograms, arthrograms, arteriography and radiographic procedures such as chests, KUBs and extremeties. All enhanced by the performance of the compact, suspensionless RFX system. And all part of a total system designed for upgradeability. Adding GE digital capability to the RFX system: the productive, cost-effective way to state-of-the-art digital imaging.

This study of a potential renal donor shows single renal arteries to each kidney and no evidence of arterial disease. The image was obtained using the 9" mode of the image intensifier at 2 frames/sec, following an SVC injection of 40 cc contrast at 25 cc/sec.

This image of the right pulmonary arteries was obtained using the 9" image intensifier mode at 4 frames/sec, following an IVC injection of 30 cc contrast at 25 cc/sec. Vessels are defined to the level of th rd and 4th order branches, with no evidence of embolism.

...means additional productivity from your R&F room.

We bring good things to life.

GENERAL ELECTRIC

my intention that every hospital be offered an opportunity to participate. Obviously, I believe that a very large number of hospitals will wish to enter into negotiations with the state. So, the whole timing process becomes critical in moving with full speed to get the program going. I foresee a logistics problem as much as anything.

Question — What problems do you anticipate in overcoming opposition from some provider groups?

Answer — I am not sure that we are going to have all that much opposition from provider groups. Remember, I am dealing with hospitals only at this point. Eventually, we also will be dealing with professional providers, and some of the other pilot and countywide programs. But the initial thrust is with the hospital community — and only involving inpatient care. Now the hospital community basically has said that it wants a competitive approach — the economic approach. This new program gives it to them. Therefore, I am not assuming any great opposition from the hospital community. I do think, however, that it is going to be hard for them and for us, too, to get the program under way. There, of course, are issues that will surface and beg for answers for the next several years. For example, there is the whole issue of medical education, and who should pay for it. This question will come up as a result of dealing with price in a negotiated base with the institution. Also, there will be the issue of hospital-based physicians and how they will be reimbursed. I believe that the old issue of physician profile practices within hospitals will tend to surface in a number of areas. Remember, for the first time, price will be a driving force, and, as a result, our thinking changes in the way that we historically have approached payment for hospital care.

Question — Do you foresee any major changes occurring in the legislative clean-up of the new law?

Answer — At the moment, I see no real change to the basic thrust. In my view, most of the clean-up will be technical in nature.

Question — Do you see any antitrust implications in the new contracting law?

Answer — No. I don't — unless hospitals attempt to get together in groups on their own to discuss price or what they intend to do. Then, I see heavy antitrust implications. The Legislature has made it perfectly clear in the law that groups of hospitals may present plans to the negotiator if they are requested by him. Therefore, in those instances, they are exempted from antitrust implication.

Question — How do you intend to cope with a possible maldistribution of facilities for Medi-Cal recipients?

Answer — I don't intend to have Medi-Cal hospitals if this can be avoided. It is my plan in each area to contract with enough capacity to assure adequate access for Medi-Cal recipients. For example, if I knew that I needed "x" number of patient days worth of facilities within a given area, I would contract with "x" plus 10 percent or 15 percent. In other words, I will contract with enough institutions to assure capacity within each area that is designated to handle Medi-Cal recipients.

Question — Some critics of the new plan say that it establishes a two-tier health care system in California? What is your viewpoint?

Answer — I don't agree with that at all. The new system would be a failure if I permitted such a thing. I consider "two-tier" the same kind of scare words that are used when we hear talk about rationing of care or some other horror. I don't intend to permit a hospital — through a contract — to set aside any given wing, floor or any other area just for Medi-Cal recipients. They will be a part of the regular normal flow of a hospital's patients. So, let me say again that we will not create a so-called two-tier system for Medi-Cal recipients.

Question — What safeguards are there in the new program to assure that the medically needy of California will receive adequate health care?

Answer — Our safeguards are based on the fact that we intend to contract with enough institutions. Remember, price is not the only bottom line involved. We plan to contract with the appropriate number to guarantee access. We are committed to do that through our request for a federal waiver. In fact, I have been pointing up the fact that we will improve access. Now, we have a lot of Medi-Cal recipients who are bounced around simply because a hospital, on a given day, won't accept them. Each individual hospital makes that decision on a daily basis. When hospitals sign a contract with the state, they will commit themselves to accept Medi-Cal recipients, who will know, in advance, that they will be accepted. Therefore, I believe that we actually will improve access to care for them.

Question — Do you foresee a number of hospitals dropping out of the Medi-Cal program as a result of this new system?

Answer — I do not anticipate as many hospitals being in the Medi-Cal program under the contracting system as we have today, but there are no magic numbers. I don't know how many will opt out.

Question — What are you doing to gear up for the start of the program?

Answer — We are spending a great deal of effort in working with the federal government on the waivers so that we can satisfy all of the required needs. We are building a small staff to handle the actual negotiating process. At the same time, we are developing the protocol that will be followed in the contracting. Obviously, this means that we had to collect all of the data needed to address the issue adequately. We plan to divide the state into various areas after we have studied the demographics on the number of Medi-Cal recipients and the types of hospitals. In negotiating with the hospitals for contracts, we probably will not follow the same procedure in every area. We will use different methods of reimbursement. For example, one method, hopefully, will be just a straight bid approach. Another will be a negotiation approach that will take place through the hospitals. Also, I hope to find an area where we can use the capitation approach.

MEDIQ Mobile CT Scanner:

You know the maximum cost before you turn it on.

When you work with some mobile CT scanners, the final bill often comes as quite a shock. Because you may never know how many slices your radiologists must take before reaching a satisfactory diagnosis.

MEDIQ Mobile has a better way: one price per scan, no matter how many slices it may take. So if you know how many patients you'll work with on a given day, you'll know your maximum cost. In advance.

MEDIQ Mobile's declining fee schedule offers tremendous discount possibilities as well.

In addition, MEDIQ Mobile's CT Scanner gives you these advantages:

- no capital investment
- added hospital income and prestige
- better patient care
- and unlike multiple-gantry CT scanners, there is no waiting to get on-line, no delay in reconstruction and no lost images.

Call (609) 665-9300 and find out more about the mobile CT scanner that lets you know your maximum cost long before you turn it on.

MEDIQ Mobile Services

The Comprehensive Mobile CT Service

Question — When do you hope to start contracting with hospitals?

Answer — We are gearing up to be able to actually start negotiations as soon as we receive the federal waivers. I hope that we will have our first contract with hospitals within 30 days thereafter. Of course, that doesn't mean with everybody because we obviously can't cover the entire state that fast.

Question — What is your opinion of that part of the new law pertaining to Blue Cross and commercial health insurers?

Answer — I must say that I was most intrigued with that legislation. I believe that the Blues and the commercial companies were exactly right in requesting permission to get into the negotiating business. Quite frankly, I feel that this potentially will have as deep — if not deeper — impact than the Medi-Cal contracting program. Obviously, Medi-Cal is the lead program. It is a government program. I believe, however, that what the private side of the equation can do is of extreme significance in the whole financing of institutional care in California. It is my intention to prod the commercials and the Blues to get into the act by negotiating and offering packages in the marketplace. What they do — along with what government does — should change the whole method of payment for institutional care in the state. This is extremely significant, and I don't underplay the potential of what the private sector can do.

Question — As the Medi-Cal czar, do you have a role in the Blues and commercial insurers' phase of the contracting program?

Answer — I have the authority under the law to run a couple of pilot programs contracting with HMOs or insurance companies for the Medi-Cal program. I intend to encourage them to develop their packages. I believe that we have an opportunity to see, under a government program, a good balance between government and the private sector. I would like to see Medi-Cal recipients have a much wider choice of coverage within the private sector. I believe that we can do this only if the insurance companies and the Blues respond to the needs in negotiating contracts with providers. Before I complete my tenure, I would like to have a couple of programs in place whereby we are actually contracting with insurance companies or the Blues and HMOs for the provision of care to Medi-Cal recipients.

Question — Some have described the new contracting system as just a different methodology for state rate control. What is your opinion?

Answer — I believe that there is a very broad difference between state rate control and contracting. From my perception, rate control tends to keep the entire institutional care (hospitals) in what I perceive to be more of a social mood. Actually, our hospitals developed as a social system, not an economic system. Therefore, the public utility or rate regulation approach responds more to a social system. This is quite different than a direct, price-driven, competitive economic system — which is what we are now establishing in California. It will be each hospital negotiating individually with heavy price-driven overtones. This is quite different than all hospitals coming before a public utility-type commission to get their rates approved. I foresee, under the economic, competitive system, that hospitals will have a multitude of rates to negotiate with different carriers. To me, this is a whole different foundation — a whole different phase — a whole different philosophy than the public utility approach.

Question — What happens after the nine-member California Medical Assistance Commission is created in 1983?

Answer — The commission members will be appointed some time after the first of the year, and they have from that time until July 1 to study what I will have been doing. It will be an education process — a period of understanding the issues involved and what the negotiator's office is doing about them. The commission takes full authority of the program on July 1, 1983. I am hoping, of course, that those appointed are extremely knowledgeable persons in the whole environment of health care financing and delivery because they are going to hold an awesome job.

Question — What happens when physicians come under the auspices of the new contracting law in 1983? How will they be involved, and what type of problems do you foresee?

Answer — The Department of Health Services has the responsibility for professional care at this time. I am not sure how that will be folded in under the Medical Assistance Commission other than the pilot program authority contained in the law. But, down the line, there is no question in my mind that there will be negotiations for all of the various elements of health care in California under the Medi-Cal program, whether it be pharmacy, physicians, ambulance service, etc. I believe that the negotiations with the physicians will follow a pattern already established in California, and that is by groups of physicians and not by individuals. Call it preferred provider, call it HMO — or whatever you like, but people will be given choices among systems of care, and negotiations in the Medi-Cal area will involve those systems.

Question — There has been criticism from elements of the provider community that the contracting legislation was developed "under very unusual and undemocratic conditions in haste and without the usual hearings by policy and fiscal committees in both Houses of the California Legislature? What is your comment? Do you plan any type of education program for providers?

Answer — Let me be blunt. I don't plan any kind of massive education program for providers for something that they virtually asked for. The debate has been going on for years. I am fully aware that the legislation was developed rather quickly. But we have been debating this issue in rather intense fashion in California for the past five or six years. Providers have had an ample opportunity for input. Therefore, I don't see any real surprises. I just don't accept the theory that all of a sudden on some Monday morning, they woke up and discovered that a whole massive change had taken place in California. There has been so much opportunity that I just don't accept the premise that this was some kind of huge surprise.□

Illinois hospitals hail 'Year of the Sunset' in legislative victory over rate control

For Illinois hospitals, 1982 probably will be remembered as the Year of the Sunset.

On October 1, 1982, Illinois' controversial hospital rate-setting program, which was legislatively-mandated in 1978, will "sail into the sunset" and into oblivion with the dubious distinction of never having become operational.

The hospitals — led by the Illinois Hospital Association (IHA) and its president, Robert O'Leary — achieved a notable political victory earlier this year when the Illinois Legislature rejected legislation to extend the life of the Illinois Health Finance Authority (IHFA) for five years, past the "sunset" date set by law, the aforementioned October 1, 1982.

The extension legislation was proposed by Republican Governor James Thompson, who, earlier in 1982, requested the IHFA to postpone the scheduled start-up of the program from May 1, 1982, to December 1, 1982 — two months after the "sunset date." In announcing the postponement, IHFA Chairman Martin Koldyke noted that the governor said the state budget could not afford the additional cost of between $25 million and $40 million to implement the program because of the state government's economic crisis.

Hospital representatives — armed with arguments against state rate-setting — flocked to the state capital of Springfield by the hundreds during the height of the nip-and-tuck struggle to kill the extension bill. The mobilization effort was directed by the IHA, which had made "sunset" of the law one of its major goals of 1982.

The IHA supported the legislation that established the IHFA and the rate-setting apparatus in 1978 but formally withdrew its backing in early 1981 — and then launched its intensive campaign to keep the program from being implemented and to let the law die statutorily.

Robert O'Leary (right), president of the Illinois Hospital Association talks with State Senator Philip Rock (D-Oak Park), Senate President, who helped lead the defeat of legislation to extend the life of the state's hospital rate control system past its October 1, 1982, "sunset" deadline.

The intensity of the battle is emphasized by the fact that the extension bill was approved by the Illinois House by a very narrow margin. But the legislation's doom was sealed when the Senate Executive Committee defeated it by a vote of 15-2.

Here is how the IHA described the death of rate-setting for its members:

"House Bill 2474 that would have given the Illinois Health Finance Authority five more years in which to implement its hospital rate review program was left dead at the close of the 82nd Illinois General Assembly.

"The defeated bill brings to a close another long and hard industry battle to defeat the efforts of the state agency to extend its life and operations.

"H.B. 2474 was killed by the Senate Executive Committee with a 15-2 vote on June 8 following an extremely narrow House passage of the measure on May 13. Despite repeated warnings that the bill would be resurrected before the close of the session (June 30), those efforts proved futile for the agency that has failed to set a single hospital rate since it was created in 1978.

"Hospital representatives played a crucial role in statewide efforts to convince legislators of the necessary defeat of the legislation. According to hundreds of their phone calls and letters to representatives, a renewal of the failed rate review program would do nothing to contain hospital costs, as is proven in other states, or create equity among payors of hospital care. Both were original goals set by the Health Finance Authority's enabling legislation.

"Business and community leaders also called for an end to the agency. According to Senate President Philip Rock (D-Oak Park), the proposed rate review program was "a noble experiment that failed."

"H.B. 2474's defeat means the Health Finance Authority's

enabling legislation stays intact. That law schedules the agency to die on October 1 of this year."

Second state to drop program

Illinois is the second state in two years to become disenchanted with its mandatory rate control program. Colorado repealed its law in 1980. Unlike the IHFA, which never became operational, the rate-setting Colorado Hospital Commission functioned for nearly two years. However, like the IHA, the Colorado Hospital Association supported the original legislation, later withdrew, and then became the leading opponent against the system.

> "Thanks to a sunset provision in the 1978 bill creating it, Illinois can now back out of this well-intentioned but misguided attempt to control hospital costs." — *Chicago Tribune*

In fact, it was a prime legislative sponsor of the original bill (setting up the Colorado system), who labeled the program "a bureaucratic nightmare" and then introduced the legislation to repeal it rather than to allow it to 'sunset' statutorily."

The *Chicago Tribune*, one of the nation's most powerful newspapers, has been a leading editorial voice against rate-setting for hospitals. It opposed the legislation in 1978 and then helped lead the clamor for its "sunset" death.

For example, while the legislative battle was gaining momentum, the *Tribune*, under the headline: *Let the Sun Set on This Law*, said editorially, in part:

"Thanks to a sunset provision in the 1978 bill creating it, Illinois can now back out of this well-intentioned but misguided attempt to control hospital costs.

"The authority, which has spent four years and several million dollars getting its red tape in order, has yet to go into operation. Although the problem it was intended to solve — runaway hospital costs — is acute, the authority would do little more than add a new and costly layer of bureaucracy.

"Seven states have a form of mandatory rate controls. Advocates say these plans have been successful. But the Illinois Hospital Association (which originally supported the authority as an alternative preferable to the federal controls proposed by President Carter) finds statistics to show just the opposite. And the proposed Illinois budget review process is so full of exceptions and loopholes that it's hard to see how it could keep hospitals from continuing to raise costs in one way or another.

"The best reason to let the authority die is that government control isn't the solution to the problem of hospital costs. In effect, the authority would rubber stamp the inefficiencies of the current system and lull those in a position to take effective action into assuming it was no longer necessary . . . The only realistic and workable way to control hospital costs is through market forces."

The *State Journal-Register* of Springfield also added its editorial support against the rate-setting scheme.

The newspaper said editorially, in part:

"It seemed like a good idea four years ago when the agency was created by legislation, to have the state actively involved in trying to curb soaring health care costs. The Illinois Hospital Association led the way in pushing for the authority's creation. Business, labor, insurance and consumer groups joined in encouraging the General Assembly to pass the bill.

"Now, after a couple of million dollars have been spent without a single hospital rate having been set, and with the hospital association having taken the agency to court over some of its projected rules, the bloom is off the rose. . . Certainly there are extreme health care cost problems, but continued operation of the Illinois Health Finance Authority will only serve to complicate those problems . . . It is another bureaucratic solution that has not worked and will not work."

On the other side of the issue, the *Chicago Sun-Times* has been a strong editorial supporter of the rate-setting program. The newspaper said in an editorial at the close of the legislative session that Illinois Governor Thompson "caved in to the hospital lobby" on the issue of Medicaid cuts.

The *Sun-Times* editorial said, in part:

"In return for biting the billion dollar bullet, hospitals got what they really wanted from Thompson: the death of the Illinois Health Finance Authority, the agency responsible for controlling hospital rates . . . Thompson contends he was powerless to prevent legislators from killing the health authority, even though it had the support of the state's Chamber of Commerce, AFL-CIO, Farm Bureau, private health insurers, consumer groups and one House of the Legislature. If the governor can't save an agency when it had that kind of backing, what can he do?"

IHA support withdrawn in 1981

After the Health Finance Authority conducted public hearings on proposed rules and regulations in January, 1981, the Hospital Association decided to withdraw its support of rate-setting and to take legal action, if necessary, to stop implementation of the program.

The IHA board of trustees met in a six-hour executive session on February 27, 1981, and voted unanimously to withdraw its endorsement — and vowed to oppose implementation of such a system.

The IHA explained its position this way at the time:

"According to the resolution adopted by the board, although IHA has had a long-standing commitment to assist the Authority to develop a workable prospective rate review system, national and state economic conditions now indicate that a rate setting system, as originally intended in the Illinois Health Finance Authority Act, may never be realized. Other resolutions adopted at the meeting allow for appropriate legal action to be taken, if necessary, to oppose implementation of the system.

"The board withdrew its support only after a lengthy review of the evolution of rate review in Illinois and IHA's ongoing involvement with it. Prior to the passage of the rate review bill in September, 1978, IHA had made the commitment to work with both the state and third party payors toward developing an acceptable system. The commitment was part of IHA's successful 1977 out-of-court settlement of the 18-month Medicaid freeze.

"According to the board's discussion at the meeting, other pressures that compelled Illinois hospitals to support a rate review system during that time were the proposed 1977 Carter cost cap on hospital revenues; the Illinois Department of Insurance director's rate order requiring renegotiation of the existing hospital/Blue Cross contract, and a proposed HEW-approved Medicaid alternative reimbursement system that was even more crippling than the existing Medicaid program.

"After the rate review bill was passed, IHA made a second pledge to the Thompson Administration, the Finance Authority and IHA membership indicating that once final proposals had been made and the system was examined according to its impact on health care delivery in the state, IHA would re-evaluate its position.

"In evaluating and subsequently altering that position, the IHA board closely examined both state and national economic and political conditions affecting rate review, and particularly the forecasts stemming from the Thompson Administration's proposed 1982 Medicaid budget cuts. The board also considered the broad-based IHA membership opposition to the system as it was finally proposed.

"The final decision to withdraw endorsement of rate review, the board indicated, reflects the association's concern that the system proposed by the Illinois Health Finance Authority will not adequately assure the financial needs of Illinois hospitals during this decade."

From that point on, the IHA held meetings statewide and marshaled its forces for the 1982 legislative battle and efforts to keep the program from being implemented.

The battle that ensued ran the full gamut of political intrigue (especially behind-the-scenes in the Legislature), challenges and counterchallenges, some legal action, and election-fever campaigning by hospital representatives on the one side, and representatives of business, labor and agriculture on the other.

O'Leary tells story behind IHA's position change

Robert O'Leary, the IHA president who is credited with quarterbacking the hospitals' strategy with the support of the IHA leadership and key staff, says, in retrospect, there were signs of trouble ahead almost immediately upon signing of the rate-setting legislation.

O'Leary told the *Review* recently, "Hindsight is such a great provider of wisdom. Almost from the day that the bill was signed, there seemed to be a dragging of the feet on the part of Administration. It took some nine months for the governor to get around to appointing the board of the authority.

"From February, 1979 (when the board was finally selected) to June, 1982, the authority went through the process of studying and researching, educating, drafting regulations, deciding what sort of computer forms they wanted for data, etc. Essentially, they strung out a process for nearly three years, a process that was supposed to last a year. By the time June, 1979, rolled around, they barely had appointed some of their staff and decided where their office was going to be.

"The really very serious danger signs started to appear in the summer of 1980 when the authority started to make decisions on its draft regulations which were being prepared for publication and public hearing. It become clear that they were going to make some substantial deviations from the law in the area of the definition of hospital costs and hospital services. They were not going to include hospital-affiliated nursing homes, home health care and that sort of thing. Also, there was a major deviation on the issue of cross-subsidization of departments between obstetrics and more profitable departments. That issue was dealt with specifically on the floor of the House [illegible]. Yet they went off on a tangent and apparently knowingly went against the intent of the law in that area.

Robert O'Leary (left), president of the Illinois Hospital Association (IHA), and Steven L. Seiler, immediate past chairman, are shown during one of the many public hearings on the Illinois rate control system.

"It also began to emerge that they were giving serious consideration to granting waivers to the federal government with discount rates. This, too, became a major concern to the Hospital Association in the summer of 1980.

"Coming into 1981, we saw no receptivity on the part of the IHFA to our concerns. They published final regulations which included provisions that we thought were substantial deviations from the law and quite objectionable to us."

O'Leary recalled in the interview that the IHA did not support an attempt to repeal the IHFA in the 1981 legislative session.

"A state representative introduced legislation to repeal the rate-setting authority. Our board, however, made a decision not to support the repeal. It was our viewpoint that we had made a commitment to support this activity from the beginning and that commitment included the bill as it was passed — which provided for a 'sunset' provision on October 1, 1982.

> "Hindsight is such a great provider of wisdom."

Only one information systems company is moving fast enough to keep pace with Allegheny General: SMS.

With $105 million invested in everything from flying intensive care units to a fully computerized cardiovascular risk program, Allegheny General Hospital's plans demanded an information system they couldn't outgrow.

After a year and a half of intensive study, they found only one company with a plan as progressive as their own. SMS.

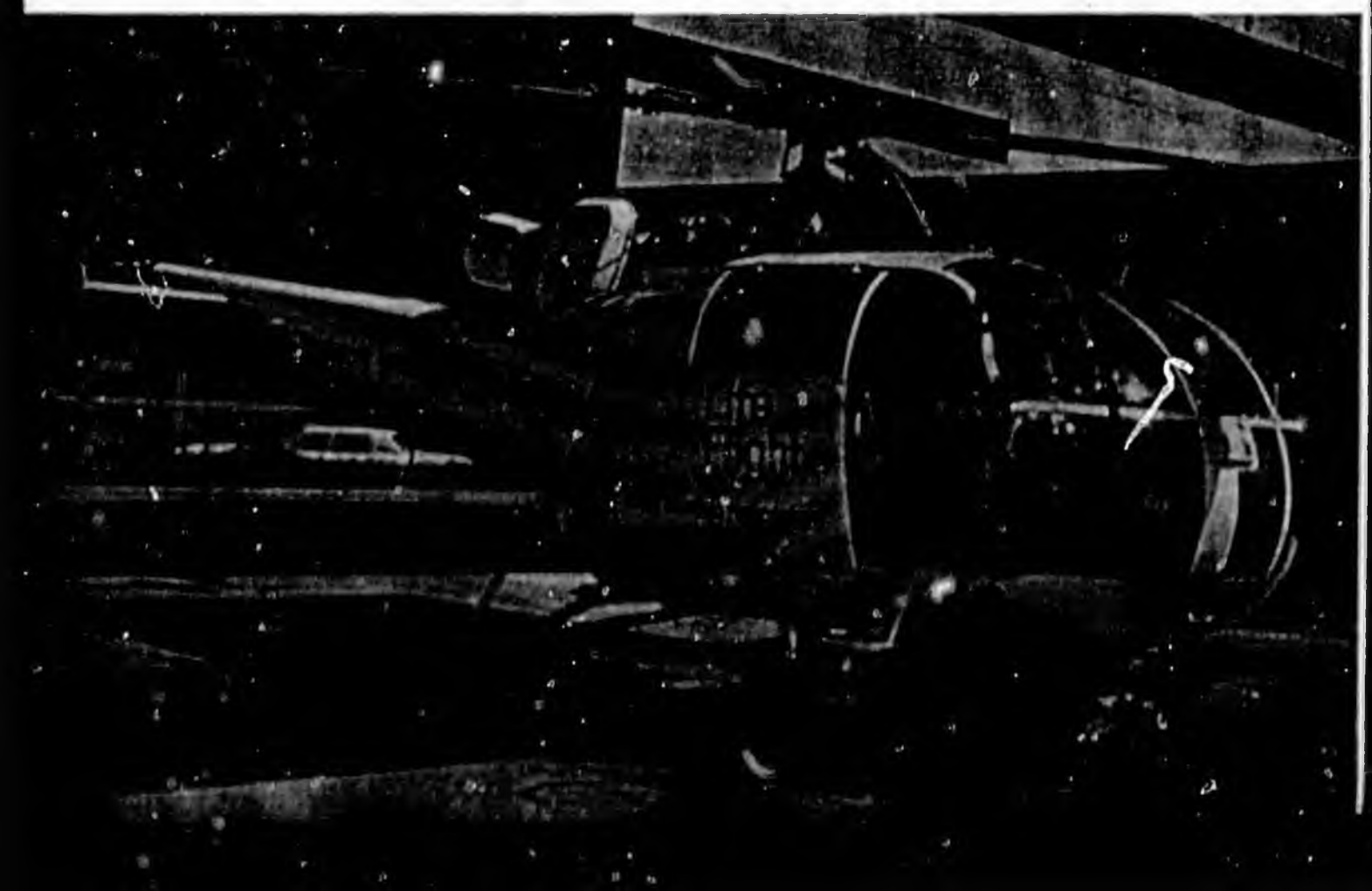
Only the SMS plan offered a continually updated financial package, plus a full range of administrative and patient care information services. Including the use of intelligent terminals and instant-access minicomputers for in-house departmental support (like Nursing and Medical Records). Effective interface with Allegheny General's own systems. And even the ability to create special programs on-site.

Because it's totally committed to the health care industry, SMS has the right plan for Allegheny General.

Until you have a plan from SMS, you won't know what you're missing.

Find out.
Write or call SMS Marketing Support at (215) 296-6300, extension 4966. Ask for our new brochure for hospital executives. And let us show you how the systems that work so well for Allegheny General can work for you.

SMS
51 Valley Stream Parkway
Malvern, PA 19355



"We did decide at this time to support the non-extension of the rate review law beyond its normal 'sunset' date. The Legislature adjourned June 30, 1981, without passing repeal and without making any changes in the rate review program's statutory origin. However, 1981 was significant because the state's growing fiscal problems became a major issue for the Thompson Administration, which cut the Medicaid program by $106 million that year.

"Over and above all of the concerns with the regulations and deviations from the legislative intent of the authority, it became very clear to us and any thinking person that the state could no longer afford to participate in the rate review program as it was originally designed. They had only one of two options: (1) publically announce that they could no longer afford the program and back away, or (2) adopt rules and regulations to produce a result that they could live with financially."

> "... It became very clear to us and any thinking person that the state could no longer afford to participate in the rate review program as it was originally designed."

The granting of federal waivers to allow the IHFA to proceed toward implementation produced a donnybrook that resulted in the IHA going to court to obtain an injunction.

The intent of the suit, according to O'Leary, was "to stop the authority from granting discounts for the Medicare/Medicaid programs until the hospitals received formal notice and had a chance to present their views," and also "to prevent implementation of the program on May 1, 1982.

O'Leary noted that it was within this time frame — the winter of 1982 — that the Thompson Administration called for a postponement of the implementation from May, 1982, to December, 1982, and asked the Legislature to extend the law for five years.

Divide and conquer ploy fails

One political manuever that failed, O'Leary said, was an amendment to the extension bill to exclude from the rate setting program all hospitals with revenues under $7 million.

"This was a political move," O'Leary commented, "to try to divide and conquer the hospital industry — essentially to try to take away our strength, especially among the down-state hospitals where their legislators are very close to the institutions. The rate review proponents thought that by exempting those smaller hospitals, they would have eliminated about 120 hospitals from the program. They thought that this would have diffused the interest of those hospitals. However, I don't believe that we lost a single small hospital because of that attempt. They stood with us and helped us present a united front. I don't think the divide and conquer ploy was even minimally effective."

O'Leary believes that attempts will be made in future years to establish "rate review-type" programs but not on the order of the IHFA.

He was asked in the interview with the *Review:*

What about the future? After registering a spectacular legislative victory, what does the IHA plan to do as far as cost containment is concerned?

O'Leary said, "The major focus of attention now is in the Medicaid program. The resolution of the Medicaid situation is a dramatic cutback in cash flow to hospitals and an 18 percent statewide cutback in utilization. We are going to be working with our hospitals to help them. It is a really devastating cutback. There are a number of inner-city hospitals with high Medicaid loads that will be very much in danger.

"On the other hand, we must look beyond 1983. As a result of this past legislative session, there is a commitment to work on a restructured Medicaid program. The hospital industry in Illinois already has indicated its willingness to work with the next state Administration to develop a process of addressing the Medicaid problems.

"Of course, what we do will be accentuated very much by what happens in Washington with the Medicare program. The combination of Medicare and Medicaid cuts is going to be a powerful double whammy, especially on a lot of our rural, down-state hospitals. And, of course, the news out of Washington isn't good." □

Tennessee governor favors federalized Medicaid

Governor Lamar Alexander of Tennessee, a member of the National Governors Association (NGA) New Federalism am negotiating with the White House, believes that Medicaid ould be federalized in view of the fact that "the program is so ig, only the national government can afford to operate it."

Alexander made this comment recently in a conversation ith Thomas Frist, Jr., M.D , president and chief executive fficer of Hospital Corporation of America (HCA) of Nashville, ennessee, during the NGA's 74th Annual Meeting at hangri-La in Oklahoma. Dr. Frist attended the meeting at lexander's invitation and spoke on corporate strategic plan- ing before the NGA's Committee on Executive Management nd Fiscal Affairs, chaired by the governor.

Alexander commented, "There is not much difference be- ween Medicaid and Medicare in terms of their ultimate purpose. herefore, I believe that they can be related more easily if they re managed by the same level of government. In this way, cost ontrols can be more effective, and the funds will go to help the eople who need it the most.

"Most governors believe that ncome maintenance programs ught to be a national responsibility – and that there ought not be a tate-by-state variation in terms of ow much we are willing to pay for omeone's illness just because that erson happens to live in Mississippi s opposed to California."

Alexander, who was named re- ently to the NGA's nine-member xecutive committee, conceded that 'there are still a number of persons n the Reagan Administration — not he President himself — who are re- uctant for the federal government to ssume all of the responsibility of he Medicaid program."

"These people," he added, "be- ieve that Medicaid is a so-called elfare program and more properly belongs with state and local overnments."

Alexander, a lawyer who formerly worked at the federal evel as an aide and counsel to Senator Howard Baker (R-Tenn), now the Senate Majority Leader, also made these comments in is conversation with Dr. Frist:

Question — There is a move in the health care industry to inject arketplace competition into the delivery system as one of the nswers to the cost dilemma rather than more regulation. This oes not necessarily mean pitting hospital against hospital but ringing alternative health delivery systems into the picture — eeping the patient out of the hospital if he doesn't need to be here through home health care, ambulatory surgery, outpatient esting, etc. Do you see this as a positive type of thing?

Answer — I believe that this is something which really ought to e explored. It is obviously one very promising way to only limit spending (although we are still going to spend a lot of money on health care) — but also to focus the emphasis on those who need the help. State governments can be helpful in this regard. For example, in Tennessee, we are focusing on early childhood development and what happens to children when they are born. We know that health care for mothers before children are born — or for children just after they are born — is absolutely crucial to the child's healthy development. We have discovered that a great many children aren't immediately tied into a doctor when they are born. If we could do this with every child in Tennessee, then we might find many children, especially from poor families, not being taken to the emergency room when a call to a pediatrician might have saved the trip and saved the dollars for a later experience when the child was really sick. Something like this wouldn't cost us much money as a state, but it might reduce health care costs or focus dollars on those who are really sick rather than those who feel bad and really don't know what to do about it.

Governor Lamar Alexander (right) emphasizes a point in a conversation with Thomas Frist, Jr., M.D., president and chief executive officer of Hospital Corporation of America (HCA) at the annual meeting of the National Governors Association.

Question — It seems that the major share of health planning is reverting to the states from the federal level. What is your viewpoint?

Answer — Health planning is important, in my opinion. I feel that states can operate such a program as well as a mixture of federal and state agencies. As governor, it has been absolutely mystifying to me to try to figure out all the various health planning agencies that people have to deal with. I know the same must be true with hospital companies, non-profit hospital boards and individuals, too. I believe that state health planning agencies are the wave of the future. It is one of the normal responsibilities that I anticipate states will be more active in during the 1980s.

Question — During the NGA meeting, we have heard governors appealing to their colleagues to explore cooperating with the private sector in a joint problem solving effort? Do you see some opportunities here for the health care industry?

Answer — There are bound to be ways that this can be done. For example, if we are trying to put state dollars into the effective management of home health care (an area in which many states are exploring now), I believe that we would do well to go to a company, such as HCA, or a public or private hospital and ask how they manage their systems and request assistance in helping us develop a model. Also, in Tennessee, we are trying to contract for health services. I happen to think that state governments, and government in general, aren't very good managers in some areas. And one such area may very well be mental health institutions. □

Arizona ready to start health experiment using Medicaid funding for the first time

Arizona, the only state without a Medicaid program, is ready to use Title XIX funds for the first time as a part of a bold, health care experiment, featuring competitive bidding, contracting and prepaid, capitated services.

The Arizona Health Care Cost Containment System (AHCCCS, pronounced Access) was established by the Arizona State Legislature in a special session last November. It will begin operations on October 1, 1982, under the watchful eyes of federal, state and county governments and the provider community. The first competitive bidding already has been conducted.

The uniqueness of the three-year experimental program is demonstrated by the mix of persons eligible for services under the AHCCCS:

☐ Indigent persons with (for a single person) incomes of less than $2,500 a year with a net worth of less than $30,000. (The $2,500 base is increased by 33⅓ percent for a spouse and an additional 17 percent for each other dependent.)

☐ Persons mandatorily eligible for services under Title XIX of the Social Security Act, including recipients of AFDC and SSI.

☐ Medically needy persons with incomes (for a single person) ranging between $2,501 and $3,200 a year. Medically needy persons will pay coinsurance averaging 10 percent of the cost.

☐ State employees, county employees (at the option of the county boards of supervisors) and private employees may participate in the AHCCCS with no public subsidy (but the AHCCCS may not be the sole option offered to such employees with the exception of small businesses with no access to other affordable coverage).

The AHCCCS will be funded from a combination of federal, state, county and private (for business employees) contributions. It is estimated that the first year of the so-called "Arizona experiment" will cost between $100 million and $150 million. Federal Title XIX funding will be made available primarily on a prepaid capitation basis with adjustments at the end of the year for the number of enrollees. The state will be "at risk" for the provision of cost effective care.

The AHCCCS cites the following as some of the cost containment features of the new system:

☐ Care will be provided as a result of a competitive bidding process on a prepaid or discount payment basis and on a fee-for-service basis only in the absence of adequate prepaid bids.

☐ System administration will be provided by a private contractor who will implement accounts and controls systems, fraud prevention measures and quality control measures, including peer review and utilization study of providers.

☐ All health care must be provided or authorized by a primary care physician.

☐ Services may be adjusted by the system administrator to guard against cost overruns.

☐ What are some of the major differences between the "Arizona experiment" and traditional Medicaid? The AHCCCS explains it this way:

Eligibility — In addition to the Title XIX mandated participants the AHCCCS has established an income/resource standard for indigent and needy persons — and also allows for the participation of state, county and business employees with no

"The premise of the system is that we will introduce some competition, and we will ask for predetermined prices on a capitation basis."

— Governor Bruce Babbitt

public subsidy.

Program Operations — (1) A private administrator under contract to the State Department of Health Services (DHS) will provide much of the program operations; (2) Services will be provided primarily on a prepaid capitated basis (on a "capped" fee-for-service basis where necessary) as a result of a competitive bidding process, and (3) The AHCCCS embodies other cost containment features such as a primary care physician model of entry into the system and mandatory copayment by participants.

Benefits — (1) The AHCCCS is establishing a comprehensive but cost effective set of benefits directed toward acute care services; (2) Long-term care, home health care, family planning, some EPSDT services, and acute care mental health services are not provided by the AHCCCS but are left to the county delivery system, and (3) Inpatient services, outpatient hospital and physician services, lab and X-ray services, prescription, emergency dental care, medical supplies and prosthetics, EPSDT services for children and medically necessary transportation services are provided.

Arizona's resistance to the use of Medicaid funds has been a political issue almost since the national program started in the mid-1960s. The state's 14 counties have been financing indigent health care. Rising costs and other inroads led to the establishment of the AHCCC, but not without a political battle both inside and outside the Legislature.

Governor Bruce Babbitt, who has championed the new program, says that "the premise of the system is that we will introduce some competition, and we will ask for predetermined prices on a capitation basis."

"Enormous" amount of interest

Babbitt said in an interview with the *Review* recently:

"There is an enormous amount of interest among governors of other states in our new system for obvious reasons. State Medicaid costs have been going out of sight at the very time that the federal government Administration is attempting to scale back its level of commitment. This has put states in a very difficult position. It is a feeling on the part of many that some kind of competitive cost containment is the only alternative to massive reduction in coverage. I believe that everybody understands that the escalation of costs, given the fiscal realities in this country, cannot continue.

"There are only two ways to address the problem of escalating costs. One is to get the cost under control through some modified market mechanism, the introduction of some competitive modalities, or, two, to start cutting back coverage — which is something that is not attractive to people in the medical community, or anybody. It would be politically very difficult to do. So, there is a sense that we must make our system work because the alternative is a very unhappy one.

"Now, let me say in all candor that we deliberately left out of the Arizona experiment a piece of Medicaid, which is perhaps the most difficult of all. That is long-term, intermediate care for the elderly. We simply left that responsibility with the counties — but knowing that we will have to come back and address it."

"There is no question that there is a trend toward the capitation fixed bid contract system. The Medicaid amendments of 1981 are clearly moving in the direction that we worked out with the Department of HHS through the use of its demonstration

authority. I believe that the saying of 'the physician prescribes, the institution provides, both after the fact, send the bill to the taxpayer,' is rapidly disappearing."

The Arizona Hospital Association (ArHA) has been conducting a massive information and technical assistance program to prepare hospitals for the AHCCCS. Thirty-two hospitals participated in the funding of the project, for which $200,000 has been committed for the first year.

Looking at potential problems

What are some of the problems that the association foresees in the start-up phase of the "Arizona experiment?"

Ronald D. Krause, ArHA president, and Sandra Spellman, who heads the association's activities related to the AHCCCS, expressed these viewpoints for the *Review:*

☐ "One of the big issues is that we have not been able to resolve our desire to essentially sequester financially the risk of hospital participation in this program from other pieces of hospital business. Where that becomes most important, obviously, is in the Medicare area."

☐ "As we get into the system, we are going to encounter some of the same provider/payor interface, slow-pay difficulties that prevail elsewhere. We would hope that it would be less cumbersome because of the way that this program is designed with private administration. But only time will tell."

☐ "The program is so new and experimental that a lot of newly-formed provider consortiums, actually corporations, are emerging. There, then, is a fiscal solvency issue. Can profits be derived in such an actuarial sound way within the context of capitation that these organizations will, in fact, survive?"

☐ "Another philosophical question involves prepaid capitation which is the emphasized mode of care and financing under the program. Generally, the data suggest that the real cost savings have to do with minimizing the utilization of inpatient services. One of the things that we will need to do is to identify what that minimization is and look at it in terms of the need to look at some alternatives to the traditional approaches to keep beds filled. We also see this as perhaps an opportunity to break our keys on this program on a much smaller scale that what we, as hospitals, may be forced to look at in the next two years with prospective payment Medicare coming down the pike."

☐ "The system itself suggests all sorts of new issues to be addressed, and problems that need to be solved. The provider consortium approach means that physicians and hospitals have to work together rather than as adversaries to really make the program come off effectively. We are seeing all sorts of new kinds of relationships growing up between providers and hospitals, particularly in the rural areas of the state where we have a more symbiotic relationship that is very different from what is happening in our two urban centers (Phoenix and Tucson), where competition is much greater."

☐ "The program is designed to be an open market competitive system. But we find that we don't have a competitive market in a lot of the rural areas of the state. What impact does that lack of competition have on the ability to develop cost contained capitation rates?"

The day-to-day management activities of the AHCCCS will be conducted by a privately-contracted administrator, the McAuto Health Services Division of McDonnell Douglas. The project director is Henry Foley, Ph.D., former administrator of the Health Resources Administration (HRA) in the Department of HHS and formerly state Medicaid director in Colorado. ☐

Florida's new health planning law puts CON responsibilities at the state level

Florida hospitals have marked up health planning reform as one of their major legislative victories in 1982.

Earlier this year, the Florida Legislature approved significant changes in the health planning process, including:

(1) Replacement of Health Systems Agencies (HSAs) with local Health Planning Councils (HPCs). (Membership on the council consists of health care providers, purchasers and consumers with a majority being purchasers and consumers — and consumer representation must include a representative number of persons over 60 with deference to Florida's high senior citizen population).

(2) Placement of Certificate-of-Need (CON) responsibilities at the state level — with the State Department of Health and Rehabilitative Services (HRS).

(3) Raising CON thresholds to the current federal levels: capital expenditure, $600,000; medical equipment, $400,000 and health care services, $250,000.

(4) Providing review of CON applications (batching) by the HRS no less than four (rather than the previous two) times a year.

(5) Shortening the CON review period from 90 days to 45 days.

(6) Changing the name of the Statewide Health Coordinating Council (SHCC) to the Statewide Health Council (SHC) and changing the membership to include the chairmen of the local health councils in the 11 HRS districts in the state — plus two members each appointed by the governor, House speaker and Senate president.

(7) Funding local health councils through CON application fees: minimum, $500, and maximum, $4,000.

Governor Bob Graham of Florida told the *Review* in an interview recently:

"What Florida has done in reaction to the retreat of the federal government from Health Systems Agencies (HSAs) is to set up a state planning mechanism, particularly with responsibility for carrying out Certificate-of-Need requirements. There will continue to be a local initial point of contact, but more of the final decision will be made at the state level."

Graham said that it would be premature to call the new Florida health planning system a possible prototype for the country because the new law only went into effect on July 1, 1982.

"One of the roles that state governments have traditionally played in our federal system is to be laboratories for experimentation," the governor commented. "And this would be one of those experiments that other states might find adaptable to their circumstances."

Graham believes that most of the problems that might be encountered as the new system evolves "will be the carryovers of the HSAs."

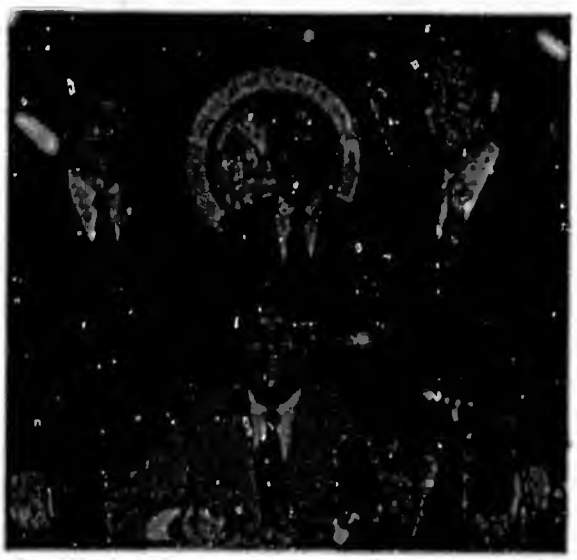
He also feels that the health planning reforms fit in well with the state government's encouragement of the formation of health care coalitions of major public and private employers as a means of trying to contain costs. He said that the state had been a catalyst for the formation of the coalitions "not as a regulator but because the state is the largest single employer, and, therefore, we are very heavily affected by increased health care charges."

"I believe," the governor said, "that we ought to be moving toward a health care system whose economics puts more emphasis on marketplace factors."

John McBryde, president of the Florida Hospital Association (FHA), explained to the *Review* some of the reasoning behind the health planning changes:

"HSAs have always been looked upon as federal agencies. From that standpoint, state legislators were quite willing to substitute something in their place, especially when it looks like they are going to be defunded by the federal government. And, of course, they have been defunded to a large degree.

"There was no strong support in the Florida Legislature for the state to assume this federal function and continue it in its present form. There were a variety of reasons.



Governor Bob Graham (seated), shown signing Florida's new Hospital Licensure, Cost Containment and Health Planning Law, says, "What Florida has done in reaction to the retreat of the federal government from HSAs is to set up a state planning mechanism, particularly with responsibility for carrying out CON requirements."

HSAs were clearly federal agencies. The money came from the Feds — and where the money comes from usually governs a great deal of the attitude of the agency itself and what it is trying to do. It was responsive to federal guidelines and developments, rather than local. Legislators, in my opinion, do not respond favorably to that sort of situation. Certainly, hospitals did not. We felt that it would be much better to have health planning in the hands of local people rather than be under a federal agency."

Noting the safeguards in the new law, McBryde said:

"The state CON law remains intact. The big difference is that there are no HSAs. The state is now charged with the full responsibility of operating the CON law. The state will contract with the local Health Planning Councils to do whatever is necessary to provide input into CON requests. But there will be only one agency making the final decision and recommendation, and that is the State Health Planning and Development Agency (SHPDA).

"In the legislation, we have limited the public hearing to one instead of the multiple hearings conducted in the HSAs. Subcouncils, committees and the full board of the HSA could hold several hearings on a CON application. Now, this process has been centralized at the state level and is limited to one public hearing — and this can be held at the local level, if requested, or at the state level."

McBryde credited legislative approval of the new health planning law "to a concerted effort of health lobbyists working together in cooperation with one another at Tallahassee."

"This," he emphasized, "included, not only the Florida Hospital Association, but the Florida Medical Association, the Florida League of Hospitals, the investor-owned hospital organization, voluntary hospital organizations, plus many individuals who were interested in changing the HSA system. So the victory was really a credit to the whole health lobby group."

Jim Krog, president of the Florida League of Hospitals (FLH), which represents the state's investor-owned hospitals, believes that one of the strong points of the new planning law is the concept and the role of the local planning council.

"The role of the local health councils," he emphasized, "is purely planning. They do not have authority at the local level to review a project. The only review in which permission is granted for a CON will be done at the state level.

"The question, "Krog commented, "was not whether we were going to abolish HSAs. The question was — How are we going to create a structure beyond the HSAs? I know there is some support in Florida to go to a commission-type CON program, similar to Texas, because of the controversy that surrounds those types of decisions.

"However, over the next six months, there is going to be an administrative battle to make certain that the new statute is implemented in a way that its philosophy is what the legislators want it to be. And that is — planning and regulation ought not be conducted by people at the local level — that they ought to be planners and decide for their community how they want their community to develop — that the regulatory scheme ought to be vested at the state level where you can have a consistent approach all the way through." □

State-by-state survey reflects leading issues impacting the hospital industry

Legislative and regulatory issues affecting the nation's hospitals in 1982 — and beyond — are spotlighted in this state-by-state survey, compiled by the *Review* for its Special Report: *The States: New Directions in Health.*

The information was provided by the various state hospital associations in response to a special *Review* questionnaire (an updated and expanded version of a questionnaire which was used as the basis for a state-by-state survey published in the January/February, 1982 issue of the *Review).*

The new survey is especially timely in view of the fact that most State Legislatures have adjourned sine die for the year, and those that convene annually won't be in session again until January, 1983.

State hospital association officials were requested by the *Review* (1) to list and briefly describe any significant legislative, regulatory or judicial actions (involving health care) occurring in their respective states since December 1, 1981, and (2) to answer the following questions:

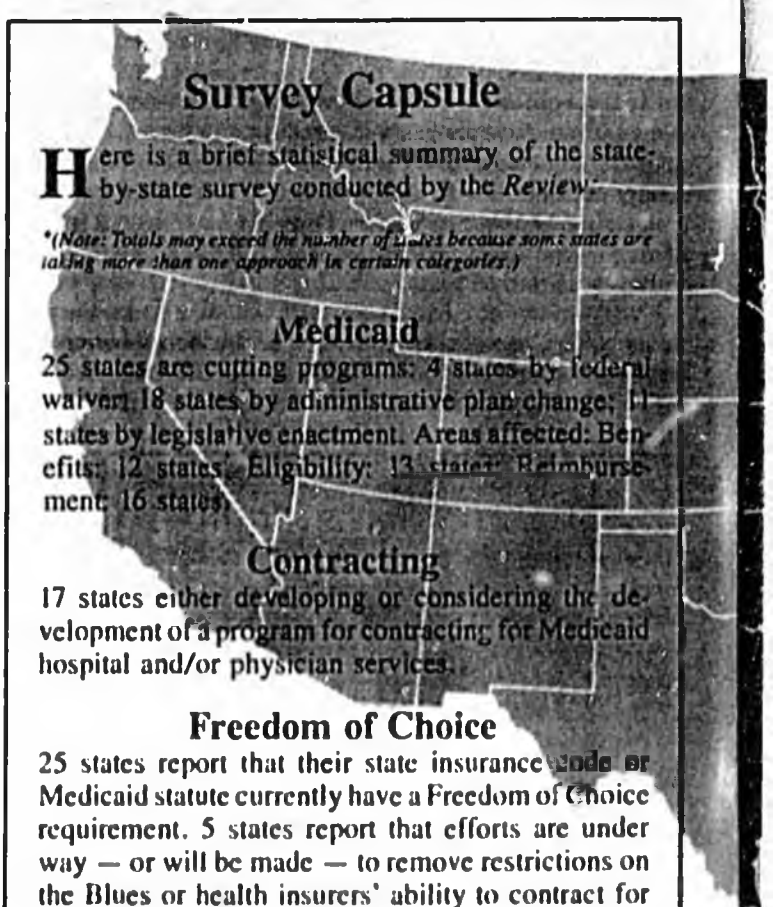
The Questions

Medicaid — Did your state cut Medicaid? Or is it going to cut Medicaid? If so, by approximately how many dollars, and what is the percentage decrease over last year? In what areas are the cuts: Benefits? Eligibility? Reimbursement? If so, how: Federal Waiver? Administrative plan change? Legislative enactment? Others?

Contracting — Is your state now developing or is there a possibility it may develop a program for contracting for Medicaid hospital and/or physician services? Briefly describe the situation. Does your state insurance code or Medicaid statute currently have a "Freedom of Choice" requirement? If so, is there any effort so far, or likely in the future, to remove this restriction on the Blues or commercial health insurers' ability to contract for alternative payment plans? Please explain.

Health Planning — What state health planning changes are occurring in your state: HSA phase-out? Single state planning authority? Increased/decreased state funding? Hospital planning fee assessment? Is the state raising its thresholds to current federal levels? To other levels? Please specify.

Other Issues and Comments — Are there other proposals to control hospital reimbursement for non-Medicaid programs? Are there any current or expected legislative or administrative proposals to implement mandatory rate setting in your state? If so, please explain . . . Any other comments?



Survey Capsule

Here is a brief statistical summary of the state-by-state survey conducted by the *Review.*

(Note: Totals may exceed the number of states because some states are taking more than one approach in certain categories.)

Medicaid

25 states are cutting programs: 4 states by federal waiver; 18 states by administrative plan change; 11 states by legislative enactment. Areas affected: Benefits: 12 states; Eligibility: 13 states; Reimbursement: 16 states.

Contracting

17 states either developing or considering the development of a program for contracting for Medicaid hospital and/or physician services.

Freedom of Choice

25 states report that their state insurance code or Medicaid statute currently have a Freedom of Choice requirement. 5 states report that efforts are under way — or will be made — to remove restrictions on the Blues or health insurers' ability to contract for alternative payment plans.

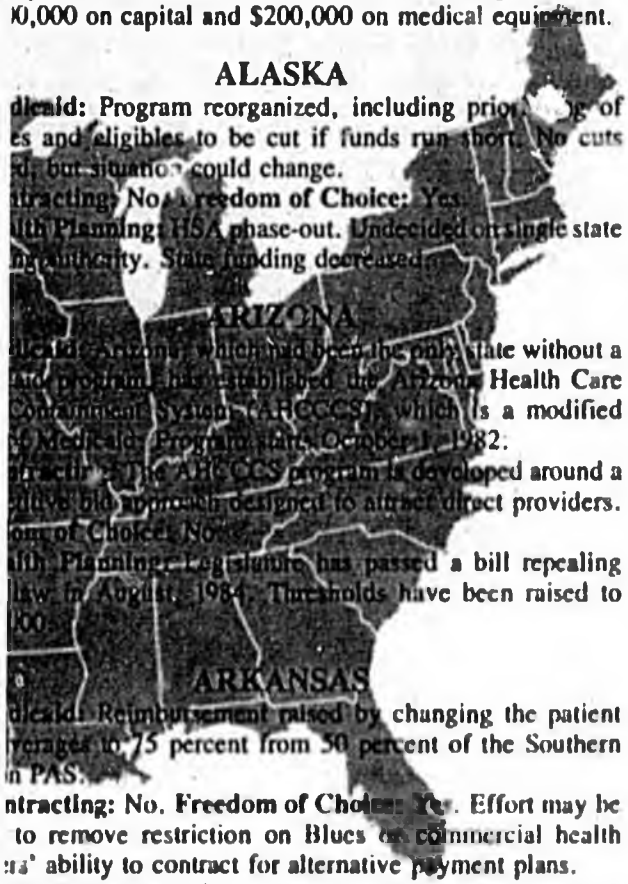
Health Planning

27 states report HSA phase-out either under way or contemplated. 15 states either have gone — or are planning to go to — a single state planning authority. 21 states have raised — or plan to raise — thresholds to current federal levels. 10 states have raised — or plan to raise — thresholds to other levels.

State Rate-setting

The majority of the states indicated that there are no current or expected legislative or administrative proposals for mandatory rate-setting.

State-by-state summary



ALABAMA

dicaid: Funds cut by $2.5 million, a 3 percent decrease. ı taken by administrative plan change to prospective reim- nent method with caps based on size of hospital and er it is rural or urban.

ıtracting: No. **Freedom of Choice:** No.

ılth Planning: HSAs phased out. Single state planning ity established. State CON law revised, raising thresholds 0,000 on capital and $200,000 on medical equipment.

ALASKA

dicaid: Program reorganized, including prio[illegible]g of es and eligibles to be cut if funds run short. No cuts d, but situation could change.

ıtracting: No. **Freedom of Choice:** Yes.

lth Planning: HSA phase-out. Undecided on single state ng authority. State funding decreased.

ARIZONA

Arizona, which had been the only state without a program, has established the Arizona Health Care Containment System (AHCCCS), which is a modified Medicaid Program to start October 1, 1982.

ıtracting: The AHCCCS program is developed around a ative bid approach designed to attract direct providers.

ion of Choice: Now.

lth Planning: Legislature has passed a bill repealing law in August, 1984. Thresholds have been raised to 00.

ARKANSAS

dicaid: Reimbursement raised by changing the patient verages to 75 percent from 50 percent of the Southern n PAS.

ntracting: No. **Freedom of Choice:** Yes. Effort may be to remove restriction on Blues on commercial health ns' ability to contract for alternative payment plans.

alth Planning: HSA phase-out. Change to single state ing authority. Thresholds raised to federal levels.

mments: Blue Cross of Arkansas has formed a Cost Con- ent Study Commission, and state rate setting may be one recommendations.

CALIFORNIA

dicaid: Funds cut up to $500 million in areas of benefits, ility and reimbursement. Action taken by federal waiver, istrative plan change and legislative enactment.

ntracting: New law establishes a prospective payment n, allowing the state Medi-Cal (Medicaid) program to iate contracts with hospitals and physicians to provide es to the poor on a prepaid basis. Initial program to be istered by a negotiator, called the "Medi-Cal Czar," who be replaced in July, 1983, by the yet-to-be appointed rnia Medical Assistance Commission, established by the Remedial legislation needed to clarify "gray" areas in new law. An amendment permits commercial health insurance carriers to enter into contracts with hospitals and physicians. **Freedom of Choice:** No.

Health Planning: Two HSAs phased-out thus far. State funding decreased. If federal planning law is repealed, state thresholds could go as high as $7.25 million. Project review requirements also would be changed.

COLORADO

Medicaid: No current plans to cut program.

Contracting: State working with two HMOs for contracting to provide services to Medicaid patients. State has received waiver for Medicaid to require recipients to contract with an HMO in one county as an experiment. Program has not been implemented. **Freedom of Choice:** Yes.

Health Planning: Two HSAs phased-out. SHPDA is single state planning authority. Thresholds raised to $750,000 with annual index capital expenditure; no operating expense threshold, and no review on non-clinical services.

Comments: Blue Cross contracts for 1983 may contain proposals to control hospital reimbursement for non-Medicaid programs. Colorado repealed rate setting law in 1979, but there are rumors of a new move to try to pass legislation in the next Legislature.

CONNECTICUT

Medicaid: No cut in funds.

Contracting: No. **Freedom of Choice:** No.

Health Planning: HSA phase-out. Thresholds raised to federal levels.

Comments: Legislation (supported by Connecticut hospitals) approved to permit hospitals, which can keep expenses per admission below inflation plus 2 percent, to be exempt from budget review by state rate setting commission. Half of Connecticut's hospitals were exempt from the commission's review for next year.

DELAWARE

Medicaid: Funding increased $3 million, but Association of Delaware Hospitals believes increase is lost because of program restrictions placed on Medicaid recipients.

Contracting: No. **Freedom of Choice:** Yes. Modifications under consideration.

Health Planning: No HSA phase-out. Consolidation of HSA and SHCC considered, but no action likely for at least a year.

Comments: In judicial action, Delaware State Supreme Court ruled that if a hospital did not have a signed contract with Blue Cross, then Blue Cross did not have to pay a patient's bill.

FLORIDA

Medicaid: No fund cuts.

Contracting: No. **Freedom of Choice:** Yes. Applies to Medicaid only.

Health Planning: Significant legislative changes made, including replacement of HSAs with local health councils; placing

CON responsibilities with the State Department of Health and Rehabilitative Services, and raising CON thresholds to federal levels. Eleven local health councils to be established under new law.

Comments: Legislation passed to allow the Florida Hospital Cost Containment Board to study third party reimbursement mechanisms and their effect on health care costs. Also, the Legislature established the Florida Task Force on Competition and Consumer Choices in Health Care to make a two-year study of the state's health care system. Rate regulation will be included in the study. Tort reform aimed at malpractice relief to be a major health goal in the 1983 Legislature.

GEORGIA

Medicaid: Program cut by $68 million, a decrease of 10.5 percent in the areas of eligibility and reimbursement.

Contracting: No. **Freedom of Choice:** No.

Health Planning: Two of state's seven HSAs terminated, and SHPDA conducting review process. CON regulations revised to eliminate from review: (1) capital expenditures of less than $150,000 which neither affect bed capacity nor change services; (2) expenditures for replacement of diagnostic or therapeutic equipment which is uneconomical to repair and/or technologically obsolete; (3) expenditures solely for repair of physical plant, and repair or replacement of equipment for physical plant.

Comments: Move under way to try to establish rate setting system. Georgia Hospital Association has adopted a position opposing hospital rate regulation as a solution to the increasing cost of hospital care.

Also, the Georgia Department of Human Resources has started a program of recognizing JCAH or AOA status of Georgia hospitals for license purposes. This Cooperative Hospital Survey Program will reduce the number of hospital surveys in that no additional departmental inspection of a previously licensed hospital will occur except in certain cases.

HAWAII

Medicaid: No cuts in program, but reductions are possible in areas of eligibility and benefits.

Contracting: The State Department of Social Services and Housing is investigating a number of reimbursement plans, including those which would call for negotiated rates to furnish services to DSSH beneficiaries. **Freedom of Choice:** Yes.

Health Planning: Thresholds raised to current federal levels.

Comments: Massive reapportionment to affect makeup of State Legislature. Future philosophy regarding health, other services may depend on outcome of 1982 elections.

IDAHO

Medicaid: Cuts planned, but impact not known.

Contracting: Not at present time, but possibility in the future. **Freedom of Choice:** No.

Health Planning: HSA phase-out. Thresholds raised to federal levels.

ILLINOIS

Medicaid: Fund cut of $46 million, a 7 percent decrease, by federal waiver, administrative plan change and legislative enactment in areas of benefits, eligibility and reimbursement. (Governor proposed $300 million in Medicaid cuts, but Legislature restored $185.5 million.)

Contracting: No. **Freedom of Choice:** Yes. Removal of restriction on ability of Blues and commercial health insurers to contract for alternative payment plans is likely, but nothing specific yet.

Health Planning: HSA phase-out. Thresholds raised to $[illegible]0,000 plus inflation for construction and modernization, and $400,000 for equipment.

Comments: Illinois rate review program abolished in one of the major legislative battles of the 1982 session.

INDIANA

Medicaid: No fund cuts.

Contracting: No. **Freedom of Choice:** Yes. No move made to remove this restriction on Blues or commercial health insurers to contract for alternative payment plans.

Health Planning: HSA phase-out, to single state planning authority. Thresholds raised to current federal levels.

IOWA

Medicaid: No decrease in total payments, but rate of increase will be less. Department of Social Services budgeted for a 10 percent increase in hospital payments in FY 1982-83. State Legislature mandated a 2½ percent reduction in hospital payments for three months prior to a prospective payment plan becoming effective October 1, 1982. Other professional providers received a 2½ percent cut in payments.

Contracting: No. **Freedom of Choice:** No.

Health Planning: One HSA has been phased out, and two others have reorganized. Legislature has passed a law to increase CON thresholds to federal levels.

Comments: The State Insurance Commissioner is reviewing Blue Cross reimbursement contract. Governor's Commission on Health Care is recommending a change in reimbursement methods.

KANSAS

Medicaid: The FY 1983 budget for Medicaid was $12 million higher than FY 1982. This is approximately a 6 percent increase in budget dollars, but due to high inflation, there is actually a decrease in buying power. Most reimbursement cuts in Medicaid program have been allowed by federal regulation.

Contracting: Program is being considered, possibly via a "primary care network" and/or contracting with certain hospitals for specific services (i.e., psychiatric, alcoholic treatment, etc.). However, no specific program has been developed. **Freedom of Choice:** Medicaid statute does not require "freedom of choice." The State Insurance Code does require, however, that, in an HMO agreement, the participant must be offered a dual choice.

Health Planning: HSA phase-out by 1983. CON and planning to phase out in 1983 unless Legislature extends them in next session.

Comments: A bill which would have implemented a state rate review program failed in the 1982 legislative session.

Several groups in the state have expressed interest in forming business coalitions.

KENTUCKY

Medicaid: Program funding cut by about 10 percent from expected hospital inpatient expenditures of $110 million for FY

'82. The State Medicaid Division has implemented a fixed ospective inpatient rate (gr ps of hospitals). Covered days ve been reduced from 21 to 14, and the number of recipient ductions is about 30,000 from a FY 1981 base of 328,000 cipients. Action taken through administrative plan changes.

Contracting: The Kentucky State Medicaid Division is in the ocess of implementing a "Citicare" plan, premised on a pitation basis of payment via physicians. It is a modification the HMO concept. Primary care physicians are eligible to rticipate. They are obligated to provide primary care and range for all other covered services such as hospital and ecialty care for each client enrolled in his/her practice. Effe- e October 1, 1982, all AFDC and AFDC-related Medicaid neficiaries will start the phasing in process to receive medical rvices under "Citicare." Other Medicaid beneficiaries will be nsidered for enrollment later. **Freedom of Choice:** Yes.

Health Planning: HSA phase-out. State CON and licensure has been amended to raise thresholds to federal levels. atutory references to HSAs and SHCC removed and replaced terms "local health planning agencies" and state health anning council, which will be responsible for developing a ate health plan.

Comments: Blue Cross/Blue Shield is implementing a "Fair yment Practices Program, which provides payment on a per- nt of charges basis. The minimum discount is 1½ percent. Also, the Kentucky Legislature approved three regulatory form laws affecting health during the 1982 session.

LOUISIANA

Medicaid: No program cuts.

Contracting: No (but Louisiana Hospital Association officials believe it is only a matter of time before such a program is undertaken). **Freedom of Choice:** Yes. No plans to remove restrictions on Blues or commercial health carriers to contract for alternative payment plans.

Health Planning: HSA phase-out. Single state planning authority established. Louisiana has never enacted state CON legislation. Reviews are conducted in accordance with Section 22.

Comments: Rate setting legislation has been discussed but has not been formally introduced.

MAINE

Medicaid: Program cut by $2.35 million, a 2.8 percent increase, by administrative plan change in areas of benefits and reimbursement.

Contracting: Prospective budgeting process anticipated — to be effected in conjunction with a mandatory budget review program. **Freedom of Choice:** Yes.

Health Planning: HSA phase-out. Single planning agency established. Thresholds changed to: $350,000, capital facilities; $400,000, major medical equipment; $125,000 and over a period of years to $145,000, new services.

Comments: Maine Hospital Association says that the state "would like very much" to put hospitals under a "cap" of its and "we will object."

MARYLAND

Medicaid: Funding cut by $25 million, a decrease of 5 percent by administrative plan change in area of reimbursement.

Contracting: No, but state is exploring various options.

Freedom of Choice: Yes.

Health Planning: No HSA phase-out. Thresholds raised to current federal levels. Legislation approved in 1982 to change the health planning structure and process. HSAs to be designated as local health planning agencies, and the State Health Resources Commission becomes the state health planning agency.

Comments: Other actions involving health care include: (1) establishment of a 20-day limit on inpatient stays; (2) initiation of preadmission review, and (c) identification of procedures that must be performed on an outpatient basis.

MASSACHUSETTS

Medicaid: Program funding cut $30 million by administrative plan change in areas of eligibility and reimbursement. Federal tightening of disability screening and a cut in AFDC eligibility have reduced the caseload of eligibles by about 30,000.

Contracting: The teaching hospitals of Boston — in combination with Boston's neighborhood health centers — have developed a "managed medical care system" that would essentially be a single entry and capitation approach to delivery of care to the AFDC caseload in Boston. The plan is still in the development phase. **Freedom of Choice:** Yes. The Massachusetts Hospital Association believes there would be an abridgement of "freedom of choice" if the "managed medical care" plan, as described, is implemented.

Health Planning: No HSA phase-out. State funding increased from "zero" to $300,000 a year to support HSAs. State raising thresholds to federal level.

Comments: Massachusetts has enacted into law a six-year plan under which hospitals will be paid prospectively for Medicare, Medicaid and Blue Cross services. The state is seeking a Medicare and Medicaid waiver. Under the plan, hospitals would be required to adhere to their budgets, which would be established according to cost definitions that government payers and insurers would honor. Hospitals would be allowed to keep excess funds if budget appropriations exceed costs. However, hospitals would have to absorb the loss if they exceed their budgets.

MICHIGAN

Medicaid: Funding cut $50 million, a decrease of 10 percent, through administrative plan change and legislative concurrence with executive order cuts, in areas of reimbursement primarily and eligibility.

Contracting: Yes. Primary physician-sponsored plan — limited to Wayne County (Detroit) — ties Medicaid beneficiaries to a specific physician who, for benefit purposes, must render all non-emergency care. This program is currently only an experiment. **Freedom of Choice:** Yes. Preferred provider contracting — a negotiated arrangement between the state and individual hospitals has been cited as an important option for future consideration.

Planning: HSA phase-out. No single state planning authority. Legislation introduced to raise thresholds for capital expenditures to $600,000 and annual operating expense thresholds to $125,000 for new services.

Comments: Significant executive order actions have been made to balance Michigan's budget (which is constitutionally required). For hospitals, this has meant significant changes in

in FY 1982-83. A new utilization review program for all inpatient hospital admissions under Medicaid is expected to save $16.8 in state funds. Other cuts involve nursing home reimbursement and the AFDC program.

Contracting: State Department of Public Welfare has been directed by the Legislature to develop a detailed plan for an optional alternative to cost-related reimbursement for medical assistance with the system for payment to hospitals to be based upon a negotiated all-inclusive capitation rate. Hospital Association of Pennsylvania says it will work closely with the DPW so that the system can be implemented by July 1, 1983. **Freedom of Choice:** Yes. (Medicaid) Also, HAP says, "We do not know of any state statute which would restrict the Blues or commercial health insurers' ability to contract for alternative payment plans."

Health Planning: One HSA (of nine) phased-out. No move for a single state planning authority. State's CON law allows an automatic "floating" of thresholds based on federal law.

Comments: Commercial insurance industry supported legislation in 1982 that would affect the discount given by hospitals to the Blues. Also, Blue Cross Plans in state have placed in some of their hospital contracts optional prospective reimbursement mechanisms. Also, governor has created a task force to study rising health costs.

RHODE ISLAND

Medicaid: Program funding cut by 2 percent.

Contracting: No. **Freedom of Choice:** No.

Health Planning: Rhode Island always a waiver state. No HSA.

Comments: The Legislature created a commission to study hospital capital expenditures and the impact of those expenditures on health care costs.

SOUTH CAROLINA

Medicaid: Program funding cut by $1.29 million, a decrease of 5 percent, by administrative plan change in the areas of benefits, eligibility and reimbursement. The South Carolina Hospital Association appealed the U.S. District Court denial of a request for a permanent injunction against Medicaid cutbacks in hospital services. Fourth Circuit U.S. Court of Appeals heard arguments in July, 1982.

Contracting: No. **Freedom of Choice:** No (not specifically).

Health Planning: No HSA phase-out. Single state planning authority proposed. Thresholds raised to current federal levels.

Comments: Rate setting proposed but not seriously considered by legislators.

SOUTH DAKOTA

Medicaid: Program funding reduced by legislative action.

Contracting: No. **Freedom of Choice:** Yes.

Health Planning: Thresholds raised to current federal levels.

TENNESSEE

Medicaid: State is restricting benefits and limiting the program growth.

Contracting: Yes. Enabling legislation has been passed for state flexibility as allowed by the Omnibus Reconciliation Act of 1981. **Freedom of Choice:** Yes. There is no known move to remove the restrictions on the Blues or commercial health insurers to contract for alternative payment plans. The Tennessee Hospital Association says that "we do expect some movement to eliminate freedom of choice on Medicaid, at least to a limited degree."

Health Planning: HSA phase-out. Establishment of single state planning authority. Legislature expected to raise thresholds in 1983.

Comments: Introduction of rate setting proposal "very possible" in the 1983 Legislature, according to the Tennessee Hospital Association.

TEXAS

Medicaid: No program cuts now, but possible reductions anticipated for FY 84-85 — possibly $80 million, an 8 percent decrease.

Contracting: Yes. The Texas Medicaid program is contracted through an insured arrangement through National Heritage Insurance Company, a wholly-owned subsidiary of Electronic Data Systems Corporation (EDS). **Freedom of Choice:** Yes. Effort made to remove restrictions on Blues and commercial health insurers to contract for alternative payment plans.

Health Planning: HSA phase-out. Thresholds raised to current federal levels. The state health planning law will be reviewed during the 1983 session of the Legislature.

Comments: The Texas Hospital Association says that since the Texas Legislature meets in regular session only every two years, the 1983 session will review many health care activities at the state level and, hopefully, future state programs will be more clearly defined at the conclusion of that session."

UTAH

Medicaid: No program cuts.

Contracting: Only with HMOs. **Freedom of Choice:** Yes. Also, efforts are being made to remove the restriction on Blues and commercial health insurers to contract for alternative payment plans. The Utah Hospital Association says a statutory change is needed for the latter, and the proposal will be ready for the 1983 Legislature.

Health Planning: HSA phase-out. Single state planning authority phasing-in. Thresholds raised to current federal levels.

VERMONT

Medicaid: Program cut by $1.5 million, a decrease of 7 percent, in the area of reimbursement.

Contracting: Yes. The Vermont Hospital Association says that there is some "serious talk about developing a primary care network of physicians for the Medicaid recipients." **Freedom of Choice:** Yes, but no effort being made to remove restriction on Blues or commercial health insurers to contract for alternative payment plan.

Health Planning: HSA phase-out. No move toward a single state planning authority. The Vermont Hospital Association says that the HSA is "phasing out due to a cut in federal funds — but was successful in obtaining some state funds that will only prolong the inevitable."

Comments: The Vermont Hospital Association notes: "(1) we have a budget review program with Blue Cross/Blue Shield that is going to be tightened up; (2) we are talking about a prospective payment plan for the Blues, and (3) the Department of Health would like a rate setting commission but we do not think it will fly in this state. Too much bureaucracy."

VIRGINIA

Medicaid: Program funding cut to $118 million, a decrease of percent, through federal waiver, administrative plan change d legislative enactment in the areas of benefits, eligibility and imbursement.

Contracting: No. **Freedom of Choice:** No.

Health Planning: Thresholds "generally comport" with eral level except that new services are reviewable irrespec- of threshold amounts, according to the Virginia Hospital sociation (VHA).

Comments: The VHA says that the existence of the Virginia alth Services Cost Review Commission "erases the continu- possibility of rate setting in Virginia."

WASHINGTON

Medicaid: Program funding cut by approximately $10 mil- percent decrease by federal waiver, administrative ing, and legislative enactment in the areas of benefits, ility, and reimbursement.

ntracting: No. Freedom of Choice: No.

alth Planning: HSA phase-out. Single state planning au- ity possible. Thresholds raised to current federal levels.

mments: The Washington State Hospital Association is administrative remedies to wage component limitation judicial remedy if necessary.

WEST VIRGINIA

dicaid: Program funding cut 15 percent in area of reim- sement. West Virginia Hospital Association complained that cut was "an illegal state government decision." The state ored the funds as of July 1, 1982.

Contracting: No. **Freedom of Choice:** Yes. Medicaid pro- m is considering plan.

Health Planning: HSA phase-out. Single state planning au- rity established. State hasn't raised threshold levels.

Comments: State rate setting proposal is made annually in islature, and it is expected to come up again in 1983.

Also, Blue Cross is establishing a payment denial on ission/care not deemed appropriate under its quality assur- ance review program.

WISCONSIN

Medicaid: Program funding cut. The Wisconsin Hospital Association (WHA) says that there will be an absolute dollar increase, but the percent of increase will be reduced significantly. The cut is by federal waiver, administrative plan change and legislative enactment in the areas of benefits, eligibility and reimbursement.

Contracting: No, but the WHA s that legislators are reviewing alternatives for revising Wi sin's Medicaid pro- am and "this could be one of the proposals considered." **Freedom of Choice:** Yes for Medicaid, and no for other health insurance policies. The WHA notes that the state recently received a waiver to contract with certain HMOs to provid health care services to certain Medicaid recipients.

Health Planning: HSA phase-out (two of seven HSA closed recently). An increase in the annual licensing fee has been proposed to increase state health planning revenue. Adjustment of CON thresholds has been postponed pendir the conclusion of a CON moratorium in the state.

Comments: More restrictive hospital rate setting legislation is "a distinct possibility," according to the WHA.

WYOMING

Medicaid: No program cuts. State plans to maintain previous levels, but if cuts become necessary, administrative reductions in eligibility appear to be the starting point, according to the Wyoming Hospital Association.

Contracting: No. **Freedom of Choice:** No. The Hospi l Association notes that there is a statutory provision agai st "discount" of charges made by a tax-supported (county or district) hospital, and the Blues are seeking to have it repealed.

Health Planning: HSA phase-out and single state planning authority. Wyoming is now out of CON compliance, but will probably retain CON "regardless," and raise limits to around ,000, according to the hospital association. The Wyoming nnium budget provides st te source revenue to continue inimal health planning and CON. □

AHS

ADVANCED HEALTH SYSTEMS, INC.

Some things never change . . .

Larrae Haydon, Administrator, 1948-1969
Raleigh Hills Sanitarium
Portland, Oregon
(Later, Raleigh Hills Treatment Center)

The scope of health care has changed dramatically over the last 40 years. Medical knowledge has increased hundred-fold encompassing techniques and procedures never dreamt possible.

But, there are some things in health care which never change. They are the compassion, understanding and caring of its people . . . the health care providers.

Years ago, when Larrae Haydon became administrator of the first Raleigh Hills treatment center for alcoholism in Portland, Oregon, its employees knew the facility existed only because of the dedication and concern of its founders. People like Larrae turned that concern into action.

(Raleigh Hills Hospitals, including its outpatient alcoholism treatment centers, is a wholly owned subsidiary of Advanced Health Systems, Inc.)

In the alcoholism treatment field, Larrae and his colleagues learned by doing. You see, not much knowledge was available about the disease of alcoholism is those days. Yet, a genuine desire to help patients overcome a life-threatening illness helped the treatment center prosper. And, some of the facility's patients can still attest to that fact after many successful years of sobriety.

In the 1940s, Larrae had to wear many hats. Not only was he the administrator, but he was also a counselor to the facility's patients. He did the paperwork, and probably much of the legwork.

Today, the health care profession draws a much finer line between the role of administrator and counselor. Administrators often have advance degrees in health care administration or business administration. They are sometimes financial wizards, overseeing many departments and solving many problems throughout the course of the day. Yet, in many cases, they still find time to be a friend and counselor to the patient.

The role of the counselor, too, is more specialized today. Counselors can play a vital role in guiding the patient to the treatment program best suited for him or her. Families often depend on the counselor for advice and direction in time of crisis. Sometimes, just as importantly, a counselor listens -- — lends an understanding ear to the problems a patient, or a spouse, may need to air.

Because knowledge in the health care field has increased, counselors can now draw on years of experience in the area of alcoholism. They have available numerous documented research studies and case histories from which to learn. Training programs are available and enable the counselor to become more proficient in every aspect of the job. In addition, alcoholism counselors are striving toward a process of credentialing, giving them increased credibility in the health care field.

We, at Advanced Health Systems, Inc., are proud to say that modern technology and academic learning have not gotten in the way of that genuine caring and concern our staff members have for their patients. No matter what tasks administrators and counselors are asked to carry out, they do so not only with utmost professionalism, but with the same dedication and commitment people like Larrae Haydon demonstrated in the early days of Raleigh Hills Hospitals.

People are the most important ingredient in the success of the services Advanced Health Systems provides . . . people who provide the service, and the people who receive it.

ADVANCED HEALTH SYSTEMS, INC., 17861 Cartwright Road, Irvine, California 92714

Governors, legislators boost leadership position of the states

By Austin Hogan
Assistant Director/State Government Relations
Federation of American Hospitals

The most significant political development of 1982 on the state health scene may be the clear emergence of the National Governors' Association (NGA) and the National Conference of State Legislatures (NCSL) as strong, active leadership organizations for state interests and concerns.

It is a development that could have potential dramatic impact on the organization, delivery and financing of health care throughout the nation.

Individual state stories have grabbed the spotlight. These include: decisive defeats for hospital rate setting in Illinois and West Virginia; innovative Medicaid experiments in Arizona and North Carolina; drastically revised state health planning systems in Florida and many other states, and statewide hospital contracting for California's multi-billion dollar Medi-Cal, Blue Cross and commercial health insurance programs. All of these have been covered in previous State Government Update columns in the *Review* this year.

However, the real state health story of 1982 — with crucial and determining nationwide influence on the shape of the hospital industry for years to come — appears to be a relatively quiet but far-reaching development on the political scene. For want of a better description, we shall call it — Son of New Federalism.

The Reagan proposal

Outlining what he termed as his Administration's "bold initiative," President Reagan called for a New Federalism in his 1982 State of the Union address to a joint session of Congress in January. This concept was based on returning a wide range of domestic responsibilities, programs and funding sources to the states — which, according to theory, were the closest level of government representation to the people, and, therefore, were in a much better position to know and respond appropriately to the needs of the local citizenry.

Upon more thorough examination and careful fiscal evaluation, however, some observers began to suggest that perhaps the New Federalism was, in fact, a return to the Articles of Confederation rather than the bulwark of fundamental principles enunciated by the nation's constitutional Founding Fathers.

Negotiating Impasse

After nearly six months of negotiating with a top-level White House team headed by Presidential Assistant Richard Williamson, Governor Richard Snelling (R-Vermont), the retiring NGA chairman, and State Senator Ross Doyen (R-Kansas), president of the Kansas State Senate and retiring NCSL president, reached this conclusion:

The Reagan Administration's version of New Federalism — plus the budget slashing propensities of OMB Director David Stockman and the adverse effect of a continuing economic recession on state revenues — would jeopardize the fiscal soundness of all future state budgets and threaten a wholesale shift of tax burdens from the federal to state level. This, of course, is never a happy prospect for any career-oriented state politician.

Medicaid is a key

The White House was unable to assure the NGA and NCSL negotiating teams of the President's agreement to a full federal assumption of financial responsibility for Medicaid and other so-called income maintenance and related food stamp programs as part of the proposed New Federalism program "swap."

So, at their annual meetings this summer, both national organizations adopted similar resolutions acknowledging the negotiating impasse with the White House on New Federalism. They expressed willingness to continue discussions while reaffirming historic NGA and NCSL principles on the federal government's primary responsibility for funding Medicaid and other income security programs.

Continued leadership

The new leaders of the two organizations — Governor Scott Matheson (D-Utah), NGA chairman, and Assemblyman William Passannante, Deputy Speaker of the New York State Assembly and NCSL president — are expected to continue their predecessors' active leadership roles as strong, articulate spokesmen for state interests and concerns.

Matheson already has appointed Snelling as "lead governor" to implement the NGA New Federalism Action Plan, which was adopted recently at the NGA's annual meeting in Oklahoma.

Meanwhile, NCSL President Passannante has appointed a high-level Congressional Liaison Team, composed of senior state legislative leaders — including Senate presidents and House speakers. The team has been directed to expand NCSL contact across-the-board and help coordinate a federalism agreement with the NGA, the White House and members of Congress. □

Hospital reimbursement controls: Will the states lead the way?

By Margo Vignola

Recent passage of the federal budget with no fundamental reform of retrospective reimbursement implies that the issue will remain in limbo for at least one additional year.

This occurred despite frenetic activity to accomplish a significant change. Warring factions managed to obliterate each other's proposal in the pell-mell rush to complete the 1983 federal budget.

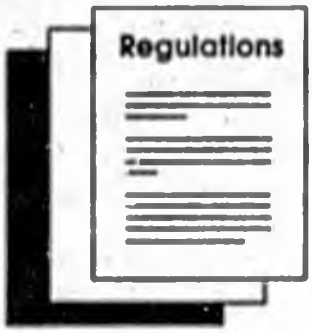
However, the pressure for reimbursement reform is not likely to diminish. The arena of debate may simply change as state governments attack their own budget problems.

One underlying tenet of the Reagan Administration is expanded responsibility for the states in numerous program areas currently under federal control. While many aspects of "new federalism" have failed to gain congressional approval, changes still have been made gradually — particularly regulatory controls in those programs where both federal and state government share a financial burden.

Most prominent among these changes is a fundamental restructuring of the Medicaid program, the states' largest overall commitment to health services. And it is these changes that could foster far more sweeping reform in Medicare, Blue Cross and commercial health insurance payments to hospitals.

In addition to modifications in the Medicaid program, the federal government has consistently fostered development of alternative methods of reimbursement through its various experimental authorities.

The Health Care Financing Administration (HCFA) and its organizational predecessors have long advocated change in hospital reimbursement and have financed countless projects to test alternative systems. It is this impetus that nurtured the development of most state rate review programs.



HCFA continues to provide financial support to several of the most prominent rate review programs currently under operation. While only a few states have seriously entertained rate review in the last few years, several key aspects of the health care cost debate may spark increased interest. Adoption of such programs by even a few states could lay the groundwork for expanded federal involvement, financing and, ultimately, widespread participation of Medicare.

Thus, these state programs may also provide the conduit through which more radical, systemwide changes may occur.

The Medicaid connection

Cost-related reimbursement of hospitals has been a feature of the Medicare program since its enactment in 1965, and, for the most part, the same is true of the Medicaid program as well. Until quite recently, most states simply mirrored Medicare's rate of hospital payment. Federal regulations had prescribed that states follow this or an alternative system approved by the Secretary of HHS. States desiring to use a different approach were required to obtain a waiver — a cumbersome process that discouraged many from applying.

Passage of the Omnibus Budget Reconciliation Act of 1981, however, altered this scenario considerably. Under terms adopted by Congress, states have been freed from the requirement of reasonable cost-related reimbursement — the Medicare system. States are now able to use any system which assures "the economic and efficient operation of hospitals," a deliberately nebulous standard of payment. The only other proviso is that some consideration must be made for hospitals with a disproportionate load of Medicaid patients.

Prospective rate programs

As a result of this significant change, many states have abandoned use of Medicare principles altogether. Those that had developed alternative systems under waiver authority were given additional authority to proceed.

Thus far, several states — including Alabama, Georgia, Mississippi and Missouri — have instituted fairly rigorous prospective payment systems for hospitals under Medicaid.

Editor's Note — Margo Vignola is director of governmental affairs and assistant vice president of American Medical International, Inc. (AMI). She is based in Washington, D.C. and is responsible for analyzing and researching federal and state health legislation and regulation. She is secretary of the Federation of American Hospitals (FAH) Provider Regulatory Committee.

While the form and structure of these programs vary significantly, they all share one common objective — reduction of overall Medicaid hospital expenses.

Most programs have constructed prospective rates using an initial base of Medicare allowable costs. Hospitals are then grouped and average rates developed. Based on this standard, adjusted in some cases by volume or other factors, rates of payment are developed. Hospitals exceeding the standard for their group are generally held to the average, regardless of actual costs.

Thus far, the federal government, as promised, has approved most alternative payment systems. Only one, a proposed 6 percent cap on payment in California, has been enjoined from implementation by the courts.

Other legal challenges to the new system have proven fruitless, however. It thus appears that, at least as far as Medicaid is concerned, these programs are likely to be maintained.

Restricting choice

In addition to changes in hospital reimbursement, some states are taking advantage of another newly available federal option. Under older Medicaid requirements, states had to guarantee beneficiaries freedom of provider choice. Under another provision of the 1981 budget act, however, states may restrict this freedom under certain instances.

The State of California has recently approved legislation which would basically restructure the entire program and entirely eliminate freedom of choice. Under the controversial provision enacted this year, the state will contract for all Medi-Cal services, presumably on a competitive pricing basis.

While details are not clear at this time, the change signals a radical departure from Medicaid's commitment to "mainstream" medicine — acknowledging that, while the program will pay for health care, it will also dictate the setting and provider. California's experience will provide a large-scale view of preferred provider arrangements which other states are sure to watch with interest.

The issue concerning most hospitals is the degree to which these systems are adopted by other payors. The Medicare program, in some instances, has piggybacked its payments to state-administered programs. However, this option has usually been adopted in states with rate review. As long as the reasonable cost-related basic standard exists, Medicare will only be able to use such systems on an experimental basis.

Historically, the program has been unwilling to follow what Medicaid dictates. However, depending on the degree to which savings are generated, Medicare's interest could be aroused enough to consider these kinds of alternatives.

The interest of commercial payors and Blue Cross has also been limited thus far. However concerns over cost-shifting — certainly exacerbated under these systems — may ultimately spur their interest as well.

In summary, Medicaid has rarely been the pacemaker in either health care delivery or payment mechanisms. The changing health care environment, however, may find these state initiatives becoming the forerunners of fundamental change.

State rate review

The most prominent, if not pervasive, form of state hospital cost containment is state rate setting. These programs generally review hospital rates or budgets on a prospective basis and may apply to all payors in a state.

Medicare participation, however, is limited to four states — Maryland, New Jersey, Washington and Connecticut. (Washington's situation is in a state of flux. New York State has also applied.) Such participation is made on an experimental basis, although the program frequently funds development operation and evaluation of rate review programs. Several others have evidenced interest in Medicare participation, although HCFA has been leery of newcomers thus far.

These legislatively-mandated programs essentially regulate hospitals as public utilities. In some states, institutions have managed to survive, whereas, in others, stringent controls have ultimately closed down facilities.

Numerous studies have attempted to evaluate the effectiveness of these programs but with little consensus on either the degree to which costs are restrained or the ultimate impact on service quality or availability.

Within the last three years, no state has adopted a rate review program, although attempts have been made in California, Michigan and West Virginia.

Four states — Colorado, Washington, Connecticut and Illinois — either have repealed or substantially altered existing programs. However, despite this apparent lack of interest in state programs, several factors may combine to make them more attractive. These include:

(1) Increasing fiscal pressures on Medicare and Medicaid.

(2) Increased availability of federal funds to assist states in developing programs.

(3) Congressional and Administration interest in state-controlled programs.

(4) Commitment of commercial insurers and, to a lesser extent, Blue Cross to expanded state rate review authority.

(5) Growing concern over cost-shifting which may ultimately interest the private sector in more rigorous controls on health service costs.

A state rate review program which mandates that all payors use the same rate of payment eliminates cost-shifting. Despite the increased financial liability of public payors under such a regime, some advocates believe that this is the only means of providing fair payment for services rendered.

The situation remains in flux and ultimately may depend on more radical reform of health care financing. At this juncture, however, rate review may become an increasingly attractive alternative — particularly if longer term reform measures continue to be forestalled.

State health initiatives in reimbursement, long overshadowed by the larger, less fragmented and more visible federal government, may ultimately lay the groundwork for massive change. It is to this arena that providers must turn. □

> "State health initiatives in reimbursement, long overshadowed by the larger, less fragmented and more visible federal government, may ultimately lay the groundwork for massive change."

New legislative changes may have effect on capital formation

By Walter J. Unger

Businessmen know that capital formation depends almost entirely on the prospect of future positive cash flows.

Less easily understood are the multiple ways in which government actions can alter these cash flows. For example, changes in government fiscal and monetary policies can influence future cash flows as can government regulation of capital markets and financial institutions. Moreover, government efforts to control the flow of capital into specific industries (such as those embodied in the National Health Planning and Resources Development Act of 1974, P.L. 93-641) can be important.

The objective of this article is to identify the effect of a few recent federal policy changes on hospitals' ability to meet future capital needs. Specifically, federal taxation, Medicare and Medicaid reimbursement and Certificate-of-Need (CON) controls on hospitals are examined.

Before embarking on this topic, three caveats should be considered.

1. In comparison to other industries, positive and stable cash flows have been relatively assured for hospitals, although significant changes are in the offing. Several factors account for this favorable condition. Extensive third party hospital insurance plans insulate consumers from the true cost of hospital services.

The advent of Medicare and Medicaid in 1965 assured payment for hospital services rendered to the old and the poor, thereby reducing hospital bad debts and charity care relative to total costs. The result is that demand for hospital services today is largely insensitive to fluctuations in prices

Review
News & Views

and incomes.

In addition, the demand for hospital services is likely to continue to increase due to an aging population and a growing number of diagnostic and therapeutic technologies. Furthermore, unlike other American industries, U.S. hospitals are largely insulated from foreign competition.

Beginning in the early 1970s, investors' recognition of these favorable economic factors contributed to opening private capital markets to hospitals. Today, these same factors give hospitals a strong ability to attract capital.

2. Hospital capital formation is more directly influenced today by private capital markets than by government policies. Federal grants, loans and loan guarantees (such as those provided under the Hill-Burton program from 1946 through 1978) no longer play a significant role in the capital development of most hospitals. Consequently, during the past decade, access to private capital markets became extremely important to nearly all types of hospitals — including investor-owned, tax-exempt and even government facilities.

Although private capital markets are influenced by government policies, they are more directly affected by the number, mix and dollar requirements of investors and sellers.

3. Predicting how the combination of federal taxes, subsidies and capital controls affect economic behavior is an inexact science. Reactions to changes in government rules are complex and defy analysis.

Federal taxation

The Economic Recovery Tax Act, adopted last year at President Reagan's request, contains a number of provisions that are important to hospital capital formation. First, by slashing individual and corporate taxes by an unprecedented $418 billion over three years and by giving strong incentives for increasing savings and investment, this historic measure sought to aid capital formation generally.

Investor-owned hospitals, like all tax-paying entities, benefit from the new Accelerated Cost Recovery System, which dramatically changes the system of tax depreciation and greatly aids effective capital formation. Improvements made in several investment tax credit provisions and origination of "safe-harbor leasing" are also helpful.

Tax-exempt hospitals,

Editor's Note — Walter J. Unger is an associate director of the Washington, D.C. office of the Healthcare Financial Management Association (HFMA). He also serves as a private management, marketing, financial and political advisor to hospitals, academic health centers and other health care organizations. Before joining HFMA in 1980, he was a special assistant to the president of the Institute of Medicine for nearly five years.

Unger

however, may have been somewhat negatively affected by the 1981 tax act. Although these hospitals do not pay federal taxes (except on unrelated business income), the interest rates that they pay on tax-exempt bond financings are partially influenced by the marginal tax rates of prospective bondholders.

Since the 1981 act reduced overall tax rates and provided new incentives to individuals to set aside funds in tax-sheltered pension arrangements, the tax-free status of interest income on tax-exempt investments diminished in value. Consequently, the cost of capital on new tax-exempt hospital bonds is increased, thereby reducing the financing advantages of this major capital formation vehicle.

In addition, lower tax rates may decrease taxpayers' incentives to make tax deductible charitable contributions to tax-exempt institutions. On the other hand, some tax-exempt hospitals may benefit in a small way from the new tax credits allowed for charitable donations by taxpayers who do not itemize deductions.

The Tax Equity and Fiscal Responsibility Act, as adopted by Senate and House conferees on August 15, 1982, would increase the tax burden on individuals and especially businesses by $98 billion over the next three years. If enacted into law, these tax increases would eliminate about one-fourth of last year's tax cuts. For all hospitals, collectively, this tax increase would have a slightly negative impact on capital formation.

The Senate tax bill also would restrict deductions for medical expenses to 5 percent of adjusted gross income rather than 3 percent, and would repeal the current deduction for half of health insurance premiums up to $150. This could have a moderate dampening effect on the demand for medical services. Furthermore, the Senate bill would place a number of restrictions on tax-exempt bonds including registration and reporting requirements. In addition, industrial development bonds (especially used by some investor-owned hospital chains) would require a public hearing and approval by an elected official or legislature. These restrictions would negatively affect capital growth for all hospitals that use these devices.

Federal reimbursement

Limits on Medicare and Medicaid outlays were necessitated by President Reagan's overall budget objectives. Since the President sought to simultaneously slow the growth of federal outlays, reduce taxes, eliminate deficits and shift budget priorities in favor of increased defense spending, nearly all domestic spending programs had to be curtailed. Inasmuch as Medicare and Medicaid account for 9 percent of the total federal budget and were increasing at the rate of 20 percent per year, they were certainly vulnerable to budget pruning.

After much debate, Congress ap-

proved cuts in Medicare payments to hospitals, caps on federal matching payments to states under the Medicaid program — and created four large block grants which transferred 20 health and social services categorical programs to state and local governments.

These changes are viewed by some as a major watershed event that will fundamentally alter the alignment of health care responsibilities and the availability of health care resources. However, in the short run, most hospitals adapted fairly easily to these payment changes without any noticeable adverse effect on their prospects for capital growth. This result occurred because hospitals anticipated these changes, planned and budgeted for them, and found ways to shift part of the Medicare and Medicaid shortfall onto other payers. Moreover, operating margins on services provided to Medicare and Medicaid beneficiaries tend to be significantly less than on services provided to other patients.

Thus, even though these two programs represent about 40 percent of a typical hospital's total revenues, they contribute very little, if anything, to the bottom line. In the long run, hospitals with large Medicare and Medicaid patient volumes would be affected adversely by further cuts in these programs.

So long as Medicare and Medicaid continue to pay for hospital services using a retrospective cost-based methodology without limits or large contractual adjustments, hospital investors and lenders are reasonably assured of positive and stable cash flows. Under the present system, interest and depreciation expense are recognized to be allowable costs by the Medicare program. Moreover, capital and certain other types of costs so far are exempt from Section 223 limits. Although there has been considerable discussion within the hospital field about potential adverse effects of future Medicare Section 223 limits on routine hospital costs, so far these limits have had relatively little effect on capital formation.

On the other hand, because Medicare recognizes depreciation based on historical costs, inadequate depreciation reserves are created during inflationary periods. In addition, Medicare does not recognize a return on equity for tax-exempt hospitals. For investor-owned hospitals, where return on equity is allowed, the return is inadequate when compared to returns obtained by other industries. The net result of these and other provisions is that Medicare does not pay hospitals their full financial requirements for serving government beneficiaries.

As mentioned earlier, major changes are in the offing. The Medicaid statute was significantly revised by the 1981 Omnibus Reconciliation Act to allow states greater flexibility in determining (a) payment rates to providers, (b) the types of services provided and groups eligible for Medicaid, and (c) when access to providers can be limited (i.e., restrictions on "freedom of choice").

Utilizing this new flexibility, the State of California, for example, recently enacted legislation that creates a state "czar" who is expected to contract selectively with hospitals for the provision of inpatient Medicaid services. These new arrangements could adversely affect fu-

ture capital formation for hospitals that fail to obtain such contracts. On the other hand, hospitals with low Medicaid volumes might improve their capital positions by not participating in the program. It is still too early to predict the full ramifications of the new latitude of action available to states.

An even greater unknown is what impact there will be on capital formation of prospectively determined rates as now authorized under the Medicaid program and as considered in the 1982 budget measure for future adoption by the Medicare program. Clearly, any prospective payment system would tend to provide fewer assurances for investors and lenders than presently exist.

Capital requirements along with operating costs and margins may have to be met from a single predetermined fixed budget. Still it is too early to predict whether a movement away from retrospective payments based on defined costs will be a positive or a negative factor on hospital capital formation.

Health planning

In an attempt to moderate medical costs increases, the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) required all states to adopt Certificate-of-Need (CON) laws by January, 1980. These CON laws were intended to control the allocation of capital resources to hospitals and nursing homes by requiring that state agencies review and approve changes in bed capacity and major equipment purchases.

Initially, states were required to review any new capital expenditure of $150,000 or more, of the purchase of any major medical equipment of $150,000 or more, or the start of any new institutional health services whose annual operating costs equaled $75,000 or more. The 1981 Omnibus Reconciliation Act changed these thresholds to $600,000, $400,000 and $250,000 respectively. In making these changes, the congressional intent was to focus the resources available for CON reviews on the most expensive and future cost-generating new investments in medical care.

More recently, the Committee on Energy and Commerce of the House of Representatives agreed to further liberalize these thresholds. The committee's proposal would permit states to increase these threshold limits to $5 million, $5 million and $1 million, respectively. However, if a state certifies to the Secretary of Health and Human Services (HHS) that it can effectively administer a CON program with lower thresholds, then it could as well reduce these limits to not less than $1 million, $1 million and $500,000, respectively.

On the Senate side, a "health planning deregulation" bill endorsed by four Republicans on the Committee on Labor and Human Resources would eliminate federal CON thresholds altogether and would prohibit states' use of federal funds for CON review programs. Even in the absence of federal requirements, most states are expected to keep their CON programs.

For those who believe that CON programs were never really effective in altering hospital capital investment decisions, the liberalization or disappearance of CON thresholds might logically be viewed as having little effect either. For those who thought that these programs had an effect, they should expect some increased compensatory capital spending although this is likely to be limited by current fiscal and capital market realities.

Nevertheless, it seems likely that CON programs did alter hospital capital investment and financing decisions in ways that are difficult to prove or measure.

First, the CON programs provided investors and lenders with some comfort in knowing that existing hospital providers would enjoy some protection from new market entrants and expansions by competing providers.

Second, the CON programs may have led to some redistributions of capital from regulated investments to those that fell below the thresholds.

Third, the CON laws caused many investor-owned hospital chains to shift their expansion plans from new construction to acquisition.

Fourth, like taxi medallions, the certificates awarded to hospitals became valuable themselves and often provided their owners with large premiums in the sale of those assets.

Fifth, the CON programs added a certain economic — if not political — discipline to hospital managers' thinking about capital expansions that was not as readily apparent prior to 1974.

Thus, the changes in health planning laws that are currently being contemplated would moderate (and possibly eliminate) the "franchise effect" for existing providers. For inefficient providers who counted on this protection from competing entities, the prospects for capital growth might be dim. On the other hand, efficient providers who have firm market niches should have a very promising future.

"Institutions that are inefficiently managed and unable to increase their market share are likely to face substantial difficulties in preserving the real value of their capital and in meeting their future capital needs."

New economic environment

Medicare, Medicaid and other payers are adopting more restrictive rules for paying hospitals. The new economic environment will emphasize incentives for operating efficiencies. Under this new system, managers will have greater latitude of movement than under the old rules, but they also will face greater business risks. Consequently, in the new environment, the quality of management skills will make a difference.

Institutions that are inefficiently managed and unable to increase their market share are likely to face substantial difficulties in preserving the real value of their capital and in meeting their future capital needs. Thus, the ability to generate positive and stable cash flows will increasingly depend on management excellence in cost control and ability to increase market share. Access to capital — and ultimately survival — are at stake. □

New drug purchasing plan cuts costs, provides incentives

By Anne Mullendore
Corporate Director of Purchasing
Charter Medical Corporation

Like other providers of hospital services, Charter Medical Corporation of Macon, Georgia, has adopted a new arrangement for purchasing pharmaceuticals that not only reduces the company's total drug costs but also provides incentives and benefits to the other two parties in the purchase transaction — manufacturers and wholesalers.

The key to the system is that it allows the hospital, in effect, to shift certain significant "hidden" costs to the pharmaceutical wholesaler. Thus, under this system, prices may be higher, but total costs are significantly lower.

Perhaps the best way to describe the new system is to contrast it with the way that Charter Medical formerly purchased pharmaceuticals for the nearly 40 psychiatric, addictive disease, general acute care and specialty surgical hospitals it owns and operates in the continental United States. (Neither arrangement applies to the hospitals that the company owns or manages in London, England, Puerto Rico and Saudi Arabia.

Under the previous system, Charter Medical would negotiate a contract with a manufacturer to purchase pharmaceutical products at a specific price for a specific length of time, usually from 12 to 24 months. Under the master contract that the corporation had with the manufacturer, each Charter Medical hospital was authorized to buy directly from the manufacturer. By buying direct, the hospital received the lower contract price. However, under this system, each individual facility absorbed a surprising number of "hidden" costs which inflated the real total cost of purchasing direct from the manufacturer.

The major hidden costs involved under Charter Medical's former pharmaceuticals purchasing were:

Order Processing: Processing a single purchase order can cost between $25 and $50. A hospital buying pharmaceutical products directly from a manufacturer may process as many as 15 to 25 purchase orders a week.

Delivery Time: Direct pharmaceutical orders may take up to 14 days to be delivered. Ten days is not unusual. Long delivery schedules require a pharmacy to carry a "long" inventory — up to 30 days' supply for some products — to avoid stock-outs. This reduces inventory turn and increases interest costs associated with carrying higher inventories.

Storage: When inventories are larger than necessary for efficient, quality patient care, it creates storage problems for many hospitals. Additional space is hard to come by in many facilities. Even when it is available, it is costly.

Receiving: When hospitals buy directly from manufacturers, it increases the workload of the receiving department, which has to handle and check in a number of small, individual orders.

Remittance: When manufacturers' bills come due, the hospitals must generate and mail several checks and maintain several individual files.

Returned Goods: Additional costs accrue when hospitals must return goods to the manufacturer. Pharmacy personnel have to pack and ship returned goods to each individual vendor. That not only takes valuable time, but also the hospital usually has to absorb the shipping or postage costs. Then, of course, there is additional administrative work required to assure that the credit was received and properly recorded.

These hidden costs help explain the statement — The price may be lower, but the cost is higher. By contrast, Charter Medical's wholesaler/hospital chargeback program may mean the company incurs higher prices relative to our old system, but we are convinced that our total costs have been reduced significantly.

Negotiating Individually

Under our new program, we negotiate individual contracts with different manufacturers for certain pharmaceutical products at a specific price for a specific length of time. This much is the same. For example, under the old program, if we received a contract price of $40 per bottle, it still would be


Mullendore

Editor's Note — Anne Mullendore, corporate director of purchasing for Charter Medical Corporation, has been associated with the company since 1971. She directs various purchasing activities for Charter in the United States, Puerto Rico and Saudi Arabia. She is a member of the Marketing Committee of the Federation of American Hospitals (FAH).

$40 per bottle under the new program.

The difference is that the manufacturer now gives each hospital an alternative: You can buy direct from us at $40 per bottle, or you can buy from your wholesaler at $40 per bottle, plus a mutually agreed upon service charge. This charge usually is between 3 percent and 5 percent, depending on the volume of purchases that the hospital makes. Therefore, if the service charge were 4 percent, the invoice price of the bottle of medication would be $41.60 under the new program instead of $40 under the former system.

Say that one of Charter Medical's hospitals buys $25,000 of various pharmaceuticals per month — and that this level of purchase means the wholesaler assesses a 5 percent service charge. Our hospital would end up paying $26,250, or $1,250 more than if the facility had purchased the same drugs directly from the different manufacturers.

However, closer analysis indicates that the additional $1,250 is more than offset by eliminating hidden costs. Here is why:

- ☐ All the hospital needs is one monthly purchase order.
- ☐ The hospital needs to cut only one monthly check.
- ☐ The pharmacy inventory is sharply reduced, freeing working capital and reducing interest costs as inventory turns more productively.
- ☐ Storage space requirements are reduced.
- ☐ Delivery time is shortened.

Returned goods are picked up and credited immediately without the loss of time and without shipping charges. This is particularly advantageous in the case of drugs that are seldom used.

All these factors more than offset the additional $1,250 service charge by the wholesaler. (In fact, service charges may not be as high as 5 percent — which would mean even greater savings.)

In a nutshell, once a contract is signed, the manufacturer says to the hospital: You may buy direct from us at $40, or you may buy from the wholesaler of your choice at $40, plus his service charge.

If the hospital selects the wholesaler option, the manufacturer authorizes the wholesaler to charge the hospital $40, even if he has to pay the manufacturer $50. (In the latter case, at the end of the month, the manufacturer would credit the wholesaler $10 for each unit that the wholesaler delivered to the hospital under contract because the contract normally would carry at least a one-year price protection for the hospital.)

In this three-party arrangement, hospitals should be sure that the wholesaler meets certain conditions prior to contracting with him. The wholesaler or distributor:

- ☐ Must have a comprehensive system for order entry and inventory control.
- ☐ Must offer emergency service or immediate delivery of drugs that unexpectedly are depleted or which are prescribed or ordered only infrequently.

Chief Pharmacist Ken Mitchell of Charter Medical Corporation's Middle Georgia Hospital at Macon checks pharmacy supplies in the hospital's pharmacy.

- ☐ Must have a formal bid purchasing mechanism.
- ☐ Must be willing to participate in a partnership arrangement, including sharing responsibility for inventory control with the hospital pharmacy.

It goes without saying that the hospital pharmacy must make a commitment to the contract and must support the hospital's half of the arrangement.

Additional benefits

There are some important additional benefits of purchasing through drug wholesalers. For example:

- ☐ Less storage space is required, not only because inventory levels generally are more efficient under this system, but also because the hospital can receive orders daily rather than once a week or less frequently. This feature is in addition to emergency deliveries.
- ☐ Our contract with the wholesaler includes participation in any volume or promotional discounts which the manufacturer makes available. These special price reductions are over and above the regular cost-plus arrangement.
- ☐ The single vendor concept of purchasing means fewer purchase orders are issued and processed, further reducing inventory costs. Under the previous method, most of Charter Medical's hospitals purchased some of their drugs directly from manufacturers and some from wholesalers. This meant that they generally carried a higher level of inventory than was required for efficient operation because of minimum shipping terms, and it required more purchase orders to be issued and more checks to be processed.
- ☐ The use of the wholesaler's computer encourages efficient inventory control in the hospital pharmacy. The wholesaler furnishes pre-printed price stickers, visual inventory control reports and accurate cost data for patient charges.

We expect our wholesaler to provide monthly drug enforcement reports to our hospitals and to keep track of the movement of pharmaceuticals by class. The wholesaler also furnishes a monthly purchase report — with all products purchased during the period listed alphabetically by manufacturer. This report includes suggested optimum inventory levels based on computerized analysis of factors, including past usage and price.

In addition, the hospital pharmacist receives a current price catalog, showing product availability, price changes, new and discontinued drugs, and other details.

It is important to Charter Medical's hospital medical staffs and pharmacists to have a selection of manufacturers' products from which to make a choice. We expect our contract wholesaler to handle all brands required. In addition, many drug manufacturers sell only through wholesalers. By having a prime vendor agreement with a particular wholesaler, some of these products can be purchased at discount.

When Charter Medical instituted this wholesaler/hospital charge-back program, one of the measurable goals that we set was to increase average inventory turn to 10 times per year within a fairly short time. Although we are still very early in our experience with the new program, preliminary indications are that this is a realistic objective — and that cost savings will be significant. ☐

Hospital reorganization: Putting all of the major pieces together

By Richard A. Blacker

Editor's Note — This is the final article in a three-part series on hospital reorganization. The preceding articles discussed the potential advantages of reorganization and the process by which the optimum structure for an institution can be determined. This last installment describes the steps necessary to bring about the reorganization itself.

Reorganization task force

The most important step in the implementation process is the creation of an appropriate task force at the institution. The task force has several functions — the most important of which is to aid in designing the new structure. To do this, the task force must identify the goals of the institution, including all endeavors which might be pursued in the future.

Significant problems confronting the institution also must be determined so that the reorganization can focus on resolving these as well.

The task force also serves as a sounding board for the advisors chosen by the hospital to guide it through the reorganization process in order that the alternatives presented by these professionals can be rationalized with the desires, philosophy and limitations of the institution.

A third function of the task force is to familiarize divergent interests within the facility with the reorganization itself in order to solicit their cooperation and allay any fears that might arise. Varying approaches are required to carry out this process with the governing board, medical staff and employees. Moreover, the best approach to take with each such group will vary from institution to institution. If properly constituted, the reorganization task force will be the best forum in which to determine the timing and focus of discussions with each of these groups.

The task force normally should include representatives of the governing board, administration and medical staff. In the case of religious institutions, it is essential that members of the sponsoring body also serve on the task force.

Task force members must have a concerned interest in pursuing their assigned tasks and should be objective regarding the concept of reorganization and alternative approaches.

These individuals should be aware that they are embarking on an effort which will require approximately one year to consummate — and should be committed to the project through its completion. Although the total time required for this effort may not be great, it is important that each individual be available for all, or nearly all meetings of the group. For maximum efficiency, it is preferable that the task force not exceed approximately 10 persons.

Designing the structure

Although it is possible to design and implement a reorganization with minimal input from the institution, no professional can do his or her best work in such a vacuum. Rather, the optimum design of the new structure depends on the task force giving the hospital's advisors the best possible information as to the future directions of the facility.

The advisors themselves must ascertain the relevant factual data regarding the organization and its operations. This requires review of established programs, contractual arrangements, deeds, leases, financial documents and the like. This process should generate a complete list of the activities which must be accommodated in the new structure and also is intended to reveal the legal and practical issues which need to be resolved in the reorganization process.

The design of the new structure will be based upon an amalgamation of the goals established by the task force and the legal and practical restraints determined by the advisors.

In almost any institution, however, several potential organizational models will be identified. It is a further function of the task force, therefore, to aid in narrowing the number of alternatives by determining those which are best suited to the particular facility. At that point, the task force has at least two choices. (1) It may present several of the better models to the governing board for final selection, with or without a recommendation, or (2) the task force itself may select that which it believes to be the optimum new structure and present that single model for approval.

The author

Richard A. Blacker is a principal in the Los Angeles law firm of Weissburg & Aronson, Inc., which acts as counsel to the Federation of American Hospitals (FAH). (The information reported in this article is not intended to be legal advice and should not be used to resolve legal problems. For legal advice, a health care institution should consult its attorney.)

Implementation process

The implementation phase includes establishing the new corporate entities, securing all necessary approvals and the actual initiation of activities under the new structure. Creation of the new corporations must be accomplished early in the process because many of the necessary approvals must be sought by the new corporate entities themselves, and hence this phase cannot begin until these corporations have been formed.

The corporate formation process requires the filing of charter documents with appropriate state authorities and holding at least one meeting of the board of directors of each new entity at which bylaws are officially adopted and corporate officers are appointed and authorized to seek the necessary approvals. After these initial meetings, the new corporations normally will remain dormant during the approval process — a period of several months.

The required consents fall into three basic categories. The first constitutes internal approvals such as the authorization of the reorganization itself by the governing body of the institution. Depending on the existing legal structure, approval also may be required by "members" of this corporation. If other corporations also exist, such as a separately incorporated foundation, the approval of the boards of directors and members of these entities also may be necessary.

The second group of approvals may be characterized as "governmental approvals." These will vary from state to state. The transfers of assets required for implementation of the reorganization, for example, may require the approval of local Certificate-of-Need (CON) or "1122" authorities — or at least prior notice to those agencies. Similar approval or notice procedures may be required by the state rate setting agency.

Necessary approvals also will vary, depending on the exact new corporate structure chosen. The hospital itself may continue to be operated by the existing corporation, or its operations may be transferred to a newly-formed entity. In the latter case, relicensing the hospital in the name of the new entity may be required, and recertification under the Medicare and Medicaid programs also may be necessary.

Non-profit institutions will require additional approvals. It is always prudent to seek the consent of the Internal Revenue Service (IRS) by requesting rulings that the newly-formed entities are entitled to tax-exempt status — that the reorganization does not jeopardize the exempt status of the existing non-profit entities — that no taxation will result from the reorganization under the "unrelated business income" doctrine, etc. Similar rulings usually should be sought from state taxing authorities.

It is prudent as well for voluntary hospitals to seek consent to the reorganization from the state attorney general or other state agency charged with oversight responsibility for charitable institutions.

It should be emphasized that, in most cases, little difficulty should be anticipated in obtaining all of the above consents. Nonetheless, the approval process must be initiated as soon as all necessary information has been assembled — and must be diligently pursued.

The final group of approvals requisite to full implementation of the reorganization may be denominated "private" approvals. These constitute approval rights which the institution has voluntarily established. Such rights are found, for example, in documents associated with public bond offerings. The documents associated with such offerings typically contain restrictions on transfers of hospital property and operations and may require the prior approval of the trustee, execution of a supplemental trust indenture — or even, in a few cases, the consent of the bondholders.

Consent requirements also may be found in other debt instruments, such as accounts receivable financing, and in equipment leases, operating contracts, etc. These consents are usually less difficult to obtain than those under public bond offerings.

A period of several months is required to obtain the approvals. These are all sought concurrently, and the other necessary preparations for consummation of the reorganization are carried out during this same period. These preparations include applications for new licenses, drafting amendments to existing contracts, establishing books of account for the new entities, etc.

Once that the above preparations have been made, and approvals have been received, the implementation itself is usually carried out on a single day rather than in phases. That is, a "closing" date is selected, preparations are made for implementation as of that time, and all

transfers of activities and assets are carried out on that date.

The implementation steps are carried out by the hospital administration and the professional advisors without disruption of normal activities. Some new procedures will be required after the closing, however, such as holding multiple board meetings rather than the single meeting to which the board may have been accustomed. The duties of professional advisors should extend through a transition period to ensure that all new procedures are well understood and, in fact, are implemented.

If the reorganization is properly designed and implemented, there is little, if any, downside risk incurred by the institution. The costs involved, although significant, are non-recurring and are normally offset by operational economies. Reorganization is not a panacea, and it is not appropriate for all facilities. It is, however, the only way in which a hospital can create the flexibility which is essential to coping with the coming changes in health care while achieving the specific benefits discussed in the first article of this series.

Simply stated, it is essential that every institution determine whether it has given sufficient attention to making its legal structure as modern and appropriate to its needs as its management structure, long-range planning and physical facilities. □

Court decisions expand industry's antitrust exposure

By J. Mark Waxman

In four recent decisions, the United States Supreme Court has continued to expand the exposure of the health care industry to the application of the antitrust laws.[1]

In potentially the most far-reaching of these decisions, the Supreme Court, in a 4-3 decision on June 18, 1982, rejected the argument that the health industry should not be subject to stringent per se antitrust rules.

The court held that agreements among physician members of foundations for medical care to accept no more than agreed upon maximum fees in full payment for medical services rendered to policy holders of specified insurance plans were per se violations of the antitrust laws.

At issue before the court was the activity of two foundations for medical care organized by local medical societies. The foundations' key function was to secure agreements among member physicians to a maximum price schedule for specific medical services. Once a fee schedule had been adopted, the foundations invited private insurance companies to participate by offering medical insurance policies based upon the maximum fee schedule.

An insured under the foundation-sponsored plan was free to seek treatment from any physician. However, the insurers provided full reimbursement to the insured if the billing physician was a foundation member. If the insured chose a physician who was not a foundation member — and the bill exceeded the foundation's maximum fee schedule — the insured was liable for the excess.

In finding this arrangement violated antitrust prohibitions, the court reaffirmed earlier rulings that: (1) agreements among competitors to fix maximum prices are as unlawful as agreements to establish minimum or uniform prices, and (2) professionals, and in particular physicians, are as subject as non-professionals to the application of stringent antitrust rules where prices are involved.

The court rejected the argument of foundation physicians that, because the courts have little experience in analyzing the economics of the health care sector, a more thorough analysis should be undertaken before finding the agreements unlawful on their face. Moreover, the court was unwilling to inquire into the alleged pro-competitive, efficiency-producing and cost-reducing effects of the agreements.

A Review

UPDATE

In reaching its determination, it is noteworthy that the court stated: (1) neither the peer review nor administrative functions of the foundations were being challenged, (2) the physicians did not claim that the quality of the professional services rendered was an issue, (3) there may be professional activities that would be treated differently if they were premised upon public service or ethical norms, and (4) the foundations involved were "not analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risk or loss as well as the opportunities for profit . . . If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper."[2]

While it is premature to determine the full reach of the court's decision in *Maricopa*, the decision implies that the following activities also would be viewed as per se violations of the antitrust laws, and, correspondingly, a defense that these activities were based upon a desire for cost containment or other pre-competitive results would not be valid:

(1) Agreements among competing health care providers to set maximum, minimum or ranges of prices to be charged patients or third party payors.

(2) Agreements among health care providers to allocate geographic territories in which they will service patients.

(3) Agreements, absent government approval, among providers to allocate kinds of services offered to patients.

(4) Agreements among providers to refuse to deal with HMOs, ambulatory care centers or other new entrants in the health care industry.

On June 21, 1982, the Supreme Court followed its decision in *Maricopa* with *Blue Shield of Virginia v. McCready*.[3] In this 5-4 decision, the court held that health care plan subscribers who incurred

costs for services rendered by clinical psychologists had standing to pursue an antitrust claim where Blue Shield would only reimburse for those services if rendered by a psychiatrist or billed by a treating physician.

The Supreme Court held that the ability to pursue such antitrust claims was not limited to competitors directly injured by the anticompetitive scheme. The court noted: "The injury (the patient) suffered was inextricably intertwined with the injury conspirators sought to inflict on psychologists and the psychotherapy market."

The *McCready* decision expands the ability of health insurance plan subscribers to file private antitrust suits attacking alleged anticompetitive practices. Health care consumers and employers funding employee health plans, who believe that their health care costs have been driven up by alleged anticompetitive practices, now may find the courts more receptive to antitrust challenges.

On June 28, 1982, the court decision *Union Labor Life Insurance Company v. Pireno*.[4] At issue in *Pireno* was whether the use of peer review committees to determine insurance company liability to pay "reasonable" charges for "necessary" medical care and services was an activity which was the "business of insurance" within the meaning of the McCarran-Ferguson Act, and, there, exempt from antitrust scrutiny.[5]

The Supreme Court held that the functions of a peer review committee, in advising an insurance company regarding the necessity and reasonableness of particular treatments and fees, were not the business of insurance because:

(1) The practice did not have the effect of transferring or spreading a policyholder's risk.

(2) The practice was not an integral part of the policy relationship between the insurer and the insured.

(3) The practice was not limited to entities within the insurance industry.

While both the majority and the dissent agreed that the claims adjustment process was an integral part of the insurer-insured relationship, the majority felt that the peer review process under scrutiny was not a part of the claims adjustment process because the findings of the committee were not binding.

The effect of the *Pireno* decision is uncertain. Antitrust claimants attacking peer review procedures still will be required to prove an antitrust violation to be successful. As the dissent points out, however, the real problem is that the decision may vastly curtail peer review simply because professionals and those companies employing professionals to perform peer review may not wish to expose themselves to potential antitrust suits as the result of the peer review process.

Finally, in a 4-4 decision, the Supreme Court, in *American Medical Association v. Federal Trade Commission*[6], affirmed Federal Trade Commission (FTC) jurisdiction over professional associations, and the determination of the FTC that the American Medical Association activities, through the issuance of ethical opinions restraining advertising, solicitation, contract practices by physicians and certain types of contractual arrangements between physicians and non-physicians, were unreasonable trade restraints.

While the FTC's jurisdiction over the professions is currently under attack in Congress, affirmance of the FTC findings may lead to an increase in competitive activity by physicians and other health care professionals.

Footnotes

[1]Prior decisions removing traditional barriers to antitrust enforcement in health care section include **Hospital Building Co. v. Trustees of Rex Hospital**, 425 U.S. 738 (1976); **Group Life and Health Insurance v. Royal Drug Company**, 440 U.S. 205 (1979); and **National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City**, ____ U.S. ____, 101 S.Ct. 2415 (1981); see generally Removal of Traditional Barriers Exposes Health Care Industry to Antitrust Barrage in the May/June 1981 issue of the *Review*.

[2]Slip Opinion, at 22.

[3]Docket No. 81-225 (June 21, 1982).

[4]Docket No. 81-389 (June 28, 1982). The decision was a 6-3 determination.

[5]A discussion of the McCarran-Ferguson exemption is contained in the July/August 1981 issue of the *Review* at pages 42-44.

[6]CCH Trade Reg. Rptr. ¶ 64,616 (March 23, 1982).

The author

J. Mark Waxman is a principal in the Los Angeles law firm of Weinberg & Aronson, which acts as counsel to the Federation of American Hospitals (FAH).


The Best

Picker International now offers the ultimate achievement in CT technology. The Synerview™ 1200SX.

To you, this is important.

Computed tomography has literally opened up new windows in diagnostic imaging. To use CT successfully you *must* have the best system.

The creation of the new Synerview™ 1200SX System marks the dawning of an exciting new era in the development of imaging electronics.

Incorporating the medical industry's most sophisticated technology with an advanced computer and electronics systems, the 1200SX is a scanner of unparalleled clinical versatility and performance.

The 1200SX scans faster and better than any other system in both routine and advanced applications.

We'd like to show you the performance and cost effective capability of this new system. Please write Picker International, Inc., 595 Miner Road, Cleveland, OH 44143; Telephone 216/ 449-3000 or Telex 980 526.

PICKER INTERNATIONAL

HMMS buys AMI's management group

Hyatt Medical Management Services, Inc. of Encino, California, the U.S. hospital management contract subsidiary of American Medical International, Inc. (AMI) of Beverly Hills, California, has been sold to HMMS Health Services, Inc.

The sale was announced jointly by Walter L. Weisman, AMI president, and Maurice Lewitt, HMMS board chairman.

Hyatt Medical Management Services was acquired by AMI in September, 1980, as part of its purchase of Hyatt Medical Enterprises from the Hyatt Corporation. Prior to this, AMI was not involved in managing hospitals in the U.S. for other owners. Company officials said that AMI would continue to own and operate the acute care hospitals and other health service divisions that it acquired two years ago. Also, the transaction does not affect AMI's continuing or future international management contract operations.

The newly-formed HMMS is headed by Lewitt and Marvin Strin, the senior officers of both Hyatt Medical Enterprises and the AMI subsidiary, Hyatt Medical Management Services. □

Howard appointed

Samuel H. Howard, vice president and treasurer of Hospital Corporation of America (HCA), has been named by Secretary of Health and Human Services (HHS) Richard Schweiker as a member of the National Social Security Advisory Council. Howard is treasurer of the Federation of American Hospitals (FAH).

Howard

The 13-member Advisory Council will assist the HHS Secretary in formulating policy pertaining to Medicare, old age and survivors, and disability programs — with special emphasis on Medicare. □

This is an architect's drawing of a neighborhood clinic for the medically indigent at Louisville, Kentucky, which is being underwritten by Humana Inc., headquartered in that city. David A. Jones, Humana chairman and chief executive officer, says that the company is underwriting the capital cost of the center and will absorb any of its operating losses for the next three years. The clinic, called ACCESS, will be staffed by University of Louisville physicians. State, county and city officials are cooperating in the project, the first of a series to be located in the underserved areas of Louisville.

Bedrosian calls for Health Reform

John C. Bedrosian, president of the Federation of American Hospitals (FAH), believes that sweeping reform in health care reimbursement and widespread competition among the nation's hospitals and insurance companies represent underlying solutions to spiraling medical costs.

Bedrosian, executive vice president of National Medical Enterprises, Inc. (NME), told the Eighth Annual Conference of the National Association of Nurse Recruiters (NANR) at Chicago recently:

"The method used to reimburse Medicare and Medicaid costs has created problems for our industry and our society. It is an expensive and inflationary system. We, as a nation, can no longer afford it."

Bedrosian cited the need for (1) reform to revamp government reimbursement; (2) reform to eliminate abuse in health care; (3) reform to promote the appropriate level of care, and (4) reform to encourage competition — "the most effective weapon of a government free enterprise system."

He said that consumer choice in health care for all Americans "is no longer an option we can ignore," because, "when you consider the alternatives, it is the only acceptable answer." □

FTC challenges HCA

The Federal Trade Commission (FTC) has filed an administrative complaint against Hospital Corporation of America (HCA) of Nashville, Tennessee, alleging that the company's acquisition of Hospital Affiliates International (HAI) and Health Care Corporation (HCC) in 1981 would reduce competition among hospital and inpatient psychiatric facilities in the Chattanooga, Tennessee, area.

The FTC claims that HCA control of hospitals increased from 10 percent to 32 percent in a 13-county area in Southeastern Tennessee and Northern Georgia, and that its control of psychiatric services increased from 7 percent to 38 percent in the region.

Stating that HCA had been singled out by the FTC because of its size as the largest hospital management firm in the U.S., company officials predicted that the agency's antitrust challenge would not be sustained.

HCA acquired Nashville-based HAI in August, 1981, and the Chattanooga-based HCC in December, 1981.

The NEW LOOK in X-Ray Shielding

CLEAR-Pb™ MODULAR X-RAY BARRIERS

Module sections 48" and 36" wide, coupled at a 45° angle, provide a complete control enclosure.

Attractive, large-area LEAD-ACRYLIC windows permit panoramic views of x-ray rooms

- Wide variety of configurations.
- Simple on-site assembly and installation.
- Full radiation protection from floor to 84" high.

Existing control areas can be easily and economically expanded, especially where space is at a premium.

Also available

CLEAR-Pb™ LEAD-ACRYLIC VIEWING PANELS

For LARGE-AREA Shielding

"Clear-Pb" installed as a large, attractive viewing window.

More economical and easier to handle than x-ray plate glass. Savings up to 35%. Shatter-resistant sizes to 6 x 8 ft. Lead equivalency 0.3 to 2 mm. Distortion-free clarity.

A large selection of assembly hardware allows a variety of barrier designs with windows up to 8 feet wide.

For full details, ask for Bulletin 3183-R

VICTOREEN NUCLEAR ASSOCIATES

VICTOREEN

100 Voice Road
Carle Place, N.Y. 11514
(516) 741-6360
A Shelter Globe Corporation Subsidiary